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BECKER'S ASC Review

PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Five Key Issues Facing Ambulatory Surgery Centers

By Scott Becker, Elissa Moore and Alison Mikula

Ambulatory surgery centers are facing several pressing issues. These include issues related to (1) the Anti-Kickback Statute, (2) tax exempt entities investing in ASCs, (3) the waiver of co-payments and deductibles (4) the changing political landscape and (5) the use of "under arrangements" structures. Ambulatory surgery centers have faced certain of these issues before and certain issues are gaining renewed prominence. This article reviews five issues that will continue to be key issues in 2007.

1. Fraud and Abuse and Anti-Kickback Issues. The Anti-Kickback Statute prohibits the knowing and willful solicitation, receipt, offer or payment of "any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind" in return for or to induce the referral, arrangement or recommendation of Medicare or Medicaid business. 42 U.S.C. §1320a-7b(b) (the "Anti-Kickback Statute"). Violation of the Anti-Kickback Statute is a felony and may result in a fine of up to $25,000, imprisonment for up to five years, as well as suspension or exclusion of providers or suppliers from participation in the Medicare or Medicaid Programs.

Perhaps the most common anti-kickback concern relates to the manner in which surgery centers sell shares to physician partners. It has become increasingly clear that existing surgery centers need to refresh the partnership and provide new capital from time to time. This is most often accomplished through the selling of additional units or shares to new physician partners or selling additional units or shares to existing physician partners. To this end, there are a number of actions to avoid and certain actions to take when selling shares to physicians.

Actions to avoid include the following:

a. Do not offer fewer or more shares or a higher or lower price based on the number of or volume or value of referrals a physician can generate.

b. Do not reallocate shares based on the volume or value of referrals.

continued on page 8

ASC Experts See Opportunities And Hurdles In 2007

By Dana Kulvin, J.D., M.P.H.

Four experts weigh in on what they consider emerging trends, opportunities and hurdles in the ASC industry for 2007. From pricing to hospital competition, from out-of-network reimbursement to physician investment, these experts provide insights into what to expect and, in some cases, how to adjust to an evolving ASC industry. Of greatest value, however, may be their forecasts of the significant opportunities ASCs have this year to generate business and increase revenue.

Q. Are prices increasing or decreasing for the purchase/sale of ASCs? What is affecting the upward or downward trend?

A. Jon Vick: Sale prices are holding steady for ASCs in the range of six – seven times earnings before interest, taxes, depreciation, and amortization (EBITDA) for a majority interest with a management agreement. There is still a strong demand and competition for ASCs and in fact, over fifty different ASC management companies are currently seeking to invest in ASCs with high cash flow, turnaround opportunities or growth opportunities. The most attractive prospects for investors are large multi-specialty centers with substantial cash flow. The least attractive include small centers with no growth opportunities. ASCs located in a certificate of need (CON) state can demand premium pricing, as can ASCs with strong cash flow in which more than one company may be interested, thus creating a competitive environment.

Mike Weaver: We are noticing stable to a slight decline in ASC pricing overall. This is a direct result of decreasing reimbursements negatively affecting some ASCs' valuation. Decreasing reimbursements are due to three main factors. One, increasing pressure from payors is resulting in a loss of out-of-network benefits for many ASCs. For ASCs that derive thirty percent or more of their revenue from out-of-network patients, the losses can result in a significant decline in valuation. Second, the actual and proposed Medicare reimbursement decreases in specialty areas like gastroenterology (GI) and ophthalmology negatively impact revenue, and accordingly lower the valuation of ASCs performing these specialties. Lastly, ASCs in states like California and Texas that have converted (or may convert) to a rate-based worker's compensation reimbursement system will see revenue declines and the resulting decrease in valuation. Some ASCs are realizing a pricing increase. For example, ASCs located in CON states and those showing significant growth potential are receiving higher valuations and accordingly, increased prices.

Bob Zasa: ASC prices are down a little in 2007, but not a precipitous drop. The decrease is primarily due to the new and proposed Medicare fee schedules, which decrease reimbursements for certain specialties. For example, ASC reimbursement for GI and pain procedures has (or will) decreased and therefore valuations for centers primarily performing these procedures also declined. However, an ASC's valuation may be buoyed if its case mix includes specialties such as orthopedics, which are still garnering high reimbursement. ASC prices have also been affected by a recent push by payors, particularly in California, to compel ASCs to go in-network. With the loss of out-of-network money, many ASCs who relied heavily on this revenue, will suffer financial losses and lower valuations *[See Sidebar 1]*. For out-of-network services, many payors have started reimbursing patients instead of ASCs, making it far more

continued on page 4

INSIDE

Letter from the Editor

This is an amazing time in the surgery center arena. Changes are occurring at a fast and furious pace. Technology, competition and the financial markets are combining to create a great number of challenges and opportunities.

1. Surgery Center Wins Initial Skirmish in Antitrust Suit. The Peoria Day Surgery Center recently survived a motion to dismiss brought by OSF St. Francis Medical Center. There, OSF St. Francis Medical Center had responded to the surgery center's complaint which brought action under the antitrust laws based on numerous alleged anticompetitive actions by OSF St. Francis. OSF St. Francis asked the court to dismiss many of the claims. Here, the court denied this motion. Thus, the center is free to continue to attempt to prove its claims against OSF St. Francis. As this case evolves, we will attempt to keep you updated.

2. IntelliMarker – 10 Key Statistics for Ambulatory Surgery Centers. IntelliMarker, developed by InforMed Healthcare Media and VMG, is the 2006 Ambulatory Surgical Center Financial and Operating Benchmarking Study. It has outstanding data. For information or to participate in the survey or to order the book please contact Chad Coben at (214) 866-0103 x402. It is a truly outstanding reference. The following are certain of the benchmark statistics from the 2006 book.

1. The Median Net Revenue for an ASC is $5.3 Million.
2. The Median Salary and Benefits Costs is 28.9% of Net Revenue.
3. The average size of a multi specialty ASC is 13,000 square feet.
4. The Median Management Fees for an ASC are $227,000 or 4.8% of Net Revenues.
5. The Median Current Long Term Debt is $1.2 Million.
6. The Mean days outstanding in accounts receivable is 52 Days.
7. The average volume of an ASC is 4001 Cases per year.
8. The 5 largest specialties at ASCs are:

GI	25%
Orthopedics	18%
Ophthalmology	14%
Pain Management	13%
ENT	8%

9. Average Net Revenue Per Case

Orthopedics	$2,136
GI	$749
Pain Management	$830
Ophthalmology	$1,145
ENT	$1,536

10. The Median Administrator Salary is $92,765.

3. June Ambulatory Surgery Center Conference. Our June Ambulatory Surgery Center Conference which focuses on orthopedic, spine, pain management, and neurosurgery includes an unprecedented number of physician leaders who will comment on their own experiences and certain topics related to surgery centers. The completed brochure will be available March 1st and online at www.Beckersasc.com.

4. Chris Schriever Blue House Publishing. In addition to the terrific effort from Professional Conference Management and Michelle and Ken Freeland, we have added Chris Schriever to our sales team to help assure that we properly work with exhibitors and sponsors for the ASC Review and for the conferences. Chris is a tremendous professional. Chris can be reached at 202-337-1892. Ken and Michelle can be reached at 858-565-9921.

5. Editorial Alert. The May-June ASC Review will focus on issues related to orthopedics, spine, neurosurgery and pain management and on developing ambulatory surgery centers. The July-August issue will again highlight 50 people to know in the ambulatory surgical center industry.

Should you have questions about any of the issues or desire to submit an article, please contact me at 312-750-6016 or at sbecker@mcguirewoods.com.

