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YALE-NEW HAVEN HOSPITAL

Annual Report for the Year 1966
Resolution on the occasion of the death of Arnon D. Thomas

The Directors of Yale-New Haven Hospital record their admiration of the life and work of their friend, colleague, and legal counsel, Arnon D. Thomas, a member of the Board and its Executive Committee since 1950, who died on November 11, 1966. In doing so they recall vividly his special qualities of mind and character. He was zealous in behalf of his clients beyond the capacity of most men, and prodigal in giving his time and energy in their interest. He was a fearless and skillful negotiator. He liked people and people liked him. They called him "the Judge" out of affection as well as respect. As he grew in his profession he drew the inspiration of his work increasingly from people rather than from papers. In the end he was a master in understanding the motives of men, their strengths and weaknesses, and the potential for good existing in their relations with one another. All this he generously applied to the benefit of Yale-New Haven Hospital. The sorrow of the Directors in losing him is tempered only by their joy in the usefulness of his life, and its effect upon the Connecticut community he loved so well.

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John M. C. Betts
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Stanley S. Trotman
Counsel
Arnon D. Thomas*
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*Deceased. November 11, 1966
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Harold L. Hahn

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Chief of Staff
Courtney C. Bishop, M.D.

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Vernon W. Lippard, M.D.
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Hugh L. Dwyer, M.D.

Secretary
Isao Hirata, Jr., M.D.

Past President
William R. Wilson, M.D.
The Changing Philosophy of Hospital Economics

Albert W. Snoke, M.D.
Executive Director

A great deal of time, thought and attention has been given, particularly in this past year, to the problems of hospital economics. By this is meant not just the accounts receivable, reimbursement formulae and the other familiar topics of red and black figures, but the over-all financial stability of a vital industry.

The voluntary hospital system of the United States is now going through an evolutionary change at a pace and manner which is revolutionary. It is imperative that current social, economic, political and medical trends regarding health care be recognized. By identifying and understanding these trends, the Yale-New Haven Hospital can more effectively plan to continue to meet its obligations to its community, its staff and its partner in the medical center, Yale University.

The mission of the hospital (its fourfold responsibility for patient care, teaching, research and community service) and its role of leadership in local, state and national health issues are of fundamental importance in our planning. Basic to the implementation of any programs required and expected by the community and the society that is served is an economically sound hospital.

At the present time, there are readily discernible trends in the financing of health care:

1. Hospital costs have been steadily increasing.
   For some years, this has been at a rate of five to seven percent a year. During the past twelve months, and for the coming year, increases probably will be 10 to 25 percent. This acceleration in rate is not difficult to understand, in light of the increasing complexity of hospital and medical care with resultant need for more personnel, equipment and buildings, the increase in national wage levels, and the fact that hospitals are a "labor intensive" industry wherein 65 to 70 percent of its costs are in wages and salaries. This percentage is substantially higher than for industry in general, and cannot be offset by increases in labor productivity as is possible in other types of industry. Unless there is some unforeseen and dramatic change in these factors, hospital per diem costs of more than $100 can be expected within a relatively few years.

2. Increasing numbers of patients are having their hospital bills paid in part or in full by third-party agencies.
   In addition to traditional commercial insurance and voluntary prepayment plans, participation by government agencies, local, state and Federal, in the financing of hospital care, is becoming increasingly a major factor. The Connecticut Hospital Association estimates that about 50 percent of all patient days in general hospitals in Connecticut will potentially be covered by governmental payment programs, the exact percentage depending upon local decisions as to eligibility. Title #18, Medicare, for those over sixty-five will account for approximately 29 percent of the inpatient days. The rest will be under Title #19, Medicaid, plus general welfare assistance and some special disease or age categories.
3. The trend is to utilize a cost basis formula in the payment for hospital patient care by third parties (Blue Cross, insurance, tax funds).

Since the passage of the Medicare law, the cost basis formula has become defined as “reasonable cost” and is expected to reflect, within reason, that cost involved in the care of patients for which a specific program has been designed. As a result, the hospitals are expected to provide separate and different cost figures for an increasing number of categories of patients, such as those over sixty-five, those covered by Workmen’s Compensation, maternity cases, Blue Cross patients, and a variety of welfare patients. The picture is further complicated by divisions between inpatient, outpatient, and emergency services for all of them.

4. The pattern for most reimbursement formulae has been based upon “accounting” principles as contrasted to “economic” principles.

There is no industry in this country that could long remain solvent if it were unable to recover sufficient income from its operations to cover losses in bad debts, required increases in working capital for increasing accounts receivable or inventory, or to replace equipment and plant at the current cost. Yet hospitals today face this dilemma. “Reasonable cost reimbursement based upon accounting principles,” as is stated in the Connecticut statutes, does not realistically recognize these needs.

5. Hospitals have traditionally overcharged the self-pay patient in order to obtain the funds necessary to subsidize the patient unable to pay his full cost.

This Robin Hood approach is economically unsound and morally unfair. As the volume of payment by third parties on a “reasonable cost” basis increases, the volume of patients paying published hospital charges naturally decreases.

6. Patients will be covered for their hospital expenses by third parties only when they meet the criteria established by the third-party agencies involved.

Classification is relatively simple for the patient over sixty-five and for the absolute pauper since in each case these categories can be well defined. However, there are many patients who are in between — the medically indigent. These are the individuals who are able to support themselves under ordinary circumstances but who do not have resources for meeting the unexpected and often costly expenses of medical care. They may be able to pay part of their incurred expense, but not all. This group causes the greatest financial loss to the hospital in its inpatient, outpatient and emergency services. It makes up the largest part of the free care subsidy which, last year, was approximately $1,500,000 at the Yale-New Haven Hospital. This group may continue to be a major source of financial loss to the hospital even after the implementation of Title #19, although it was planned to care for them. “Medical indigency” has no clear-cut definition. Decisions as to eligibility limits and amounts of payment need to be made at the local or state level, and on the individual circumstances of each case.

During the past two years, there has been a great deal of interest and activity on the part of the Community Council, the Mayor of New Haven and the mayors and selectmen of the area towns, in trying to understand and to help in solving the financial problems incurred by the Hospital of St. Raphael and the Yale-New Haven Hospital in rendering areawide community health service. The primary focus of these studies was the outpatient department. Policies and procedures have been clarified. In spite of the time, the effort and the good will, there still has been no substantial financial improvement.

There should be in Connecticut a new, bold and comprehensive approach to the provision of care for all hospital patients through a more equitable and realistic financial relationship between government agencies and health care institutions. This must come soon because of the serious present financial position of hospitals, which is being made more difficult by increasing demands made upon them.

The following guiding principles are suggested as a basis for such an approach. These have evolved over several years and have been brought into clearer focus by recent conferences with authorities in various pertinent fields.
1. The hospital’s responsibility should be that of providing efficient, economical and high quality patient and community service within the limits of its physical, financial and personnel resources to all individuals requiring such care. Society, through its government agencies, has the responsibility of underwriting this service totally for individuals unable to pay the cost and in a supplementary manner for those able to pay only part of the cost.

Hospitals should be concerned primarily with the provision of high quality health service that is economical, efficient, comprehensive, forward looking and community oriented, along with their concomitant responsibilities of teaching and research. The talents and time of the hospital staff should be devoted to professional patient care objectives which are major challenges in themselves. Their time and effort should not be diluted or inhibited by the necessity for searching for funds for the financing of the care of those individuals unable to pay part or all of the cost. Government has the responsibility for providing the funds for those who are the legal and moral responsibility of society in general.

