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BECKER'S ASC Review
AMBULATORY SURGERY CENTERS BUSINESS AND LEGAL UPDATE

Pricing for Redemption – Two Key Options

This article provides a brief discussion of the various options for redemption pricing under an ASC Operating Agreement. An Operating Agreement often provides for certain events designated as "Adverse Terminating Events" and certain other events designated as "Non-Adverse Terminating Events." The Adverse Terminating Events are those events for which the Company may, at the Company's sole option, elect to redeem a Member, whereas the Non-Adverse Terminating Events are those events for which the Company is often obligated to redeem a Member and purchase such Member's ownership interest in the Company. There is often a distinction between the pricing for an Adverse and Non-Adverse Terminating Events. The redemption price for an Adverse Terminating Event often yields a lower redemption price than that for a Non-Adverse Terminating Event.

In short, the redemption methodologies for Non-Adverse and Adverse Terminating Events should work such that the Adverse Terminating Event methodology should not yield a higher result than the Non-Adverse Terminating Event methodology.

There are two basic valuation options: a formula approach and an appraisal approach. As to the formula approach, there are also two basic methods with many variations (e.g., formula based on a multiple of earnings or based on book value). This article provides an overview of those methods.

I. Non-Adverse Terminating Event Options.
Options for redemption pricing for Non-Adverse Terminating Events include the following:

A. Formula Approach. A formula amount is often based on the Company earnings for a designated period. Such a formula amount is mechanical to administer and can serve as a very rough approximation of the fair market value of the Member's ownership interest in the Company. This approach avoids the time and expense involved in an appraisal. It is also intended to limit disputes over fair market value. The big drawback to a formula amount is that it is not always a good approximation of fair market

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Selling an Ambulatory Surgical Center

This article examines four issues related to the selling of an ambulatory surgical center. First, the article examines the two key reasons why owners of surgery centers choose to sell their centers. Second, the article discusses the two types of national buyers for surgical centers. Third, this article addresses the ways in which the center should prepare itself for a sale and handle the sale process. Fourth, the article discusses the eight to ten key legal and business issues that a center should focus its negotiations on.

I. Choosing to Sell.
There are two critical reasons why a center chooses to sell or align with a partner. First, it may be seeking to simply take "cash off of the table" or balance the portfolio of its partners. Second, it may be seeking a partner to help the center improve its operations and performance.

A. Risk Reduction.
A typical situation in which a center may find itself is exemplified by the following situation. One of the surgery center owners has a net worth of $1 million. He also has an interest in a surgery center that is equal to 10% of the center. The center generates income of $1.5 million a year. Hence, based on a typical sale multiple, the Center has a value of $9 million. Thus, the owner has a net worth of $1 million, however, $900,000 of his net worth is tied up in his interest in his surgery center. In essence, the value of his 10% of $9 million is worth $900,000. In this situation, from a pure portfolio allocation model, he or she has way too much of his or her net worth in a surgery center.

When the surgery center examines a sale closely, it then has to analyze the value of the present opportunity to sell the center versus the value of continuing to obtain distributions. Here, the example is as follows.

1. The surgeon who owns 10% currently receives $150,000 a year in distributions.

2. In a sale, we assume that he would sell half of his or her right to those distributions. In essence, he or she would give up $75,000 a year in distributions.

3. On an after tax basis, that $75,000 a year translates into approximately $45,000 a year after the physician pays taxes at the 40% level on the $75,000. Thus, a sale of 50% of the center would equate in simple terms to giving up $75,000 a year which equals $45,000 a year after tax. He or she still would receive the other $75,000 in earnings per year.

4. In connection with the sale, he or she would receive $450,000. This equates to 10% of the value of the center (or $900,000) divided by 50%. This is the portion of his or her interest that he or she would sell. After taxes, this $450,000 equates to approximately $390,000. This is because this is taxed at a capital gains rate of 15% and not at higher ordinary income rates.

5. Thus, given a present cash inflow of $390,000 it would take him or her approximately nine years at earnings of $45,000 to earn the same amount of money if he or she just simply held on to that 50% interest. He or she would also receive interest or some return per year on the $390,000 that he or she receives. Assuming he or she receives interest of approximately $13,000 to $15,000 a year after taxes, the real holding period to break even on simply holding onto the ASC interest is closer to 12 years as opposed to 9 years.

