PHONE: (626) 403-9555 FAX: (626) 403-0966 www.asdconsulting.com
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The 5 CARDINAL SINS TO AVOID WHEN DEVELOPING AN ORTHOPEDIC ASC

Presented by: Robert J. Zasa, MSHHA, FACMPE
Managing Partner, ASD Management

A. 5 Pitfalls
   1. Don't overbuild
   2. Don't over equip
   3. Don't under capitalize
   4. Don't over staff
   5. Don't allow too many units/shares to be owned by one person or just a few investors.

B. DON'T' OVER BUILD
   1. Fit space to 100% of projections + only 30%. In first year, less than 100% of cases will be done due to payer ramp up and newness of facility for surgeons.
   2. Co-utilize pre-op and recovery space
   3. Fit rooms to State's licensing standards. Utilize definition of procedure rooms (use State's standards) to save space using larger procedure rooms for some types of surgery. Usage of procedure rooms per hour per day is more than operating rooms. Calculate capacity of ASC correctly- don't over or understate
   4. Try to use/share common area space in the building to save on leased space. This applies for space for HVAC, vaccum pump, electrical, phone, emergency generator.
   5. Every extra 1000 square feet relates to another $40-45,000/yr. In operating expenses related to rent, CAM, utilities, housekeeping, taxes.

C. DON'T OVER EQUIP
   1. Buy or lease just what you need to start. Most equipment is readily available quickly. Better to have just what is needed than having equipment sitting around creating more interest charges.
   2. Can get leasing line for equipment and use over time. Leasing for 5 or 7 years better if you can buy equipment at $1 at end of lease. This type leasing is available non-recourse. Doctors don't have to personally guarantee lease.
   3. Avoid incurring extra interest charges by closing lease at least one month after Medicare inspection. Can always open new lease with same financing company.

4. Have vendors loan equipment for 1st six months. Can lease or buy from vendors on a deferred basis. Can use demo equipment to reduce price. Stryker, Linvatec, Smith+Nephew, among the large vendors, will do better in bid situation than national contracts. They all offer deferment and loaner programs.
5. Equipment costs can be lowered by volume commitments on supplies. Shop this and equipment via your group purchasing organization (GPO). Sometimes better to do the equipment deal committing to volume of supply use, depending on volume of group when making price comparisons.
6. Don't over purchase supplies and drugs. GPO usually does not have implant deals. Must shop those or use GPO for consolidation pricing.
7. Don't sell DME equipment (crutches, braces, etc) in the ASC. Have a registered DME company do so for regulatory purposes. Also, don't rent space for DME in the ASC. If you want money from DME providers, let them contribute money appropriately for educational programs or dues such as attending BONES. Rules for the ASC are different than the group practice of doctors related to DME products. You can do crutch walking training as part of your ASC, but just basic training. Staff will not have time, as is in done in P.T., to do this extensively since they are focused on the surgical patient, and recovery of same.

D. DON'T UNDER CAPITALIZE THE ASC

1. Ramp up is slow due to most payer contracts taking about 4 months after Medicare certification (Effective Date) of the ASC.
2. Must raise enough equity or have large enough credit line to carry new ASC for at least 6-7 months (including two months before Medicare since staff needs to be there to prepare for licensure and Medicare inspections).
3. Equity raised should be approximately 25-30% of total equipment costs to qualify for non-recourse loan for equipment. Tenant improvement will always be recourse, although terms may be negotiated for less than 100% guarantee and 24-month burn-off of guarantee under certain conditions, such as strong monthly volume, good payment history, adequate ramp up and strong cash flow.
4. Credit line should always be gotten for at least 25% more than you project you need to have a back up of cash. A new ASC eats up cash. You must have enough. Important that credit line has pro rata (several, not joint and several) guarantees. Get as large a credit line as the ASC can afford. You will only draw down what you need, but have a large line available. Banks never give you money when you need it, get it on the front end of the project.

E. DON'T' OVER STAFF

1. Staff expenses are one of the two largest variable expenses of an ASC. It is also the most controllable if managed correctly.
2. Use parameter of 10-12 productive, work-hours per patient, not procedure. Always measure ASC parameters in cases, which equals patients, never procedures. This will include at least three persons in the business office of the ASC to do insurance verification, billing, collections, reception and cashering. These are good guidelines using an annual caseload ranging

from 2000-3200 case per year. Guidelines will be less per patient as one gets over 3200 cases and higher if annual caseload is less.

3. Use a lot of PRN staff. Build your own PRN staff. ASCs use a lot of part-time people. This helps create economies in staffing to keep costs down so the ASC owners do not pay personnel when they are not needed. I
4. It is easier to add staff than to fire staff. The RN Administrator who hires the staff is always reluctant to fire them, yet this is one of the largest costs and controllable costs of and ASC. Set parameters for staffing on front end using caseload as guideline, and parameter as discussed above. Be flexible at the beginning. The staff will not be efficient in their new setting for at least three months. This is a “grace” period. Start “fine-tuning” staffing after this time. Constantly monitor it.
5. Strong experienced people cost more, but overall, they are more efficient when staffing.

F. DON’T ALLOW ONE PERSON OR A FEW INVESTORS TO OWN TOO MUCH

1. This creates great professional jealousy. This point does not assume all shares/units are equally held. There can be variances in the number of units held by doctors, but the range should be rather close. The problem comes when one or a few surgeons own 30-55% and all others own 2-5 units. The disparity of large range of ownership units is the problem.
2. This creates problems for new surgeons whose practices are growing fast and want to contribute to an ASC over a short period of time since they have too few units.
3. The disparity of units de-motivates other using the ASC.
4. It delays ramp up of the business.
5. Large disparity in ownership of units creates legal and accounting time and effort for an inevitable “fix” to the issue. Avoid the problem on the front end.