2. Reimbursement for hospital services should reflect the total amount required to finance the hospital’s essential, efficient operations and necessary development.

The hospital should offer its health care facilities to those needing it at a charge that will enable the hospital to continue to function as a financially solvent institution. The charge for the services or the reimbursement rate established for third parties should be based upon sound economic principles as well as the traditional accounting ones. The determination of a reimbursement rate to hospitals on the basis of full and reasonable costs should reflect the total actual cost of operating the hospital as a business, not merely utilize accounting formulae that disregard or do not include income necessary to keep the hospital solvent.

3. A realistic definition of medical indigency requires the recognition by governmental agencies concerned with the concept of “part-pay.”

In defining medical indigency, it is important to recognize that in addition to the totally indigent and those who can maintain but cannot pay for medical care, there are those who are able and willing to pay for part of their medical care. The identification of those persons should be a part of the government’s total function as a purchaser of medical care for individuals who require such assistance. This decision should not be passed on to the hospitals. Any confusion as to whose responsibility is the determination of medical indigency, either in principle or in practice, may well defeat the purposes of the total program. The government should assume the financial responsibility to the hospital for the care of the indigent and the medically indigent including the part-pay patients. The obvious corollary is that the government should assume the responsibility of collecting the maximum amount indicated from the part-pay patient. Such a policy clearly places the government, not the hospital, in the position of underwriting the cost for those who are unable to pay for themselves. The need of the patient and a simplified demonstration of his ability or inability to pay for necessary services should be the primary determinants of eligibility for governmental assistance.

This philosophy would appear to be wholly consistent with current social trends. Through the past few decades government at all levels has evidenced an increasing tendency to purchase medical service rather than to provide medical care for persons whose care is defined as government’s responsibility. There has thus been developing a concept of “health security.” Basic to the health security concept is the principle that the government is responsible for paying the costs of health care of citizens wherever that cost exceeds the reasonable ability of the individual to pay. The goal is to rehabilitate the total person by averting the pauperizing effects of illness.

4. A single comprehensive state agency with uniform policies and procedures should be the method by which public medical and hospital care programs are administered.

In Connecticut, the existing governmental structure for administration of health and welfare programs is extremely complicated and confusing. The Yale-New Haven Hospital must deal with 169 separate city and town mayors and selectmen, as well as with local and state health and welfare officials. Reimbursement rates, eligibility requirements, administrative efficiency,
local budgets, and even philosophy, may differ markedly from town to town although the state department of welfare actually bears much of the cost, either directly or through matching local welfare payments. The State of Connecticut is small and compact. Its multitude of local and state welfare agencies could be integrated to form a single state agency to finance medical and hospital care for the indigent and medically indigent of the state. Such an integrated agency would promote efficiency and would provide a mechanism to assure high standards of care and utilization.

The Connecticut State Department of Welfare is the appropriate agency within whose framework such a program could be developed – particularly if it were possible to have the program separated from the name or connotation of welfare. This suggestion is not just semantics – there are fundamental underlying historical, philosophical and humanitarian principles and differences involved. “Health care” is now considered an individual right similar to that of food, clothing and shelter. It is of material advantage to society that citizens be healthy and self-supporting and that the concepts of preventive medicine, early diagnosis and treatment of disease and of rehabilitation be understood and readily available. “Welfare” has an unfortunate connotation that deters many individuals from seeking help from health care institutions. Governmental “welfare” bureaucracy also runs the risk of overcomplicating the mechanism by which the individual in need can obtain the financial assistance available from government agencies. This defeats the purpose of optimal health care and of adequately financing the health care institutions.

5. Simplified administrative procedures should be developed to certify eligibility and to permit efficient and economical high quality care.

Both the State of Connecticut and the voluntary hospital system in the state desire to provide the best health services to its citizens in an economical and efficient manner. It is essential to develop simplified procedures for the determination of eligibility, for transfer to less expensive and more appropriate centers for continuing care, for taking maximum advantage of the part-pay potential of the presently ignored large number of medically indigent and for developing smooth administrative relationships among a large number of institutions. These factors give additional emphasis to the desirability of establishing a single agency which would deal, in fiscal matters, with doctors, health care institutions and the home health agencies, as well as with the recipients of care.

6. Assurances need to be provided that government and other third-party reimbursing agencies receive full value for the payments that are made.

If hospitals are to receive full reimbursement for the services they provide to patients financed by third parties, hospitals must be prepared to provide adequate guarantees of efficiency, of quality of care, and of protection against unnecessary utilization and unnecessary expansion of facilities and/or programs. This guarantee will undoubtedly involve controls that hospitals must be prepared to accept in return for adequate reimbursement. Hospitals and their medical colleagues must also be prepared to explore in good faith alternate approaches to the control and distribution of health services if they expect to have the government and other third parties accept the principle of full-cost reimbursement for those health services provided. It is not reasonable for hospitals or physicians to expect a “blank check.”

The voluntary health system is facing a serious challenge. Questions are continually being raised concerning the increasing costs of medical and hospital care at the same time that social forces and governmental actions are forcing hospital costs to increase. There are national efforts toward “creative federalism,” in which the national government is assuming a widening influence in its partnership with voluntary institutions. Society cannot have it both ways. It cannot expect the voluntary hospital system to remain strong and viable if it is limited in its income but required to increase its expenses. The voluntary system equally cannot expect continued support as the major resource for hospital services without answering satisfactorily legitimate questions about quality, efficiency and economy. It is essential that all those concerned join in actively encouraging realistic and equitable policies, procedures and programs upon the part of local, state and national government as well as voluntary hospitals if the voluntary hospital system is to continue to serve this nation.
It is an annual custom and responsibility for a hospital

...
Hospital people serve a variety of needs: in the emergency department an average of one "emergency" every ten minutes; for the specialized requirements of the new 10-bed clinical research center on Hunter 5, less than one patient per day during its first year of service.
Report of the Administrator

Constant change is a traditional challenge and characteristic of an outstanding university teaching hospital. In institutions such as Yale-New Haven, a great deal of effort and activity continuously is directed towards bringing the latest advances of medical research and new technology to the care of the patient. To these on-going challenges were added, in 1966, those presented by the broad social health legislation which was enacted by the 89th Congress – Medicare, Medicaid and Regional Medical Programs. The full impact of these new programs, which comprise the most significant health legislation enacted in our nation’s history, will be increasingly felt over the next few years. 1966 saw only the initial steps of planning and implementation.

Our medical center can be justifiably proud of its activities to date with respect to the Regional Medical Programs. Briefly, the purposes of this legislation are to promote cooperative and comprehensive regional planning and action on the part of all concerned to make modern health care readily available to the people of a region in the most efficient and effective manner possible.

In the spring of 1966 an application for a planning grant under this program was prepared by representatives of the Yale-New Haven and University of Connecticut Medical Centers. A two year grant of $800,000 was awarded in June. This grant was one of the initial five awarded in the country and the organization and approaches contained in the application have been widely used as models for subsequent applications from other regions. Definitive planning began in earnest in October with the appointment of Henry T. Clark, Jr., M.D., formerly Administrator for Health Affairs at the University of North Carolina, to the position of Program Director of the Connecticut Regional Medical Program. The potential impact of this activity on the organization and quality of health care in Connecticut, and on Yale-New Haven Hospital, certainly is very significant.