6. Comparing Two Management Theories. There are two distinctly different business theories espoused in the E-Myth by Michael Gerber versus in the book Good to Great by Jim Collins. Gerber tends to advocate great systems and placing relatively inexpensive people in those systems. Collins, in contrast, says find the best people you can and, in part, build the plans and goals around them. He places less emphasis on "systems" and more emphasis on finding and retaining terrific people. Gerber points to the concept that most highly talented people are too expensive and that you can only achieve scale and a larger business through systems and lower cost people.

In watching ASCs thrive or struggle, I tend very heavily towards the belief that Collins has the better answer. I.e., I agree that centers and national chains have to have clear and core systems. That stated, the difference between success and failure of many centers and of small hospitals can be the quality of the on site leadership and the center's staff. While it's expensive, I believe that it is much easier to have great success if you build around more talented people than around the lower cost model.

7. Evaluating Management Teams and Companies. As a follow up to the Gerber versus Collins discussion, we also note the following conclusion principally relating to the contribution of talent and leadership to the strength of growing companies. First, a company needs a certain amount of "A" players to really drive and to develop some level of scale to its efforts. I define an A type of leader in this context as one that is intelligent, brings a sense of urgency to the efforts of the company, and requires little or no management. In essence, the person can help drive the company and handle situations to help grow the company without much management effort by another person. As I watch companies either thrive or struggle, it is apparent that having some number of people at the A talent level is absolutely critical. In watching companies with one A player, the CEO, and a great deal of reasonably strong vice presidents, I have essentially come to the conclusion that it is almost impossible to thrive as a company with just one complete A player. Rather, to build a company and to build a management team I tend to believe that there is some base of people which is north of three, in essence at least four or five A type leaders that are needed if you really want to grow a company beyond simply a small revenue level. These people don't all need to be all "C suite executives" meaning CEO, CFO, or COO, but there is a need for that level of depth to be able to take a company beyond initial success and to transition into the future. Many of the companies that we work with have increasingly embraced this concept. Moreover, the ability to achieve a higher level result and provide a plan for the future tends to exponentially increase with each additional person of the highest level of quality which you can add to a company. In essence, it makes everything work better at all levels of the organization. In addition to this level of talent, each of these companies, of course, needs many people that can contribute to the Company. The quality of these people, if not extremely solid, can also make it impossible for a company to thrive at a higher level.

8. Will the Health Care Buyout Binge End in a Horrible Hangover. During the past twelve months, we have witnessed enormous healthcare deal after deal. HCA has been acquired by a group of private equity funds for more than 20 billion dollars, USPI is being acquired by Welsh Carson, and HMA, one of the largest hospital management companies, is going private in a highly leveraged transaction. Further, HealthSouth appears to be in the process of selling its ASC division for a large large sum. Most of these deals need a great deal of debt to consummate the transactions. For example, it has been reported that HCA will now need approximately 2 billion of its 4 billion dollars in annual cash flow to service debt. The HMA deal will change the financial structure of debt to one where instead of 1.7 times debt to cash flow, they will be close to 5.4 times debt to cash flow. In simple terms, this can mean that 6 to 8 cents of every ten cents earned must be used to make debt payments. Rather than banking on success, one can almost predict with certainty that due to changes, industry wide and/or other factors that are outside management's control, certain of the large leveraged deals will end up in serious financial straits. We don't at all know nor predict which ones.

9. Pre-Conference Orthopedic, Spine, Neurosurgery, and Pain Management Driven ASC Conference. We have developed an outstanding agenda for this meeting. We have six

different terrific pre conferences. For example, Brent Lambert, M.D. of Ambulatory Surgical Centers of America will provide a pre conference on Establishing Ambulatory Surgical Centers, Joe Zasa and Steve Dobias, respectfully of Woodrum ASD and Somerset CPAs will provide a pre conference on A Blueprint for Establishing Surgery Centers, Bill Southwick, the CEO and President of HealthMark will provide a pre conference on Developing Hospital Physician Joint Ventures, and finally Prexus Health including A.J. Mangal, M.D., Maryann Gellenbeck, Donald Jansen and Mike Griffin will provide a pre conference session on Establishing Physician Owned Hospitals. Finally, Regent Surgical Health will provide a conference related to Turning Around Surgery Centers. A description of their session produced by John Harris is as follows: Nearly one-third of ASCs in the U.S. break even or lose money. In this session focusing on turnarounds, learn how to improve your center's financial health and how to avoid problems that impact profitability. Regent Surgical Health, a turnaround specialist and de novo developer of ASCs and physician-owned hospitals, will present tested methods for financial improvement through case studies and analytical tools by Tom Mallon, CEO, and Jeff Simmons, President Western Region, and Dr. Jim Lynch, neurosurgeon from Surgery Center of Reno.

10. What Advertisers and Exhibitors Say About the ASC Review and ASC Communications, Inc. Conferences.

"SCA has been advertising in the ASC Review for many years. It is a very high quality publication with excellent circulation." *Caryl Serbin, President Surgery Consultants Inc, Surgery Center Billing, LLC.*

"CitiCapital Healthcare Finance has now been an advertiser in Becker's ASC Review for over 5 years. It is one of the few select industry publications in which we advertise. The Review provides our staff with timely updates on trends and other key industry information. Equally important, advertising in ASC Review provides our business exposure to multiple decision-makers who are responsible for the selection of financing and financial service providers." *Ken Seip, Vice-President CitiCapital.*

"Scott…This opportunity came to us as this surgeon listened to our speech on spine and gastric banding at your last conference, thank you," *Jeff Simmons, President, Western Region, Regent Surgical Health, LLC.*

"Scott Becker's ASC Review always contains fresh, practical, and important information on ASCs. We are pleased to support it. The ASC Review is our primary advertising vehicle and we appreciate the exposure to the decision makers it facilitates. *Jon Vick, President, ASCs Inc.*

"As advertisers in Becker's ASC Review, we appreciate the visibility that is created for McShane. Because of the publication's strategic distribution, we receive greater recognition from the industry's decision makers as an experienced provider of construction and real estate services for the healthcare industry. My thanks to Scott Becker for creating such a highly regarded publication." *John Daly, Jr., AIA. McShane Construction*

11. GAO Reports ASC Costs.

The Government Accounting Office recently reported ambulatory surgical center costs as being approximately 84% of the cost to perform the same surgeries in a hospital outpatient department. This is obviously a much higher cost level than was set forth in the 62% number suggested by CMS for reimbursement of surgery centers. In essence, that surgery centers would be reimbursed 62% of the payments made to hospital outpatient departments. It is expected that CMS will finalize their ASC payment plan this spring. We are hopeful, but not necessarily optimistic, that the number will be closer to the GAO number than the previously suggested CMS number.

12. How Capitalism Can Save American Healthcare.

This is a book I was recently provided by the Physician Hospitals of America courtesy of Molly Gutierrez. The book explains why a market competitive approach to healthcare is a better solution than a single payor system or other type of nationalized system. The book is by Dr. David Gratzer. Dr. Gratzer who has practiced in both Canada and the United States, is a Senior Fellow at the Manhattan Institute for Policy Research. He provides a relatively compelling case. To join the Physician Hospitals of America, please contact Molly Gutierrez at 605-275-5349. We also strongly encourage people to join FASA and/or AAASC. To join FASA, the nation's largest trade association for ambulatory surgery centers, please contact Kathy Bryant at 703-836-8808. To join AAASC, another great association, please contact Craig Jeffries at 423-915-1001.

13. United Surgical Partners to be Acquired by Welsh, Carson, Anderson & Stowe.

United Surgical Partners announced on January 8th that Welsh Carson, one of the founding private equity firms invested in USPI, would acquire all the stock of USPI for a premium above market price of 13%. In essence, the share price in the deal is approximately $31. From an ambulatory surgical center market perspective, because privately held private equity funded companies are often more disciplined in buying centers for cash flow than for the ability to arbitrage the center pricing against public market pricing of their stock versus, we do not view this as an overly positive sign for valuations in the ASC business.