270,000 Connecticut citizens, and more than 20 per-
cent of Yale-New Haven’s patients on any given day, became beneficiaries of Medicare on July 1, 1966. Largely due to the complexities of the legislation, the advent of this program necessitated the planning and implementation of a number of new and complex systems and procedures, especially in the Hospital’s business operations. Despite its built-in complexities in the area of paperwork processing, Medicare has many inherent qualities in addition to the obvious economic one which will be of lasting benefit to the health care consumer. The most significant of these is the accelerated study of, and changes in, the Hospital’s traditional relationships with extended care facilities, home health agencies and other purveyors of health care which it has motivated. This increased attention to closer cooperation and coordination between all health care agencies cannot help but significantly benefit the over-all quality of health services.

The attention given to the new social challenges in no way interfered with the Hospital’s continuing efforts to improve its facilities and services. Among significant improvements and additions during 1966, in addition to the Coronary Care Unit, which is discussed in Dr. Bishop’s report, were:

- The opening of a 21-bed unit on the fourth floor of the Hunter Building specifically designed for the care of older children. The availability of this facility has ended, for the present, the extreme shortage of pediatric beds that has plagued the Hospital for several years and has permitted a better grouping of children by age on all pediatric floors. A considerable portion of the financial resources necessary to construct this facility were provided by the New Haven Foundation and by donors to the Hospital’s Completion Fund of 1964.

- The opening of a clinical research center on the fifth floor of the Hunter Building. The construction of this facility, which was financed largely by generous gifts from the Lawrence M. Gelb Foundation and the Federal government, makes available considerably expanded and improved facilities for the conduct of clinical research, a vital factor in transmitting the knowledge gained in research laboratories to the armamentarium available to physicians and other health personnel in their treatment and care of patients.

Other improvements during the year were the construction of a children’s intensive care facility; new and expanded admitting and business services facilities in the New Haven Unit; and the modernization and renovation of the Hospital’s pharmacy. A large part of the pharmacy project was made possible by a generous gift of $50,000 from the Women’s Auxiliary.

At year’s end work had also begun on the construction of new diagnostic radiology and medical records facilities in the New Haven Unit and on a Perinatal Center in the Memorial Unit. This latter facility will permit considerable expansion of the medical center’s research and treatment programs for newborns.

As important as it is for a hospital to provide adequate facilities, the primary ingredient of excellent health care is people – the proper number of people, appropriately directed, who possess the required education, experience and skills. Thus, it is with great concern that we and other hospitals and health agencies throughout the nation face the ever increasing shortage of health manpower. The accelerating demands for all types of health personnel have more and more outstripped the available supply. Too late, it has been realized that the nation’s health programs and goals are in jeopardy due to the fact that health careers have not been competing effectively for the attention of the types of people who are required.

Although significant strides have been made in the recent past to reduce the economic gap that has existed for years between health careers and those in other fields, a considerable gap still exists which must be closed as soon as possible if a long range solution to the present crisis is to be approached.

In the fall of 1966, the Board of Directors of Yale-New Haven Hospital foresightedly authorized the largest increases in salaries and improved benefits in the Hospital’s history. These improvements alone involve an annual cost of $1,300,000 – more than $5.00 per patient per day. Other such steps will be necessary in the future if we are to continue to attract and retain the types of personnel required to provide the highest quality of care. Therefore, continuing significant increases in the cost of hospital care are inevitable.

Parallel with our activities to improve the economic status of our personnel, we are continuously intensifying our efforts to utilize our present resources in the most
effective and efficient manner. To assist in this area, Robert R. Schwarz, an industrial engineer, was appointed Systems Engineer in September 1966. Also, a new position of Director of Employee Education was established to which Lawrence A. Loomis has been appointed. In this capacity, Mr. Loomis, formerly Director of Transportation, Aides and Communications will assume responsibility for development of the Hospital’s employee orientation and supervisory training programs.

Other important appointments in 1966 included David Dolins as Administrative Assistant in Hospital Administration, James W. Allaben as Director of Pharmacy Services, replacing William S. Brown, who resigned, and Harold L. Hahn as Director of Transportation, Aides and Communications replacing Mr. Loomis. Also, in April 1966, Miss Patricia Tourey returned to her former position as Chief Medical Records Librarian which she left in 1965.

New members elected to the Board of Directors at the annual meeting in February 1966, were John E. Ecklund, James H. Gilbert, Lionel S. Jackson and Frank Kenna, Jr.

The death of Arnon D. Thomas in November was a tremendous loss to the Hospital as well as to the New Haven community. Mr. Thomas had been a valuable member of the Board of Directors since 1950 and for many years served as the Hospital’s legal counsel.

During the fiscal year which ended September 30, 1966 the volume of services to patients increased in all categories except in maternity and newborn services. The continuing decline in the number of births and maternity and newborn patient days in Yale-New Haven Hospital is consistent with national experience. During the late 1950s and early 1960s experts predicted a “baby boom” beginning in 1965 and were concerned that hospital obstetrical facilities were not being expanded sufficiently to meet the coming demand. Instead of a “boom”, in 1966 Yale-New Haven and several other Connecticut hospitals received authorization from the State Department of Health to assign, under carefully controlled conditions, some obstetrical beds to gynecological patients. This has resulted in slightly improved utilization of the under-used obstetrical facilities.

As shown in the financial statement, the Hospital had an operating loss of $550,675 for the year ending September 30, 1966. Consistent with the practice of previous years, endowment and other non-operating income was diverted from other necessary purposes to reduce the final deficit for the year to $91,244.

1966 brought little improvement in the Hospital’s chronic problem of financial undernourishment. In April the long planned and awaited program through which area cities and towns assumed responsibility for payment for clinic services to medically indigent patients went into effect. However, excessively stringent eligibility restrictions and the reluctance of many persons to “apply for welfare” have combined to keep the amount of financial assistance from this program far below the level originally anticipated. An increase in July of $1.00, from $5.00 to $6.00, in the State’s maximum payment for indigent patient clinic visits and an increase of $1.50, from $6.00 to $7.50, in their payment for emergency service visits did not even keep pace with the preceding year’s increase in the cost of providing these services. The causes of the major financial problems of the Hospital, therefore, remain unchanged — unrealistic eligibility standards for welfare assistance and inadequate welfare reimbursement for the care of ambulatory patients. Legislative action to correct these situations is absolutely essential in 1967.

In summary, 1966 was a year of considerable advance and improvement in many areas at Yale-New Haven Hospital, as well as a year which presented a number of exciting new challenges to both the Hospital and the health field generally. The fact that significant improvement was possible is a tribute to all — employees, medical staff, Board members, volunteers and friends, whose dedicated efforts make Yale-New Haven Hospital the outstanding, dynamic institution that it is.
Lobby, Memorial Unit
Report of the Chief of Staff

Under the able guidance of Dr. Hugh L. Dwyer as president, formal organizational activities of the Medical Staff continued without interruption throughout the year. The staff met for dinner and business meetings in October, December, February and April. Dr. Isao Hirata, Jr., as Secretary, created with artist's touch an historical record of accurate detail.