14. DISTRIBUTION EMAIL LIST.

IF YOU OR SOMEONE YOU KNOW WOULD LIKE TO BE ADDED TO THE E-WEEKLY DISTRIBUTION LIST, PLEASE EMAIL MYSELF OR SIGN UP AT WWW.BECKERSASC.COM

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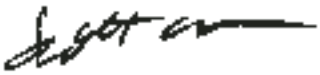

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ASC Experts See Opportunities And Hurdles In 2007 **continued from page 1**

difficult for ASCs to collect the money. This practice affects the net revenue and therefore the EBITDA for valuation, not to mention the cash on cash returns to the ASC.

Steve Dobias: While there has always been a market for ASCs, prices for some ASCs have recently increased. As the industry has matured, the opportunity to develop new ASCs has declined and as such, there has been a shift by the industry's profit players from building new ASCs to buying interests in existing operations. With so much interest in investing, in markets where there is stiff competition and a healthy supply of ASCs (such as Denver, Phoenix and Atlanta), ASC pricing has increased. However, not all ASCs have faired equally. For example, in smaller markets where the demand for ASCs is not as sizable, prices have declined. In addition, for ASCs focused on GI and ophthalmology, prices may decline until the uncertainty over proposed Medicare reimbursement changes are resolved.

Q. Are you seeing more competition from hospitals?

A. Jon Vick: Over the last couple of years, hospitals have become more interested in entering the ASC market. Unfortunately, they are a little late in the game as the ASC market is now maturing. Clearly, the more ASCs, the more competitive is the environment. But because there are over 5,000 ASCs nationwide and many are well-established within their communities, hospitals developing ASCs may have a hard time competing. In addition, hospitals are having a difficult time joint venturing with physicians to join or develop an ASC, because most of the physicians are not willing to give up majority control to them and most hospitals want at least fifty-one percent ownership. One of the reasons the HealthSouth joint venture model failed was because HealthSouth had a disproportionate share (up to eighty percent) ownership in their ASCs.

Mike Weaver: Hospitals are looking to develop ASCs and see a tremendous growth opportunity to do so in 2007. If ASCs already exist in the market, certainly new ASCs developed by a hospital will create a more competitive environment. In specific markets, hospitals present different competitive threats to ASCs. For example, in certain markets where hospitals are in a leveraged position, hospitals will continue to try to bind payors to exclusive contracts and use economic credentialing techniques to protect their interests against well established ASCs.

Bob Zasa: ASCs should not expect much competition from hospitals in 2007. Certainly 2007 will continue the trend of hospitals attempting to joint venture with physicians to develop or join ASCs, however, except for in certain markets where hospitals are well leveraged, these actions should not harm existing ASCs' business.

Steve Dobias: ASCs will likely encounter the same amount of competition from hospitals in 2007. Hospitals are expected to be very active when it comes to pursuing joint ventures with existing ASCs or establishing ASCs with physicians not yet invested. Hospitals owning fifty percent or more interest in an ASC may have a competitive advantage against other ASCs because of the hospitals' ability to garner more profitable payor contracts. For example, hospitals with a majority interest in an ASC may be able to include the ASC in their contracting network umbrella, resulting in higher procedure reimbursement for the ASC. This will likely attract physician investors who cannot obtain equal reimbursement at another ASC.

Q. Are you seeing centers more or less dependent on out-of-network reimbursement?

A. Jon Vick: ASCs that have been out-of-network have generally done very well, but are now feeling pressure from payors to stop providing out of network services. Payors are increasingly reducing the number of out-of-network patients an ASC can serve or discouraging the practice outright. The pressure is forcing ASCs to rely less on out-of-network reimbursement and increase their in-network contracts. This requires ASCs to have access to professional contract negotiators to continue to do well.

Mike Weaver: As payors continue to curb costs by pressuring centers to curb their out-of-network practice, more ASCs are almost exclusively converting to in-network reimbursement. This could be a big financial blow as statistics suggest that many ASCs derive a disproportionate share of their revenue from out-of-network reimbursements *[See Sidebar 1]*. States like California, with a large number of ASCs, are particularly feeling the pressure from payors and in adjusting accordingly, are realizing the negative economic consequences. ASCs in more remote areas have probably yet to feel the pressure and as such, should continue to rely on out-of-network reimbursements and not jump to convert until compelled.

Bob Zasa: To the extent possible, ASCs are trying (and should try) to maintain their out-of-network revenue because generally the reimbursement is higher. In reaction to payors tightening their reins on out-of-network payments, ASCs are being much more selective about their payor contracts and in many cases walking away from those contracts that restrict out-of-network payments.

Steve Dobias: While all ASCs attempt to capture out-of-network business, most realize that the higher out-of-network reimbursement amounts are at risk long term and cannot be sustained. For example, currently payors are pressuring patients and referring physicians to use in-network ASCs. In addition, payors are threatening to kick referring doctors out of contracts if they refer patients to out-of-network ASCs. Even with this knowledge, many ASCs are not prepared for the severe impact the loss of out-of-network reimbursement will have. With so many ASCs dependent on out-of-network revenue, it is imperative that they start recognizing the potential negative impact to operations and strategizing methods to adjust.

Q. What is the climate for physician investment in ASCs? Are physicians more excited or less about investing?

A. Jon Vick: As the success of the ASC industry continues to boom, there are an increasing number of physicians looking for opportunities to invest in ASCs. However, they still are cautious when investing and need good documentation of expected results and a solid business plan. Physicians generally feel that risk is greatly reduced, particularly in multi-specialty centers. They are also eager to provide more efficient services to their patients outside of the hospital. As a caveat, many physicians still find investing in a single-specialty ASC a risky venture.

Mike Weaver: Physician investors are still bullish on the ASC market. The biggest factor driving the physicians' interest is not their return on the investment but rather other material returns. For example, an ASC offers physicians an efficient and high-quality means to serve their patients with an expanded role in directing the provision of that care. Further, the ease and efficiency of performing procedures in an ASC allows the physician more time to devote to a group practice, a commodity of time hard to find in a hospital environment.

Bob Zasa: Physician investment in ASCs is still very strong in 2007. While ASC investment returns remain attractive, physicians are associating with ASCs primarily because they can better leverage their surgical time and devote more time to their practices. In addition, there are ample opportunities for physicians to invest in ASCs in 2007 as many older physicians are retiring and ASCs are resyndicating. Lastly, recently graduating physicians are comfortable in an ASC setting because many have been trained in an ASC and want to participate in one.

Steve Dobias: Physician interest in ASC investment is expected to remain stable in 2007. Physicians continue to desire an interest in a profitable ASC and if given the opportunity, will invest. However, hospitals and politicians persistently attempt to limit physician ownership in new ASCs, making investment opportunities harder to find. On the other hand, where hospitals and physicians are jointly investing in ASCs, there will be expanded physician investment opportunities. Additionally, in CON states, physicians will have more difficulty finding ASC investment opportunities. Undoubtedly investment opportunity is best evaluated on a state by state basis, as some states have almost reached a saturation point while in others, physician investment in ASCs is just commencing.

Q. What are the newest opportunities you see for ASCs?

A. Jon Vick: In 2007, three chief opportunities present themselves in the ASC industry. One, investing in turn-around centers – where investors seek to convert underperforming centers into profit centers by adding new physicians and employing cost containment and management strategies. Two, expanding existing multi-specialty ASCs into small surgical hospitals *[See Sidebar 2]*. Lastly, in the current strong medical real estate market, physicians selling the real estate on which their ASC stands and simply maintaining ownership of the ASC's operation. With medical real estate generally selling at multiples of seven to ten times net operating income, compared with the ASC operation itself which sells at a six to seven times multiple of EBITDA, it is an opportunity many physician investors are finding attractive.

Mike Weaver: In 2007, three distinct opportunities will be available for ASCs. One, ASCs can benefit from materially improved technologies. For example, certain spinal and bariatric procedures that could not be performed in ASCs even as little as three years ago, are not only now performed in ASCs but also being reimbursed by payors. In 2007, ASCs will further diversify their cases by relying on the growing technologies. Two, multi-specialty ASCs will have opportunities to be converted into surgical hospitals *[See Sidebar 2]*. Three, prospects for ASC consolidation is enormous. Of the more than 5,000 ASCs that exist, the vast majority is independently owned and only about thirteen percent are owned by five of the biggest ASC corporations [*See Sidebar 3]*. This fragmented market, combined with the investment banking industry's strong interest in the stronger segments of the market, will result in consolidation opportunities.

Bob Zasa: Two main opportunities exist in 2007 for ASCs. One, new technology will give ASCs the opportunity to perform a wider variety of procedures on an outpatient basis, such as bariatric lab banding and various plastic surgery and orthopedic procedures. Two, as a result the "downward pressures" of reimbursement cuts and operating room (OR) nursing shortages, ASCs will take advantage of micromanagement processes that will help them further streamline their expenses. For example, ASCs will be more engaged in pricing strategies, enter into more group purchasing supply and drug contracts and act more cautiously about overbuilding their centers. In addition, in order to retain staff, specifically OR nurses, ASCs will more vigorously develop staffing retention strategies and enhance staff benefits and incentives.

Steve Dobias: ASCs have a superior opportunity to increase their business in 2007 by focusing on marketing their services to referring physicians and the community. Patients will usually go to the facility used by their physician and therefore marketing efforts to referring physicians is imperative. Marketing to the community is equally important. Most inpatient facilities lack the beds and ORs necessary to meet patients' demands. While ASCs are an excellent long-term solution to meet the needs of the community and provide high-quality outpatient healthcare, most ASCs do not take advantage of the opportunity to inform the community of their services and benefits. Focusing on their marketing efforts can enhance ASC business and provide a necessary service to the community. ■

SOURCES:

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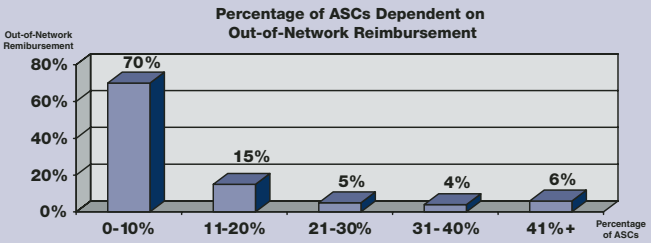
SIDEBAR 1

ASCs Dependent on Some Percentage of Out-of-Network Reimbursement

In an October 2006 survey conducted by the American Association of Ambulatory Surgery Centers (AAASC) and analyzed by Deutsche Bank, 195 ASC respondents were asked to identify the percentage of their net revenue derived from out-of-network reimbursement. Up to fifty percent of the respondents indicated that they received some percentage of out-of-network reimbursement. Up to ten percent of the respondents indicated that they derived a disproportionate share of their revenue (up to seventy percent) from out-of-network reimbursements.



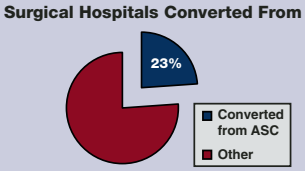
Statistics were provided courtesy of AAASC and Deutsche Bank. The full report can be found at http://www.aaasc.org/features/documents/DeutscheBankReport10.6_000.pdf.

SIDEBAR 2

Informal Survey Confirms Trend in ASCs Converting to Surgical Hospitals

Experts calculate that almost twenty percent of existing specialty hospitals were converted from ASCs. "Of the approximately 130 existing specialty hospitals, an informal estimate yields at least twenty-five were once surgery centers," says **John G. Rex-Waller**, Chairman, President and CEO of National Surgical Hospitals, Inc. In reality, that statistic is probably higher when considering the fact that at least twenty of those specialty hospitals are cardiac or women's hospitals, which would never have originated as ASCs, he adds. With this caveat, the percentage of existing surgical hospitals that were previously ASCs is almost twenty-three percent.

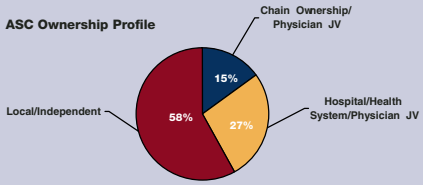
Rex-Waller forecasts these percentages to increase in 2007 and beyond. The Center for Medicare and Medicaid Services' new reimbursement system pays ASCs at sixty-five percent of HOPD reimbursement. "The higher HOPD reimbursement may encourage more ASCs to convert to surgical hospitals. However there are substantially higher costs associated with running a hospital which justifies the higher payment. Furthermore, a surgical hospital, even with the higher payments for outpatient procedures relative to an ASC, still needs a stream of inpatients to survive financially. The drive to conversions will continue to be to provide surgeons with a more efficient and friendly environment in which to do more of their cases" he contends.



SIDEBAR 3

Fragmented ASC Ownership is Ripe for Consolidation

In an October 2006 survey conducted by the American Association of Ambulatory Surgery Centers (AAASC) and analyzed by Deutsche Bank, 199 ASC respondents were asked to identify their ownership status. Fifty-eight percent of the respondents indicated they were "locally owned" or "independent," twenty-seven percent identified themselves as being owned by a hospital or health system and fifteen percent stated they were owned by a corporate chain. "These statistics clearly point to a fragmented market. This is the type of market that is ripe for consolidation and the industry should be prepared for a lot of amalgamation in 2007 and beyond," says Mike Weaver, Senior Vice President Acquisitions and Development, Symbion Healthcare.



Statistics were provided courtesy of AAASC and Deutsche Bank. The full report can be found at http://www.aaasc.org/features/documents/DeutscheBankReport10.6_000.pdf.

Five Key Issues Facing Ambulatory Surgery Centers continued from page 1

c. Do not focus on individual distributions being tied to the number of patient referrals. Never make any indications that could lead a potential investor to believe that referrals or performance will determine an individual's "piece of the pie." Focus on overall distributions and profits.

d. Physicians should not be allowed to invest based upon the fact that they can generate referrals for another physician who may use the center. These types of referrals are referred to as "indirect" referrals and are the type of referrals with which the government is particularly concerned.

e. Avoid providing physicians with estimates as to the amount of revenue that will be generated from their referrals or from another physician's referrals.

f. Except as to compliance with the quantitative tests as outlined in the ambulatory surgery center safe harbor regulations accompanying the Anti-Kickback Statute (i.e., the 1/3 tests), do not develop investor eligibility determinations based on the number of potential referrals. In evaluating physicians, examine compliance with all of the safe harbor criteria.

g. Do not create "target lists" of physicians based on their ability to make high amounts of referrals.

h. If a list has been created, avoid making notations indicating the potential number of referrals, the growth potential of the physician's practice, that a certain physician is a good target (based on referrals), etc.

i. Avoid using age as an influencing factor when targeting physicians.

j. Subject to non-discrimination rules, consider excluding Medicare and Medicaid referrals from any internal revenue and investment analysis.

k. Do not offer remuneration or special treatment under various disguises, such as directorship contracts or discounted lease arrangements, in order to induce investors.

l. Do not pressure physician investors to shift their current referral patterns.

m. Do not make any indications to investors that low-referring physicians will be pressured to withdraw.

n. Units should not be sold at a discount from the then fair market value.