The Medical Board met regularly each month except August. In addition to its routine business, special attention was directed to implementation of the Articles of Affiliation between the Hospital and Yale University which had been formally accepted by the Board of Directors on March 22, 1965. Pertinent to this implementation was revision of the Bylaws for the Medical Staff. The final draft of the new document - in which had been incorporated all changes necessary in terms of the affiliation - was completed during the fall, transmitted to the Board of Directors and approved by them in January. These Bylaws became effective July 1, 1966.

After exhaustive study by an ad hoc committee, the Medical Board approved its report which described the study of the five approved programs for family practice residency in university medical centers. The report recommended that, since success of these programs was minimal and there remained more than a few unfilled positions in them, there be no change in the resident training programs of the Yale-New Haven Medical Center.

In anticipation of the requirement for a Utilization Committee of the medical staff the Board voted to
establish such as a new standing committee. The committee was authorized to review appropriate samples of all categories of patients regardless of age and source of payment. It was the intent of this review to foster the maintenance of high quality patient care and enhance the effective utilization of hospital services through an educational program that emphasizes the study of patterns of care. The functions of the committee were defined as investigative and fact finding rather than punitive; its recommendations will be submitted to the Medical Board for implementation.

Patient Care

In addition to regularly continuing improvement and extension of patient care facilities throughout the hospital, two especially significant new services were initiated during the year. Increased flexibility of use of certain obstetrical and gynecological beds was also achieved.

On July 5, 1966, a five-bed Coronary Care Unit, structurally contiguous to the Intensive Care facility on the eighth floor of the Memorial Unit, was opened to serve as the primary receiving station for patients admitted for care of acute myocardial insults. An initial gift by the family of the late Frederick D. Grave and subsequent supporting gifts by the family of the late Harold Mossberg, the New Haven Heart Association memorials account and the John Echlin Foundation provided the essential financing. The unit has been fully equipped with built-in electronic monitoring and warning devices so as to provide its staff of specially trained physicians and nurses maximum opportunity for modern, sophisticated care during the life threatening early days of this major component of medical admissions.

Upon recommendation of the Medical Board and approval of the Board of Directors, in an effort to provide badly needed private beds and simultaneously enhance the teaching program, ten additional patient beds on 8 East were assigned to the medical service on July 1, 1966. Patients admitted to these beds with approval of their private attending physicians have been identified for medical student instruction and for teaching rounds conducted by the full time faculty.

Under new provisions of the Connecticut Public Health Code which permit use of common facilities by obstetrical and uncomplicated gynecological cases, ten beds on 4 West A were designated for this purpose in mid-summer of 1966. Operational policy established priority of use of these spaces for maternity cases.

Staff Organization

Having served with distinction as Chief of the Department of Surgery since October, 1947, Dr. Gustaf E. Lindskog voluntarily relinquished this post on September 1, 1966 and was succeeded by Dr. Jack W. Cole. Dr. Cole, a graduate of the Washington University School of Medicine and the surgical residency of The University Hospitals of Cleveland, served as a member of the faculty of the Western Reserve University School of Medicine and the surgical department of The University Hospitals from 1952 to 1963. Following three years as Chairman of the Department and Chief of Surgery at Hahnemann Medical College and Hospital of Philadelphia, he brings to the Yale-New Haven Hospital a rich experience in teaching and research as well as a dedicated concept of patient care.

Also on September 1, 1966, Dr. Edward J. Quilligan assumed the position of Chief of Obstetrics and Gynecology to succeed Dr. C. Lee Buxton who withdrew for reasons of health after 12 years as Chairman of that Department. Dr. Quilligan received his undergraduate and the early years of his postgraduate education in medicine at Ohio State University. Following completion of his residency in Obstetrics and Gynecology at The University Hospitals of Cleveland he continued his academic association with the Western Reserve University School of Medicine to become, in 1963, Chairman and Director, Department of Obstetrics and Gynecology at the Cleveland Metropolitan General Hospital. Beginning in 1965, he served in the same capacity at U.C.L.A. School of Medicine, Los Angeles and the Harbor General Hospital in neighboring Torrance, California. An enthusiastic investigator and able teacher, Dr. Quilligan brings to the Hospital an unusual clinical ability that will provide effective leadership to that service.

During the period of this report, Dr. Robcliff V. Jones, Jr., withdrew from his position as Director of the Division of Physical Medicine and Rehabilitation to devote his full energies to an investigative program in this discipline.

Other changes in status of the Medical Staff from October 1, 1965 to September 30, 1966 are as follows:
Coronary Care Unit opened July 5, 1966.
### Appointments

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Rank</th>
</tr>
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<tbody>
<tr>
<td>Alan Balsam</td>
<td>Psychiatry</td>
<td>Associate</td>
</tr>
<tr>
<td>Robert E. Becker</td>
<td>Psychiatry</td>
<td>Assistant Attending</td>
</tr>
<tr>
<td>Octavio Bessa, Jr.</td>
<td>Psychiatry</td>
<td>Physician to Outpatient Dept.</td>
</tr>
<tr>
<td>Abner G. Bevin</td>
<td>Surgery</td>
<td>Associate</td>
</tr>
<tr>
<td>Malcolm B. Bowers</td>
<td>Psychiatry</td>
<td>Assistant Attending</td>
</tr>
<tr>
<td>Robert S. Briggs</td>
<td>Medicine</td>
<td>Physitian to Outpatient Dept.</td>
</tr>
<tr>
<td>Gerard N. Burrow</td>
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*status changed during year. See list of changes.

†Full-time.

Appointments: Full-time, 44; Other, 19; Outpatient, 13. Total new appointments: 76.
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<td>Stephen P. Magyar</td>
<td>Surgery</td>
<td>(Otolaryngology)</td>
<td>Associate</td>
<td>Resigned</td>
</tr>
<tr>
<td>Gilbert S. Melnick</td>
<td>Radiology</td>
<td>Associate</td>
<td>Associate</td>
<td>Resigned</td>
</tr>
<tr>
<td>Richard H. Paul</td>
<td>Obs./Gyn.</td>
<td>Associate</td>
<td>Associate</td>
<td>Resigned</td>
</tr>
<tr>
<td>William B. Rich</td>
<td>Psychiatry</td>
<td>Attending</td>
<td>Attending</td>
<td>Resigned</td>
</tr>
<tr>
<td>James W. Rowe</td>
<td>Radiology</td>
<td>Ass’t Attending</td>
<td>Ass’t Attending</td>
<td>Resigned</td>
</tr>
<tr>
<td>James H. Scatliff</td>
<td>Radiology</td>
<td>Ass’t Attending</td>
<td>Ass’t Attending</td>
<td>Resigned</td>
</tr>
<tr>
<td>Allan L. Simon</td>
<td>Surgery</td>
<td>Courtesy</td>
<td>Courtesy</td>
<td>Resigned</td>
</tr>
<tr>
<td>Norman Smith</td>
<td>Surgery</td>
<td>(Otolaryngology)</td>
<td>Associate</td>
<td>Resigned</td>
</tr>
<tr>
<td>Mark W. Steele</td>
<td>Pediatrics</td>
<td>Physician to Outpatient Dept.</td>
<td>Physician to Outpatient Dept.</td>
<td>Removed from area</td>
</tr>
</tbody>
</table>

**Net increase in staff: 41**
Entrance, New Haven Unit
In April 1967 the Women’s Auxiliary will mark its fifteenth anniversary. During these years, through the efforts of our volunteers, the public relations committee and by our fund-raising projects, the Auxiliary has created and maintained an active partnership with the staff of this Hospital.

The Auxiliary aims at encouraging greater understanding and appreciation of the Hospital in the community by means of its quarterly newsletter and the showings of its film, “Today’s Medical Center.” Leading members of the staff and Medical School have spoken at meetings of the Board and general membership.

Last year more than 37,000 hours were donated by 450 volunteers of whom 171 were juniors. They served in the admitting offices, emergency room, clinics, on the pediatric floors, in preparing surgical dressings as well as in staffing the coffee and gift shops and library cart.

All operating expenses of the Auxiliary have been met through the dues of its 800 members. During our financial year ending March 31, 1966, the Coffee Shop netted $10,754 and the Gift Shop $17,588. This, together with a $1,500 commission from the Baby Photos, enabled us to budget $29,842 in Hospital projects for the year 1966–1967. Included in this sum is the first of two payments of $25,000 towards the renovation of the Pharmacy area and $2,150 in drawing accounts to be used by the pediatric divisions, clinics and for other special patient needs.

Since the spring of 1952, therefore, the Auxiliary has donated a total of $303,817 to the Hospital.
Medical Staff
as of September 30, 1966

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Kurt F. Schmidt
Robert I. Schrier
Daniel C. Weaver
Robert L. Willenkin
Michel Wugmeister

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Demetrios B. Kalas
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Etsuro Motoyama

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Director of Clinical Microbiology
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Wilbur D. Johnston
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Milton Lisansky
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David Stamm
Herman B. Tenin

Associate
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George O. Gelnas, Jr.

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Stanton B. Fater
Richard H. Ferraro
Arnon R. Hertz
Harvey A. Lichter
Elliott S. Perlman
Gerald St. Marie
Jerome M. Serling
Earl Slusky
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Angus F. White

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Associate Chief
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A. Bliss Dayton

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Harold L. Ehrenkrantz (Pulmonary)
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Barnett Greenhouse
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John S. Hathaway
Kirby Howelett, Jr.
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Louis H. Nahum
John B. O’Connor
John R. Paul
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C. Seaver Smith

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Elisha Atkins
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Hyman A. Chernoff
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Gideon K. deForest
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James W. Innes
Carl A. Jaeger
Herman L. Kamenetz
(Physical Medicine)
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Neville Kirsch
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Alvin Lichtman
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Nicholas Milazzo
(Cardiopulmonary)
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Abbot A. Newman
Robert G. Nims
James T. Nixon
Kristyna Nyerick
Ulrich K. Rathey

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Haskell M. Rosenbaum
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Raphael D. Schwartz
Morris J. Seide
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Philip Felig
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Ronald Fishman
Morris Freedman
Josephine M. Fuhrmann
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Leonard Garren
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and Gynecology

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*leave of absence

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Averill A. Liebow
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S. Evans Downing

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Philip M. Sarrel
Maclyn E. Wade

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Stefanie Z. Roth

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David F. Conway, Jr.
Edward J. Day
Michael H. Lavorgna
Edward B. O'Connell
William V. Palluotto
William D. Riordan
Bernard R. Swan
Gertrude J. Vermande

Clinical Fellows
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Adnan Mroueh

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Associate Chief
David H. Clement

Assistant Associate Chief
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Grover F. Powers

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Herman Yannet
Carlos B. Zilveti

Emeritus
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Vivian Tappan
Joseph Weiner

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Frederic M. Blodgett
Paul L. Bossert
Harold D. Bornstein, Jr.
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Charles D. Cook
Charles S. Culotta
Raymond S. Duff
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William Glaser
Louis Gluck
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Jerome A. Grunt
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Elizabeth R. Harrison
Dorothy M. Horstmann
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Alan C. Mermann
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Nelson K. Ordway
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Charles F. Schohlamer
Milton J. E. Senn
Albert J. Solnit
Carter Stilson
Norman S. Talner
Morris Wessel
Ruth Whittemore
William R. Wilson
Harrison F. Wood
Assistant Attending
Francis J. Albis
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Assistant Chief
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Consulting
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Despine L. C. Liebhaber
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C. Robert Rubenstein
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Marc D. Schwartz
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Assistant Chief
Arthur R. Clemett

Consulting
Ralph J. Littwin

Attending
Arthur R. Clemett
Michael D'Amico
Richard H. Greenspan
Morton M. Kligerman

*leave of absence
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Maxwell Lear
Anthony J. Mendillo
Ralph W. Nichols

Attending
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*leave of absence
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Peter Iaccarino
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Wilbur D. Johnston
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Angus F. White

Consulting
Denis S. O’Connor

Attending
Alexander L. Bassin
Russell V. Fuldner
William S. Perham
A. David Poveman
Earl J. Rhoades
A. Lewis Shure
Ned M. Shutkin
Charles K. Skreczko
Wayne O. Southwick

Assistant Attending
Hubert S. Bradburn
Eugene J. Frechette
Willard F. Greenwald
Martin L. Sumner

Associate
James A. Albright
Alan H. Goodman
Kristaps J. Keggi
Robert N. Margolis
Donald A. Nagel
Ulrich H. Weil

Physicians to the Outpatient Department
George E. Becker
Oscar D. Chrisman
Donald S. Dworken
MacEllis K. Glass
John H. Moore
Philip L. Staub

Emeritus
Harry L. Berman

Consulting
Paul B. MacCready
Samuel J. Silverberg

Attending
John A. Kirchner
Charles Petrillo
Howard W. Smith

Assistant Attending
David A. Hilding
Robert S. Rosnagle
Eiji Yanagisawa

Orthopedic Surgery
Section Chief
Wayne O. Southwick

Otorhinolaryngology
Section Chief
John A. Kirchner

Associate Section Chief
Charles Petrillo

Emeritus
Harry L. Berman

Consulting
Paul B. MacCready
Samuel J. Silverberg

Attending
John A. Kirchner
Charles Petrillo
Howard W. Smith

Assistant Attending
David A. Hilding
Robert S. Rosnagle
Eiji Yanagisawa

Emeritus
Jacob Sharp
Attending
Augustine L. Cavallaro
Newton E. Faulkner
Terry E. Hiltunen
Peter Iaccarino
Donald F. Johnston
Wilbur D. Johnston
William A. Kirschner
Walter S. Langston
William M. Lawrence
John B. Noll
James P. Pigott
Herbert R. Sleeper
Howard W. Smith

Assistant Attending
Philip S. Gordon
Bernard Levine
Milton Lisansky
George M. Montano
James A. Piccolo
Samuel C. Rockoff
David Stamm
Herman B. Tenin

Associate
Benjamin Ciola
Wilbur N. Falk
George O. Gelinas, Jr.