The following actions may be taken when selling shares to physicians:

a. Offer equal amounts of units per investor.

b. Offer units at the same price per unit.

c. Offer units at the then fair market value per unit.

d. Provide investor with the current proforma financial statements and not their potential revenues.

e. Offer units to only physicians that will comply with the safe harbors – meet all tests and not just the 1/3 tests.

f. If there is a hospital or management company partner, clarify that the hospital or management company partner does not generate referrals for the surgery center.

g. Review investors against compliance with the requirements of the safe harbors.

h. If potential physician partners do no currently use the surgery center, such physicians may be asked why they choose not to use the surgery center.

Another significant anti-kickback issue relates to pressure from parties for productivity based returns. As surgery centers become more like physician practices, there is an enhanced desire by physicians to be paid on some sort of productivity basis. Fortunately or unfortunately, there are strong arguments that it is not lawful under the Anti-Kickback Statute to pay people based on productivity.

2. Joint Ventures and Tax Exempt Hospitals. Increasingly, a tax exempt entity partners with surgeons and often a national management company to develop a surgery center joint venture. At the same time, tax exempt entities are facing increased scrutiny on a federal and state level with respect to whether their operations serve exempt purposes and whether or not their involvement in projects including joint ventures furthers their tax-exempt charitable and community purposes.

Control issues as well as whether the operations furthered charitable purposes were issues of importance to the tax court in Redlands Surgical Services v. Commissioner and to the Fifth Circuit in St. David's Healthcare System v. United States. In Redlands, the court looked at a number of facts and circumstances in deciding that a surgery center, jointly owned by a for-profit and not-for-profit entity, did not allow one of its owners to qualify for exemption stating as follows:

> Based on all the facts and circumstances, we hold that petitioner [the tax-exempt partner] has not established that it operates exclusively for exempt purposes within the meaning of Section 501(c)(3). In reaching this holding, we do not view any one factor as crucial, but we have considered these factors in their totality: The lack of any express or implied obligation of the for-profit interest involved in petitioner's sole activity to put charitable objections ahead of noncharitable objectives; petitioner's lack of voting control over the General Partnership; petitioner's lack of other formal or informal control sufficient to ensure furtherance of charitable purposes; the long-term contract giving SCA Management control over day-to-day operations as well as a profit-maximizing incentive; and the market advantages and competitive benefits secured by the SCA affiliates as the result of this arrangement with petitioner. Taken in their totality, these factors compel the conclusion that by ceding effective control over its operations to for-profit parties, petitioner impermissibly serves private interests.

"Control" was also a deciding element in the St. David's Healthcare System v. United States case involving a whole hospital joint venture. There, the court articulated the legal test to be applied with respect to control:

> [T]o ascertain whether an organization furthers non-charitable interests, we can examine the structure and management of the organization…[W]e look to which individuals or entities *control* the organization…If private individuals or for-profit entities have either formal or effective control, we presume that the organization furthers the profit-seeking motivations of those private individuals or entities…When the non-profit organization cedes control over the partnership to the for-profit entity, we assume that the partnership's activities substantially further the for-profit's interest.

As 2007 evolves, tax exempt hospitals will work harder to balance two conflicting goals: balancing the goal of physicians to have increased ownership in joint ventures and increased management powers with the goal of the tax exempt entity to clearly demonstrate that the joint venture is serving community purposes. For example, the tax exempt entity will need to consider the following issues as the joint venture documents are negotiated:

a. Does it have control of the Board?

b. If it does not have control of the Board, does it have sufficient reserve powers and does it have a unilateral power to assure that the venture is a community benefit?

c. Does the joint venture operating agreement contain language to clarify that a principle purpose of the joint venture is to serve charitable purposes?

d. If there is an arbitration clause, is it clearly stated that the arbitrator should prioritize the tax exempt purposes in a dispute where such purposes are relevant?

Further, once operational, the entity will need to take steps on an annual and periodic basis to assure that the venture is actually operating in accordance with community purpose.

Both on a state and federal level, increased scrutiny of tax exempt entity involvement in joint ventures is expected.

3. Waivers of Co-Payments and Deductibles. Managed care payors are tightening the screws on surgery centers. Surgery centers continue to attempt to operate out of network. Insurers are increasingly taking a number of actions to reduce out of network activity such as rejecting payments, agreeing to only pay patients, trying to recoup payments, and engaging in negotiations for tighter exclusive contracts. The following is a list of possible strategies for operating in part as an out of network facility. Each strategy contains different risks. A surgery center should consult with its own legal counsel. Further, it must (1) research the laws of its own state on this issue, and (2) adopt further safeguards if the patient is a Medicare or Medicaid patient.

a. **Full Waiver**. The most risky strategy is to fully waive co-payments, co-insurance or deductibles on a fairly generalized basis.

b. **Partial Waiver Without Disclosure**. A second highly risky strategy is to match in-network benefits but not provide disclosure to the payor.

c. **Partial Waiver With Disclosure.** A moderately risky strategy is to adopt a policy that includes some discounts or in-network benefit matching coupled with full disclosure of such approach to the payor. The surgery center may provide some waiver of co-payments, co-insurance or deductibles (preferably discounts rather than complete waivers) or might also refrain from collecting deductible amounts (but this practice should be limited to situations in which the surgery center has a reasonable and good faith belief that the patient's deductible obligation is being met through payments to other providers). In both situations, full disclosure to the payor should be made. Full disclosure can be made by stamping the claim for services rendered, indicating that a discount was provided to the patient. Further, the center when it calls the payor to verify benefits should discuss the reduction. This should be followed by a fax letter confirming the conversation and disclosure.

d. **Partial Waiver With Disclosure; Allow Payor to Reduce Payment**. A slightly less risky strategy is to match in-network payments but also allow the payor to pay a similarly discounted in-network charge. It is still possible that a state or payor would view this as a waiver or discount, particularly if the practice is not authorized by the payor or if the payor pays more than its share of the total amount paid. Here again, full disclosure is critical.

e. **Charge Out-of-Network Based on Payor's Payment**. Another strategy that presents some degree of risk is to charge the patient the out-of-network full payment amount based on what the payor pays rather than on the usual and customary charge. Full disclosure to the payor of such practice as applied to each patient is important.

f. **Case-by-Case Reduction of Co-payments Based on Need; Full Disclosure to Payors.** Another strategy is to waive or reduce co-payments, co-insurance or deductibles on a case-by-case basis considering each patient's need and particular circumstances. With this approach, financial need may be based on the federal or poverty guidelines. Full disclosure of waiving or reducing co-payments, co-insurance or deductibles would be made to the payor.

g. **Charge Full Co-payments**. The least risky of all strategies is to charge the patient the out-of-network full co-payment, co-insurance or deductible based on the surgery center's usual and customary charges.

4. Political Concerns. As political power shifts both in Washington and at the state level, there is increased concern that new legislation related to the development of physician owned facilities will be introduced. The recent decreases in reimbursement for imaging services may be a foreshadowing of what can be expected at the federal level. Moreover, Senators Max Baucus and Charles Grassley and Representative Pete Stark issued letters to CMS requesting further investigation of a recent patient death after a transfer from a Texas physician-owned hospital. In their letter, they asked for an accounting of any Medicare dollars that may have gone to a physician-owned specialty hospital in West Texas during a congressionally imposed 18-month moratorium on Medicare payments to these hospitals and also asked for a list of physician owners of the facility. In addition, Representative Stark noted that physician-owned hospitals "suck money out of already cash-strapped community hospitals." Industry groups issued press releases in response to the letter.

While much of the legislation at both the state and federal level is aimed principally at physician owned hospitals and at physician owned imaging centers, arguments are being made as to physician ownership in surgery centers as well. The political strength of the America Hospital Association is expected to grow with a Democrat-controlled Congress and could potentially cause more trouble for physician owned facilities than under the previous Republican controlled House and Senate.

Even at the state level, the battle against for physician owned facilities such as ambulatory surgery centers is increasing in intensity. States such as Pennsylvania and Kansas are looking at self referral statutes and introducing or reintroducing certificate of need requirements for development of surgery centers. In Ohio, Governor Bob Taft signed into law a moratorium on physician owned hospitals primarily or exclusively engaged in the care and treatment of one or more of the following: (1) patients with a cardiac condition; (2) patients with an orthopedic condition; (3) patients receiving a surgical procedure; or (4) patients receiving any other specialized category of services specified by the Ohio Director of Health. Ohio State Senate Bill Number 116, Section 4(A). The bill only applies in counties with a population of more than 140,000 but less than 150,000. In addition, section 4(C) provided an exception to the prohibition, i.e., any project that had obtained all local permits necessary to begin construction were obtained on or prior to the effective date of the act. A similar moratorium was passed by the Montana legislature that is effective until July 1, 2007. Although these moratoriums applied to physician owned hospitals more so than ambulatory surgery centers and focus on a federal level has been on physician-owned imaging centers, such moratoriums are indicative of a trend that could have an impact on ambulatory surgery center ownership.

It has become more and more critical that the physicians, through organizations like FASA, AAASC, and PHA, work to increase their political voice and strength in Washington and at the state level through strong political relationships. Increasingly, physicians are beginning to understand the need for political empowerment and a louder political voice. However, there remains a long way to go to match the strength of the American Hospital Association and their counterpart state entities.

5. Under Arrangements. Over the last few years, there has been substantial development of "under arrangements" joint ventures. The Social Security Act permits hospitals to bill for services furnished under contract by a non-hospital provider, as services provided "under arrangements." This type of arrangement is different from the provider-based rules which permit an entity that is operationally integrated with a main hospital (i.e., it operates under the same name, ownership, and administrative and financial control of a hospital) such that it is permitted to bill for services under the hospital's provider number. In an "under arrangements" situation, physicians may work with a hospital to develop an infrastructure entity that provides essentially all of the services of a surgery center. The hospital then buys each of the services on a "per click" basis "under arrangements." The hospital proceeds to bill the services to third parties, including Medicare, Medicaid and commercial payors, as though it, the hospital, provided the services.

42 C.F.R. § 409.3 states that "arrangements" means arrangements which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services. However, there are no regulations that specifically address the provision of services "under arrangements". The Medicare

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Acquisition Finance
CIT Healthcare
Sole Lender

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NATIONAL RENAL ALLIANCE
Senior Secured Credit Facilities
Acquisition Finance
CIT Healthcare
Sole Lender

$21,000,000
Catholic Health System
Mercy Hospital of Buffalo
Senior Secured Credit Facility
Working Capital
CIT Healthcare
Collateral Agent

$14,000,000
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Senior Secured Credit Facility
Working Capital
CIT Healthcare
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Acquisition Finance
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Information, Eligibility and Entitlement Manual, Pub. 100-1, Ch. 5, § 10.3, establishes that in order for services provided under arrangements to be covered by Medicare, the provider must exercise professional responsibility over the arranged-for services, including:

(a) Applying the same quality controls as are applied to services furnished by salaried employees;

(b) Accepting the patient for treatment in accordance with its admission policies;

(c) Maintaining a complete and timely clinical record on the patients, which includes diagnoses, medical history, physician's orders, and progress notes relating to all services received;

(d) Maintaining liaison with the attending physician regarding the progress of the patient and the need for revised orders;

(e) Ensuring that the medical necessity of such services is reviewed on a sample basis by the utilization review committee if one is in place, the facility's health professional staff, or an outside utilization review group.

On its face, this strategy seems like a win-win. The hospital is able to bill at higher rates. The physicians do as well as they would have done if they had owned their own surgery center. However, while it may be beneficial for physicians and hospitals (and thus has become very attractive), it is not necessarily viewed as such by Medicare, Medicaid or the commercial payors. "Under arrangements" raise a significant number of concerns from their vantage point. Specifically, rather than enjoying the lower rate that surgery centers bill, the payors, including Medicare and Medicaid, pay the higher rates chargeable by hospital outpatient departments. In addition, there are a number of other legal concerns from several perspectives:

(a) It raises issues from an Anti-Kickback Statue and Stark Act perspective.

(b) To the extent a tax-exempt hospital is involved, it raises issues as to private inurement and of proper use of tax-exemption proportion for the hospital partner (if a tax-exempt entity).

(c) It raises anti-trust issue (i.e., are the hospital and physicians, as two separate parties, arranging to jointly do business together so as to raise the rates chargeable to payors).

Thus, it is expected that there will be increased concerns over the use of this type of model. ■

Evaluating Opportunities in Outpatient Surgery Centers: Using Benchmarking Data to Ensure Success

By Chad Coben, Informed Healthcare Media and Greg Koonsman, VMG Health

The outpatient surgical market continues to gain momentum with an increasing number of surgical cases directed to both ambulatory surgical centers (ASCs) and their larger counterparts, hospital outpatient departments (HOPDs). With this growth in case volume, the outpatient surgical business continues to become increasingly important to the profitability and financial health of many healthcare organizations.

Now more than ever, close attention is being paid to opportunities in the outpatient surgical market. Whether it is evaluating the potential spin-off of a hospital outpatient surgical department into a freestanding license, analyzing the performance of an existing freestanding surgery center partnership or turning around an underperforming center, having a clear understanding of the details of the business is increasingly important.

Information, or business intelligence, is critical to running any business successfully. Consistently reviewing internal financial and operating reports is a critical process in understanding operating performance of any business, outpatient surgical center businesses are no exception. Reviewing static information from a single reporting period is a necessary step in getting a picture of an ASC's level of performance. Evaluating the information period to period is also helpful in understanding trends and getting a clearer view of how the business is performing. The picture, however, is not complete without putting it into the context of how it performs in comparison to other outpatient surgery centers.

Understanding relative performance helps provide clarity on the business as a whole. It can help to identify areas that are operating smoothly, as well as areas for improvement. In evaluating potential transactions, relative financial performance detail and industry benchmarking data provides the insight necessary to make educated judgments about moving forward or not.

In evaluating opportunities, like the spin-off of an HOPD into a licensed, freestanding ASC, the analysis is even more dependent upon comparable data to provide a model of the proposed business. Without quality comparable benchmarking data, opportunities are inappropriately evaluated and often overlooked.

Take, for example, a provider-based hospital outpatient surgical department. The facility has three operating rooms in the medical office building adjacent to the hospital complex. This facility currently accommodates approximately 3,350 cases per year from predominantly four specialties, Orthopedics, Pain Management, Podiatry and Otolaryngology (ENT). The health system is contemplating re-licensing the facility as a freestanding ASC and syndicating a percentage of the equity ownership to qualified surgeons in the marketplace.

In order to evaluate the opportunity and ultimately effect a transaction, the hospital system's executive management needs to understand the financial impact on their operation. What would this new entity's financial statements look like on a pro forma basis? What would be the value of this new entity in connection with a transaction that would also support the Fair Market Value standard as required by anti-kickback statutes and tax laws?

The departmental financial statements of this HOPD are the right place to start, but they would not be representative of the new entity. Hospital reimbursement rates are different than licensed, freestanding ASCs rates, rendering the reported historical net revenue largely irrelevant. The HOPD expenses, which likely include indirect allocations of staff time, overhead and other expenses, often misrepresent the true expense profile of the center.

Given that the departmental financial statements would not be representative of the new entity, what is the best way to develop a clear picture of what this new ASC would look like?

By using the reliable components of current operating information coupled with high quality benchmark data and other intelligence on the ASC market, new pro forma statements can be developed providing management a clear understanding of the pro forma ASC results. This process is dependent upon high quality benchmark data.