Courtesy
Louis Angell
Joseph J. Dickstein
Stanton B. Fater
Harry Goldner
Richard D. Grossman
Harold L. Horton
Harvey A. Lichter
John J. McDougall
Richard F. McGuire
Daniel C. McMahon
Irving W. Mohr
Harold T. Moore
Francis R. Mullen
Conrad W. Newberg
Samuel H. Pinn
William H. Pitts
David A. Rozen
Gerald St. Marie
Robert W. Seniff
Jerome M. Serling
Charles M. Stain
Albert K. Snyder
William R. Tyson
James A. Washington, Jr.
Angus F. White

Consulting
Denis S. O’Connor

Attending
Alexander L. Bassin
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Kristaps J. Keggi
Robert N. Margolis
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Ulrich H. Weil

Physicians to the Outpatient Department
George E. Becker
Oscar D. Chrisman
Donald S. Dworken
MacEllis K. Glass
John H. Moore
Philip L. Staub

Emeritus
Harry L. Berman

Consulting
Paul B. MacCready
Samuel J. Silverberg

Attending
John A. Kirchner
Charles Petrillo
Howard W. Smith

Assistant Attending
David A. Hilding
Robert S. Rosnagle
Eiji Yanagisawa
House Staff

Internal Medicine

Residents

John E. Fenn (to 12/31/66)
John H. Hagemann (to 12/31/66)
Jean E. Morin (from 1/1/67)
Warren D. Widmann (from 1/1/67)

Assistant Residents

O. Joseph Bizzozerio, Jr.
James L. Boyer
John P. Burke
Robert L. Capizzi
Robert C. Charman
Richard N. Collins
John P. Comstock
Joshua Fierer
Robert H. Gifford
John A. Godley
Peter B. Gregory
William J. Hall
Glen W. Hamilton
Walter J. Hierholzer, Jr.
David A. Hill
Harvey I. Hurwitz
E. Larry Knight
Edwin L. Prien, Jr.
R. Beavens Randall, Jr.
William A. Renert
Leonard M. Selsky
Barry S. Strauch
Robert C. Talley
James W. Wood

Interns

John D. Baxter
A. Roger Bobowick
Robert W. Hayward
Robert B. Jaffe
Edward B. Lewin
Charles J. Lightdale
William H. Likosky
David B. Melchinger
Arthur J. Merril, Jr.
Robert J. Mignone
Elie H. Newberger
Edward J. O'Keefe
O. L. Puttler
David H. Riddick
James G. Saming, Jr.
Robert T. Solis
Arne S. Youngberg

Veterans Administration Hospital

Resident

William B. Burns, Jr.

Assistant Resident

John N. Forrest, Jr.

Physical Medicine and Rehabilitation

Resident

Nessan McCann

Surgery

Residents

John E. Fenn (to 12/31/66)
John H. Hagemann (to 12/31/66)
Jean E. Morin (from 1/1/67)
Warren D. Widmann (from 1/1/67)

Assistant Residents

Constantine Anagnostopoulos
Paul J. P. Bolanowski
Alan L. Breed
David D. Burtner
David G. Campbell
Girad A. Chapnick
Michael J. Cummings
Richard O. Danford
Richard S. Dutton
Joseph D. Ferrone, Jr.
Robert A. Gryboski
Jerald J. Principato
A. Richard Pschirrer, Jr.
Robert A. Ralph
Richard M. Rubinson
John H. Seashore
Robert L. Shelton
Charles P. Shoemaker, Jr.
John R. Soeter
Daniel W. Van Heeckeren
Robert B. Winslow

Cardiovascular

Residents

John A. Galloway (from 1/1/67)
William G. Meffert (to 12/31/66)
Joshua Miller

Thoracic

Residents

John A. Galloway (to 12/31/66)
William G. Meffert (from 1/1/67)

Assistant Residents

Interns

Robert C. Bone
David W. Connors
Robert E. Dragon
James H. Drews
Gerard A. Engh
Bruce W. Jafek
Thomas J. Koontz
Joseph W. Lewis
Caroline O. McCagg
Donald C. Rankin
Joel B. Singer
James D. Slavin, Jr.
Richard L. Snider
Joan L. Venes
Lawrence J. Warter
George W. Wharton

Anesthesiology

Residents

Leonard Gold (from 9/1/66)
Hiroshi Naito
John A. Short (to 8/31/66)

Otolaryngology

Residents

Robert S. Gillcash (to 9/30/66)
Irving Guttenberg
(From 10/1/66 to 12/31/66)
Seth U. Thaler (from 1/1/67)

Oral Surgery

Residents

Ramiro Alfaro
Leonard G. Othon

Orthopedic Surgery

Residents

John B. H. Caldwell
Douglas E. Gaasterland
John W. Garden
Philip M. Gaynes (to 12/31/66)
Michael Gilman

Neurosurgery

Residents

Paul J. Jakubiak (to 12/31/66)
Norman H. Gahm (from 1/1/67)

Assistant Residents

Michael L. Apuzzo
David M. Geetter
John N. German
Richard M. Swengel

Ophthalmology

Resident

Philip M. Gaynes (from 1/1/67)

Assistant Residents

John W. Gainor
Richard P. Hockman
Glenn L. Kelly
Gerard J. Lawrence
Richard M. Linburg
Elliot Schiffman

Radiology

Resident

William A. Miller (to 12/31/66)

Assistant Residents

Joseph W. Andreole
Frank H. Boehm
Peter A. Fleming
John A. Freeman (from 8/1/66)
Gary L. Gross
John C. Hobbins
Marshall R. Holley
Robert F. Maudsley
Kenneth A. Pruett
Robert Resnik
Edward C. Werner
Leonard H. Zamore

Urology

Residents

James W. Thompson (to 12/31/66)
Stuart J. Schwartz (from 1/1/67)

Assistant Residents

Norman A. Bloom
Marvin B. Brooks
Howard C. Pomeroy
Martin Schiff, Jr.

Obstetrics and Gynecology

Residents

Philip J. DiSaia
Philip M. Sarrel

Assistant Residents

Joseph P. Andriele
Frank H. Boehm
Peter A. Fleming
John A. Freeman (from 8/1/66)
Gary L. Gross
John C. Hobbins
Marshall R. Holley
Robert F. Maudsley
Kenneth A. Pruett
Robert Resnik
Edward C. Werner
Leonard H. Zamore

Pathology

Resident

Robert R. Rickert
Composition of the Medical Staff

Honorary ........................................ 12
Consulting ........................................ 37
Emeritus ........................................... 10

Active Staff
Attending ......................................... 230
Assistant Attending ............................. 154
Associate .......................................... 212
Total .............................................. 505

Courtesy ........................................... 134

Dentists and Physicians to the Outpatient Department ......................................... 154
Total ................................................ 288
Less Duplications ................................ 7
TOTAL MEDICAL STAFF ..................... 845

House Staff
Clinical Fellows .................................... 121
Interns and Residents ........................... 219
Total .............................................. 340

Professional Staff (non-M.D.) ................. 21

GRAND TOTAL ................................... 1,206

Included in the above are:
Full-time physicians* ........................... 197
General practitioners ........................... 59

*Includes physicians with offices at Veterans Administration Facility and Mental Health Center who also have Yale-New Haven Hospital appointments.
# Comparative Statement of Income and Expense

*For Years Ended September 30, 1966 and 1965*

## INCOME FROM PATIENT SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room, board and nursing</td>
<td>$8,800,659</td>
<td>$8,745,045</td>
</tr>
<tr>
<td>Clinics</td>
<td>657,523</td>
<td>671,317</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>424,185</td>
<td>311,240</td>
</tr>
<tr>
<td>Special services</td>
<td>9,695,891</td>
<td>7,572,736</td>
</tr>
<tr>
<td><strong>Total – Gross</strong></td>
<td>$19,578,258</td>
<td>$17,300,338</td>
</tr>
</tbody>
</table>