The analysis would begin with case volume by specialty and payor mix. By using the case volume and mix from the detailed operating reports, and applying what we know from industry benchmarks, we can arrive at a good estimate of what gross charges and net revenue should be.

In this example, the case volume detail, across the four contributing specialties, is approximately 1,200 (or 46.7%) Orthopedic cases, 750 (or 10.7%) Pain Management cases, 500 (or 16.2%) Podiatry cases and 900 (or 26.4%) ENT cases. Using industry benchmark data[1], gross charges and net revenue for the ASC on a pro forma basis are estimated. Using data that draws upon centers with greater than 50% orthopedic volume ensures the comparability and increases the quality of the pro forma results.

Gross charges and net revenue for Orthopedics in ASCs of similar size, volume and case mix are reported to be approximately $6,009 and $2,136, respectively. Using the Orthopedic case volume and the benchmark gross charges and net revenue, the pro forma revenue from Orthopedics is estimated to be $7.2 million. Using the same gross charge and net revenue detail for the other specialties, the total pro forma gross charges and net revenue for the new entity are estimated to be $15.4 million and $5.4 million, respectively.

Based on a count of the current staffing at the facility and a review of staff hours per case in the benchmarking data, the initial staff requirement is estimated to be 24 full time equivalents – 12 nurses, 5 techs, an administrative staff of 6 and one full time administrator. Administrative staff necessary to run the surgery center as a stand alone partnership basis was estimated. Based on the respective wages of all of the employees, the total salaries and wages to staff the ASC is expected to be just over $1.15 million. Utilizing the actual benefits structure of 22.5% of the total salaries and wages, the total expected employee expense is slightly over $1.41 million, or 26.2% of total net revenue.

Benchmark information is used to verify the total staffing levels and costs by comparing the expected staffing to comparable centers. Based on the benchmark data, staffing levels in a facility of this size are typically in the 20-25 FTE range with the detail of nursing, technicians and administrative staff consistent with what has been estimated. Using staff worked hours per case, the staffing levels were supported using ASC benchmark data. Additionally, the industry reported wages and benefits expense information is also consistent with initial estimates, at 21.4% for employee salaries and wages and 4.8% for benefits expense (26.2% total).

Medical supplies represent the second largest expense category behind staffing in outpatient surgical facilities. Based on industry benchmark data[2], the average medical supplies in a multi-specialty ASC, including medical supplies, pharmaceuticals and implantable devices are approximately $275 per case. In facilities with concentrations in Orthopedics, this expense category is typically higher. Using an estimate of $355 per case, the pro forma expense for total medical supplies would be $1.2 million. This represents 20.1% of net revenue, in line with the industry benchmark of 24% of net revenue. Hospital supply cost data was also used to verify the supply expense.

The existing facility is a three operating room facility with two procedure rooms located in the Southwest. The facility is 11,750 square feet in total and has three years remaining under its lease agreement. The current occupancy costs, including

[1,2] The benchmark information is taken from the *InforMed Multi-Specialty ASC Intellimarker*. *InforMed's Multi-Specialty ASC Intellimarker* is a study of over 250 licensed, freestanding ASCs around the country developed using actual operating data from participating ASCs. InforMed Healthcare Media is an independent research and consulting company providing business intelligence on the outpatient surgical market.

utilities, janitorial and security, is $29.50 per square foot, or $346,625 per year. Actual lease information is always more reliable; however, a comparison can be made to benchmark data in order to understand whether the facility cost is higher or lower than the benchmarks. Based on benchmark data, other comparable ASCs in the Southwest report total occupancy costs of $30.76 per square foot. The existing lease expense and the comparable facilities are very close together in estimating total facility expenses. As a result, the facilities expenses are likely to be a reliable estimate in the pro forma.

In the case of this newly formed entity, hospital management intends to hire an independent management company to help oversee the facility and attend to the management responsibilities of the center. Management fees for the newly formed partnership are expected to be 6% of net revenue less bad debt. Industry benchmark data confirms a 6% management fee is consistent with the industry benchmarks for management services contracts.

Because the freestanding ASC will be operated separately from the hospital and by a management company, other expenses are likely to more closely resemble other ASCs than the historical experience of the HOPD. As a result, general and administrative expense benchmarks can be used to estimate the remaining expense categories in developing the pro forma statements. For example, insurance costs are typically slightly over 1%; bad debt is approximately 1% and other general and administrative expenses are would be expected to be consistent as well as in the 9% of net revenue range.

The total expenses, based on the combination of actual data from the HOPD as it operates today and intelligence gathered from industry benchmarks, are expected to be approximately $3.9 million, resulting in earnings before interest, taxes, depreciation and amortization (EBITDA) of slightly over $1.5 million, a 28.6% EBITDA margin. The table below illustrates the summary pro forma income statement for the new entity.

Revenue Detail	Case Volume	$ per Case (1)	Pro Forma	%
Gross Charges				
Ortho	1,200	$ 6,009	$ 7,210,800	*46.7%*
Pain	750	$ 2,205	$ 1,653,750	*10.7%*
Podiatry	500	$ 5,002	$ 2,501,000	*16.2%*
ENT	900	$ 4,528	$ 4,075,200	*26.4%*
Gross Charges	3,350		$ 15,440,750	
Net Revenue				
Ortho	1,200	$ 2,160	$ 2,592,000	*16.8%*
Pain	750	$ 848	$ 636,000	*4.1%*
Podiatry	500	$ 1,569	$ 784,500	*5.1%*
ENT	900	$ 1,550	$ 1,395,000	*9.0%*
Net Revenue	3,350		$ 5,407,500	

(1)Based on information drawn from InforMed's Multi-Specialty ASC Intellimarker.

Summary Income Statement	Pro Forma (1)	%
Gross Charges	$ 15,440,750	
Contractual Discounts	(10,033,250)	
Net Revenue	$ 5,407,500	*100.0%*
Salaries and Wages	1,154,853	*21.4%*
Taxes and Benefits	259,560	*4.8%*
Rent and Occupancy	346,625	*6.4%*
Medical Supplies	1,088,750	*20.1%*
Other Medical Expenses	100,500	*1.9%*
Insurance	59,483	*1.1%*
Bad Debt	54,075	*1.0%*
Mgmt. Fees	324,450	*6.0%*
Other G&A	470,453	*8.7%*
Total Expenses	$ 3,858,748	*71.4%*
EBITDA	$ 1,548,752	*28.6%*

(1) Based on information drawn from InforMed's Multi-Specialty ASC Intellimarker and historical financial and operating information.

Other information can also be developed to supplement the income statement using industry benchmark information. A balance sheet can be created using the same approach. The capital cost necessary to build and equip the surgery center in

addition to the resulting return on investment (ROI) can be estimated using the benchmark data and local estimates of costs. Revenue cycle detail and working capital needs can also be developed through a combination of the internal data and the industry intelligence.

With the pro forma financial statements complete, the process of budgeting and creating projections for the future is nothing more than an extension of the same process, using a combination of internal information and outside benchmark data to confirm both revenue and expense estimates. Using both sets of information provides additional and independent verification of assumptions and provides an additional layer of comfort in the reliability of the numbers.

Fully evaluating opportunities has never been more important. While this example illustrates the spin-off of a provider based outpatient department, the process of developing pro forma numbers for comparison can be used in a number of ways. Whether it is in evaluating the spin-off of a provider based outpatient department, valuing or analyzing an opportunity to buy into a physician owned partnership, isolating operating performance issues in an existing ASC or trying to effect a turnaround of an underperforming ASC, understanding the situation is the necessary first step and information is the critical tool. Leveraging internal information is the starting point, but the picture is not complete without quality comparable data. ■

BIOS:

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Efficient Staffing Models – An Interview With Dr. Brent Lambert

By John Harris

To Brent Lambert, turning around a money-losing surgery center is a simple matter. "If staffing costs are 40 percent of revenues, I know we can turn the center around," says Lambert, co-founder of ASCOA. "In money-losing centers, staffing is usually the biggest offender."

According to estimates from McGuire Woods, more than one-third of all ASCs break even or lose money. Lambert says ASCOA continues to see an increasing number of broken centers. "Staffing costs across the industry are about 32 percent," he says. "And we see some centers at 50 and 60 percent of revenues."

"Our centers average 20 percent of revenue for staffing because we developed a model that blends strong management, respect and appreciation for hard work and a tremendous emphasis on efficiency," says Lambert.

Today, ASCOA owns and manages more than 25 surgery centers across the country.

Lambert stresses that the key to a great staff comes from the people you hire – and how you manage the staff. His keys to successful staffing:

■ Hire the right people and give them a stimulating, fast-paced work environment. "We hire high energy people who like to work," Lambert says. "These are people who get bored standing around working at a hospital. They work hard, they inhale their lunches and keep going. But they also don't have to work nights, weekends or holidays, and they aren't on call either."

■ Run lean. Typically, ASCOA puts only a few full-time people on its payroll. The scheduler, for example, also serves as the receptionist. The billing department consists of two to three people. "We use a lot of PRN people we can pull in quickly," says Lambert. The other advantage: Lambert says his people often do the work of one-and-a-half people.

By employing mostly part-time staff, ASCOA also avoids many holiday, vacation and sick day issues. "We recently looked at investing in a center that gave its employees eight weeks of paid vacation time," Lambert recalls. "The owners of the center wanted to protect these people and their benefits, so we walked away from the deal."

■ Hire part-time staff that desire flexibility. Lambert says ASCOA centers employ mostly part-time staff to keep costs down and provide highly skilled employees with a flexible work schedule. "Take a mom with kids. She gets someone to watch the kids two days a week, she gets out of the house and keeps her sanity," he says. "It's a great arrangement. They're paid well."

■ Compress the schedule. Many ASCOA centers operate only two or three days per week from early morning to mid-afternoon. "Our operating rooms run non-stop. We just schedule everything back to back, so no one can be late, including the surgeon. There's no lunch break per se—often the nursing coordinator scrubs in so others can take a break—and we just keep going," says Lambert. "When the cases are done, we turn out the lights and go home. So you're only paying people for time they work. No overtime, no downtime."

■ Make work enjoyable. "We like to run a friendly place and treat staff and patients with the greatest respect. We like to have a sense of humor too," Lambert says, adding that ASCOA pays an annual bonus to staff members. "There's a queue to work in our centers."

■ Reward leadership. ASCOA administrators fulfill the role of CEO, CFO and COO, so hiring a great leader and empowering the administrator to run the center is critical to ongoing success. "Our administrators share in the success of the center. We have never had a doctor complain because the center runs efficiently." Lambert says.

At ASCOA, staffing the center—and the costs associated—drive efficiency and profitability. And there is an added bonus: staff stability. Lambert says ASCOA's retention rates are considerably higher than the industry average. "When we go in to fix a center, we're very clear about all the ways we can help turn a center around," says Lambert. "Staffing is the big one, and we're very clear that by driving down costs we can also improve productivity—and morale—and return the center to health quickly." ■

For information on the June Orthopedic, Spine, Neurological and Pain Management Driven ASC Conference, please visit www.beckersasc.com or call Michelle Freeland at 858-565-9921 or Scott Becker at 312-750-6016.

Statistics Chart

Number of Public Hospitals Decrease

1985 1,578
1995 1,350
2005 1,110

Source Modern Health Care, Oct. 23, 2006; American Hospital Association

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Administrator Salaries

National

2006 Mean $86,353
2006 Median $84,922
High $467,060
Low. $12,000

Source FASA Salary and Benefits Survey, 2006

States With Most ASCs

California. 619
Texas 314
Florida 338
Washington 214
Pennsylvania. 191

Source FASA Salary on Benefits Survey, 2006

Director of Nursing Salaries

2006 Mean $65,853
2006 Median $69,663
High $140,000
Low. $15,000

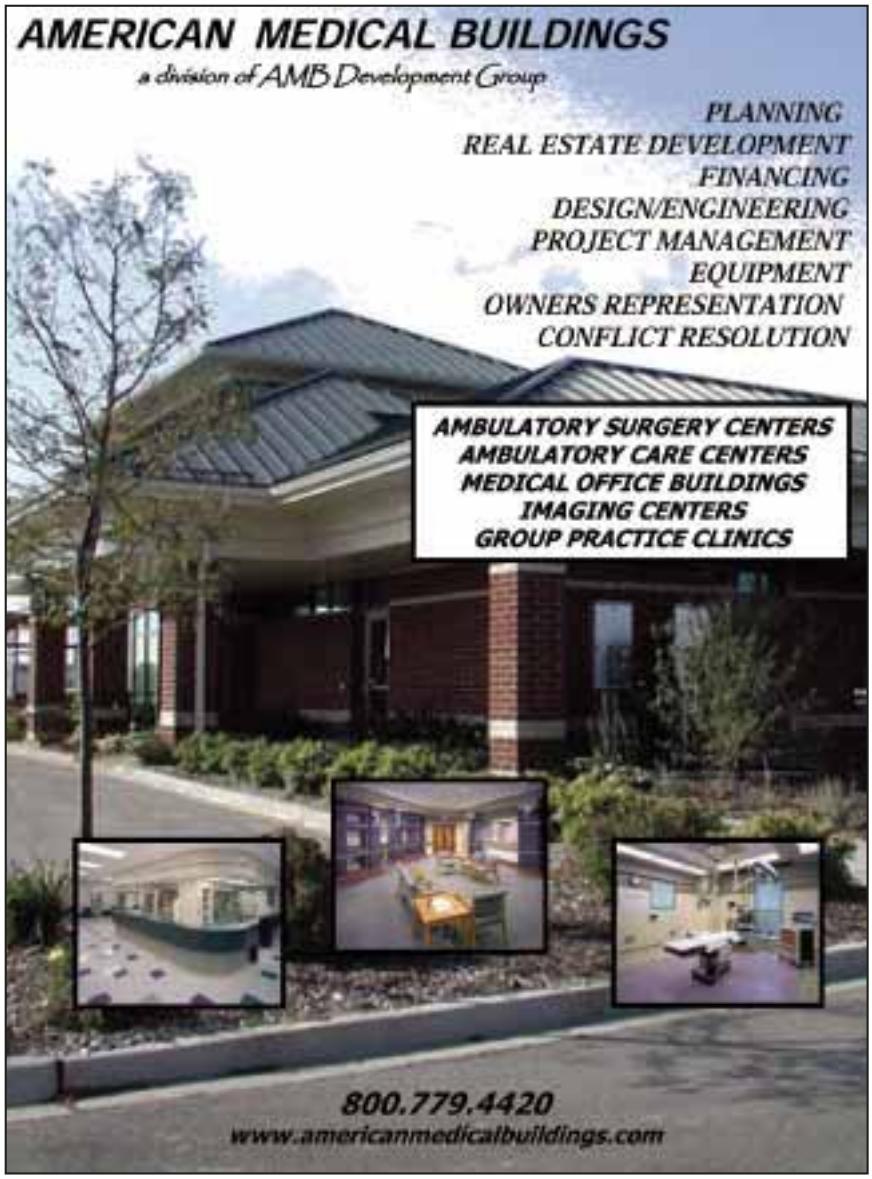
Source FASA Salary and Benefits Survey, 2006

Medical Director

Time Devoted to Medical Director Activities

Median 10%
Mean 18.8%
Low 1%
High 100%

Source FASA Salary and Benefits Survey, 2006



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