### Income Deductions

<table>
<thead>
<tr>
<th>Category</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual allowances</td>
<td>$1,520,442</td>
<td>$1,220,962</td>
</tr>
<tr>
<td>Other allowances</td>
<td>706,086</td>
<td>681,699</td>
</tr>
<tr>
<td>Provision for bad debts (Net of Recoveries)</td>
<td>1,528,055</td>
<td>869,084</td>
</tr>
<tr>
<td><strong>Total – Deductions</strong></td>
<td>$3,754,583</td>
<td>$2,771,745</td>
</tr>
</tbody>
</table>

**Total – Net Income from Patient Services**

<table>
<thead>
<tr>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,823,675</td>
<td>$14,528,593</td>
</tr>
</tbody>
</table>

## INCOME FOR PATIENT CARE

<table>
<thead>
<tr>
<th>Source</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Bed Funds</td>
<td>$139,783</td>
<td>$135,237</td>
</tr>
<tr>
<td>United Fund</td>
<td>58,773</td>
<td>55,828</td>
</tr>
<tr>
<td><strong>Total – Income for Patient Care</strong></td>
<td>$198,556</td>
<td>$191,065</td>
</tr>
</tbody>
</table>

**TOTAL – OPERATING INCOME**

<table>
<thead>
<tr>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>$16,022,231</td>
<td>$14,719,658</td>
</tr>
</tbody>
</table>

## OPERATING EXPENSES

<table>
<thead>
<tr>
<th>Category</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and supplies</td>
<td>$15,623,531</td>
<td>$14,452,048</td>
</tr>
<tr>
<td>Depreciation</td>
<td>886,582</td>
<td>796,791</td>
</tr>
<tr>
<td>Interest</td>
<td>62,793</td>
<td>65,358</td>
</tr>
<tr>
<td><strong>Total – Operating Expenses</strong></td>
<td>$16,572,906</td>
<td>$15,314,197</td>
</tr>
</tbody>
</table>

**OPERATING LOSS**

<table>
<thead>
<tr>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>$550,675</td>
<td>$594,539</td>
</tr>
</tbody>
</table>

## NON-OPERATING INCOME

<table>
<thead>
<tr>
<th>Source</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endowment Fund income</td>
<td>$135,119</td>
<td>$120,679</td>
</tr>
<tr>
<td>Yale University appropriation</td>
<td>205,000</td>
<td>187,031</td>
</tr>
<tr>
<td>State of Connecticut appropriations</td>
<td>64,287</td>
<td>59,687</td>
</tr>
<tr>
<td>Other</td>
<td>90,529</td>
<td>92,665</td>
</tr>
<tr>
<td><strong>Total – Gross</strong></td>
<td>$494,935</td>
<td>$460,062</td>
</tr>
</tbody>
</table>

### Less non-operating expenses

<table>
<thead>
<tr>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>35,504</td>
<td>34,432</td>
</tr>
</tbody>
</table>

**TOTAL – NON-OPERATING INCOME**

<table>
<thead>
<tr>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>$459,431</td>
<td>$425,630</td>
</tr>
</tbody>
</table>

**EXCESS INCOME OR (EXPENSE)**

<table>
<thead>
<tr>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ (91,244)</td>
<td>$(168,909)</td>
</tr>
</tbody>
</table>
# Comparative Balance Sheet

*For Years Ended September 30, 1966 and 1965*

## Assets

### GENERAL FUNDS:

<table>
<thead>
<tr>
<th>Item</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$111,061</td>
<td>$386,405</td>
</tr>
<tr>
<td>Accounts Receivable (Net)</td>
<td>3,736,191</td>
<td>3,740,583</td>
</tr>
<tr>
<td>Inventories</td>
<td>651,221</td>
<td>630,611</td>
</tr>
<tr>
<td>Other Assets</td>
<td>233,420</td>
<td>200,380</td>
</tr>
<tr>
<td>Due from Temporary Funds</td>
<td>170,503</td>
<td>102,017</td>
</tr>
<tr>
<td>Due from Endowment Funds</td>
<td>154,240</td>
<td>70,840</td>
</tr>
<tr>
<td><strong>TOTAL – GENERAL FUNDS</strong></td>
<td><strong>$5,056,636</strong></td>
<td><strong>$5,130,836</strong></td>
</tr>
</tbody>
</table>

### ENDOWMENT AND SPECIAL FUNDS:

<table>
<thead>
<tr>
<th>Item</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$(11,672)</td>
<td>$(149,515)</td>
</tr>
<tr>
<td>Investments</td>
<td>11,723,683</td>
<td>11,724,256</td>
</tr>
<tr>
<td>Due from General Funds</td>
<td>2,208</td>
<td>—</td>
</tr>
<tr>
<td>Land, buildings and equipment</td>
<td>876,353</td>
<td>886,391</td>
</tr>
<tr>
<td><strong>TOTAL – ENDOWMENT AND SPECIAL FUNDS</strong></td>
<td><strong>$12,590,572</strong></td>
<td><strong>$12,461,132</strong></td>
</tr>
</tbody>
</table>

### TEMPORARY FUNDS:

<table>
<thead>
<tr>
<th>Item</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$18,746</td>
<td>$79,602</td>
</tr>
<tr>
<td>Investments</td>
<td>650,379</td>
<td>588,453</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>275,506</td>
<td>104,276</td>
</tr>
<tr>
<td>Due from Endowment and Special Funds</td>
<td>1,024</td>
<td>—</td>
</tr>
<tr>
<td><strong>TOTAL – TEMPORARY FUNDS</strong></td>
<td><strong>$945,655</strong></td>
<td><strong>$772,331</strong></td>
</tr>
</tbody>
</table>

### PLANT FUNDS:

<table>
<thead>
<tr>
<th>Item</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land, buildings and equipment (Net)</td>
<td>$17,875,120</td>
<td>$17,205,433</td>
</tr>
<tr>
<td>Construction in progress</td>
<td>500,130</td>
<td>582,639</td>
</tr>
<tr>
<td><strong>TOTAL – PLANT FUNDS</strong></td>
<td><strong>$18,375,250</strong></td>
<td><strong>$17,788,072</strong></td>
</tr>
</tbody>
</table>

### GROSS TOTAL – ALL FUNDS:

<table>
<thead>
<tr>
<th>Item</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less inter-fund accounts</td>
<td>327,975</td>
<td>189,447</td>
</tr>
<tr>
<td><strong>NET TOTAL – ALL FUNDS</strong></td>
<td><strong>$36,640,138</strong></td>
<td><strong>$35,962,924</strong></td>
</tr>
</tbody>
</table>
## Liabilities, Capital and Principal of Funds

### GENERAL FUNDS:

<table>
<thead>
<tr>
<th>Description</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts payable</td>
<td>$796,636</td>
<td>$996,649</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>166,628</td>
<td>129,905</td>
</tr>
<tr>
<td>Deferred income</td>
<td>196,870</td>
<td>201,117</td>
</tr>
<tr>
<td>Special purpose funds</td>
<td>336,931</td>
<td>460,125</td>
</tr>
<tr>
<td>Due to endowment and special funds</td>
<td>2,208</td>
<td>16,590</td>
</tr>
<tr>
<td>Working capital</td>
<td>3,557,363</td>
<td>3,326,460</td>
</tr>
<tr>
<td>TOTAL - GENERAL FUNDS</td>
<td>$5,056,636</td>
<td>$5,130,836</td>
</tr>
</tbody>
</table>

### ENDOWMENT AND SPECIAL FUNDS:

<table>
<thead>
<tr>
<th>Description</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal of Funds</td>
<td>$2,634,975</td>
<td>$2,648,472</td>
</tr>
<tr>
<td>Free Bed</td>
<td>2,223,804</td>
<td>2,235,725</td>
</tr>
<tr>
<td>Restricted and non-expendable</td>
<td>26,002</td>
<td>26,707</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>7,550,527</td>
<td>7,479,388</td>
</tr>
<tr>
<td>William Wirt Winchester</td>
<td>154,240</td>
<td>70,840</td>
</tr>
<tr>
<td>Due to General Funds</td>
<td>1,024</td>
<td></td>
</tr>
<tr>
<td>Due to Temporary Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL - ENDOWMENT AND SPECIAL FUNDS</td>
<td>$12,590,572</td>
<td>$12,461,132</td>
</tr>
</tbody>
</table>

### TEMPORARY FUNDS:

<table>
<thead>
<tr>
<th>Description</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to General Funds</td>
<td>$170,503</td>
<td>$102,017</td>
</tr>
<tr>
<td>Principal of Funds</td>
<td>775,152</td>
<td>670,314</td>
</tr>
<tr>
<td>TOTAL - TEMPORARY FUNDS</td>
<td>$945,655</td>
<td>$772,331</td>
</tr>
</tbody>
</table>

### PLANT FUNDS:

<table>
<thead>
<tr>
<th>Description</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgages payable</td>
<td>$1,354,625</td>
<td>$1,403,605</td>
</tr>
<tr>
<td>Capital invested in property and equipment</td>
<td>17,020,625</td>
<td>16,384,467</td>
</tr>
<tr>
<td>TOTAL - PLANT FUNDS</td>
<td>$18,375,250</td>
<td>$17,788,072</td>
</tr>
</tbody>
</table>

### GROSS TOTAL - ALL FUNDS:

<table>
<thead>
<tr>
<th>Description</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>GROSS TOTAL - ALL FUNDS</td>
<td>$36,968,113</td>
<td>$36,152,371</td>
</tr>
<tr>
<td>Less inter-fund accounts</td>
<td>327,975</td>
<td>189,447</td>
</tr>
<tr>
<td>NET TOTAL - ALL FUNDS</td>
<td>$36,640,138</td>
<td>$35,962,924</td>
</tr>
</tbody>
</table>
## Comparative Statistics

*For Years Ended September 30, 1966 and 1965*

<table>
<thead>
<tr>
<th>Category</th>
<th>1966</th>
<th>1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients discharged during the year</td>
<td>29,811</td>
<td>30,244</td>
</tr>
<tr>
<td>Patient days care rendered</td>
<td>246,005</td>
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<tr>
<td>Average length of patients' stay (days)</td>
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<td>Average daily patient census</td>
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<td>62</td>
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<tr>
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<td>Laboratory examinations</td>
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<tr>
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<td>Prescriptions filled</td>
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<tr>
<td>Laundry processed (pounds)</td>
<td>5,384,977</td>
<td>5,367,982</td>
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### Discharges
*For Years Ended September 30, 1966 and 1965*

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>ADULTS</strong></td>
<td></td>
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</tr>
<tr>
<td>Gynecology</td>
<td>2,128</td>
<td>2,192</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>4,764</td>
<td>5,051</td>
</tr>
<tr>
<td>Psychiatry (Tompkins)</td>
<td>115</td>
<td>126</td>
</tr>
<tr>
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<td>42</td>
<td>47</td>
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<tr>
<td>Medicine</td>
<td>5,052</td>
<td>5,083</td>
</tr>
<tr>
<td>Surgery:</td>
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<td></td>
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<tr>
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<td>487</td>
</tr>
<tr>
<td>Dental</td>
<td>200</td>
<td>239</td>
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<tr>
<td>Neurosurgery</td>
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<td>697</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>612</td>
<td>616</td>
</tr>
<tr>
<td>Orthopedic</td>
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<td>708</td>
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<tr>
<td>Plastic</td>
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<td>5</td>
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<tr>
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<td>217</td>
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<tr>
<td>Urological</td>
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<td>1,287</td>
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<tr>
<td>General</td>
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<tr>
<td><em>Total – Adults</em></td>
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<tr>
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<tr>
<td>Surgical</td>
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<tr>
<td><em>Total – Children</em></td>
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<tr>
<td><strong>NEWBORN</strong></td>
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<tr>
<td>Normal</td>
<td>4,246</td>
<td>4,487</td>
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<tr>
<td>Special Care</td>
<td>426</td>
<td>410</td>
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<tr>
<td><em>Total – Newborn</em></td>
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<td>4,897</td>
</tr>
<tr>
<td><em>Total – All Patients</em></td>
<td>29,811</td>
<td>30,224</td>
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</table>

### Patient Days
*For Years Ended September 30, 1966 and 1965*

<table>
<thead>
<tr>
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<th>1966</th>
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<tbody>
<tr>
<td><strong>ADULTS</strong></td>
<td></td>
<td></td>
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<tr>
<td>Gynecology</td>
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<td>11,625</td>
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<td>Surgery:</td>
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<tr>
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<td>7,947</td>
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<tr>
<td>Dental</td>
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<td>625</td>
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<tr>
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<tr>
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<tr>
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<td><em>Total – Adults</em></td>
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<td><strong>CHILDREN</strong></td>
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<tr>
<td>Medical</td>
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<td>13,365</td>
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<tr>
<td>Surgical</td>
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<td>11,788</td>
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<tr>
<td><em>Total – Children</em></td>
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<td>25,153</td>
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<tr>
<td><strong>NEWBORN</strong></td>
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<tr>
<td>Normal</td>
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<td>20,638</td>
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<tr>
<td><em>Total – Newborn</em></td>
<td>24,109</td>
<td>26,185</td>
</tr>
<tr>
<td><em>Total – All Patients</em></td>
<td>246,005</td>
<td>242,166</td>
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Clinic visits totalled 111,856 last year.
## Clinic Visits

*For Years Ended September 30, 1966 and 1965*

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<th>Department</th>
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<th>1965</th>
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</thead>
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<td><strong>MEDICINE</strong></td>
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<td>1,525</td>
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<td>623</td>
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<td>5,340</td>
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<tr>
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<tr>
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<td>8,457</td>
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<tr>
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<td>3,312</td>
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<td>585</td>
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<td>Chest</td>
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<td>498</td>
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<td><strong>TOTAL – ALL</strong></td>
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</tr>
<tr>
<td>CLINIC VISITS</td>
<td>111,856</td>
<td>103,494</td>
</tr>
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</table>
Form of Bequest

I GIVE, DEVISE, AND BEQUEATH TO THE YALE-NEW HAVEN HOSPITAL,
IN THE CITY OF NEW HAVEN, A CHARITABLE INSTITUTION ORGANIZED
UNDER THE LAWS OF THE STATE OF CONNECTICUT, THE SUM OF

$ ..................................................