6. At the end of nine years, if one chooses to hold the ASC interest, in addition to having received the distributions for nine years, he or she still also owns the entire 10% interest in the surgery center. Thus, if someone is optimistic about the future of the center and does not have a great concern about the risks, even though modern portfolio theory may encourage the person to sell his interest in the surgery center, he or she would be better off holding onto the interest.

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SEE PAGE 5 FOR INFORMATION ON 2006 CONFERENCES.

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Letter from the Editor

1. Selling an ASC; Turning an ASC Around; Redemption Pricing in ASC Transactions. This issue includes several articles we hope you will find of interest. Please email me with questions or comments or arguments you have related to these articles.

2. Questions and Comments. If you submit a question that we use in the ASC Review Q and A section, ASC Communications will pay you $50. If you submit detailed and reasonably constructive and useful comments on either the ASC Review or the Becker ASC website (www.beckersasc.com), we will provide a check for $100 (up to 10 people). Please email questions or comments to sbecker@mcguirewoods.com.

3. Orthopedic Driven ASC Conference – June 22-24, 2006. This issue includes the brochure for the Orthopedic, Neurosurgical, and Pain Management Driven ASC Conference. This conference is being held June 22 to 24th, 2006 at the Hilton Hotel on Michigan Avenue in Chicago. We are delighted to have the best array of speakers that we have ever had. The conference includes a larger number of physician leaders speaking than we have had before as well as three pre conferences and a number of very operational driven topics. Topics include a physician's view point on partnering with national companies and partnering with hospitals, topics related to items such as staffing ratios, recruitment of physicians, out of network versus in network operations, managed care contracting and several other subjects. The pre conferences relate to (1) "turning around" an ambulatory center (Regent Surgical Health contact Tom Mallon at 708-686-1522), (2) developing an ambulatory surgical center (Ambulatory Surgical Centers of America contact Dr. Brent Lambert at 781-258-1533), and (3) establishing and operating physician hospital joint ventures (Woodrum ASD contact Robert Zasa at 626-403-9555 or Joe Zasa at 214-912-9502 and Surgery Consultants of America, Inc. contact Caryl Serbin at 888-453-1144). Overall, we think it is a terrific agenda.

4. Congressman Tom Price, M.D. We have added to the agenda Congressman Tom Price, M.D. Dr. Price is both a United States Congressman and an orthopedic surgeon. He will be speaking on Saturday morning, June 24th.

5. Exhibitors. At last year's Orthopedic Driven ASC conference, we had a great line up of exhibitors and sponsors. We are very thankful for their participation. These included:

Ambulatory Surgical Centers of America	Brent Lambert, M.D. (781) 871-3311
Arthrex, Inc.	Renee Power (239) 643-5553
B. Braun Medical	Karen Kingston (610) 997-4259
Caperian, Inc.	Jeni Williams (407) 367-0944
Cirrus Health	Melanie Arriola (817) 837-1100
CIT Healthcare	Jeff Fox (770) 592-1859
CitiCapital	Ken Seip (847) 548-3931
GHN-Online	Jennifer Campbell (214) 696-5717
Health Inventures	Richard Hanley (720) 304-8997
HealthCare Appraisers, Inc.	Todd Mello (561) 330-3488
HR America	Ryan Stoneburner (260) 436-3878
Lauth Property Group	Michael Wagner (317) 575-3069
Managed Network Strategies, LLC	Steve DuFresne (301) 774-7597
Marasco & Associates, Inc.	John Marasco (303) 832-2887
MarCap Corporation	Peter Myhre (800) 621-1677
Marshall Erdman & Associates	Lowell Hansen (608) 218-6412
MedCapital Group	Todd Tidmore (972) 385-8500
MedHQ	Mitzi Babich (708) 492-0519
Medline Industries, Inc.	Karen Scott (847) 949-4186
Mobile Instrument Service	Beverly Young (937) 592-5025
National Medical Billing Services	Lisa Rock (636) 273-6711
NovaMed, Inc.	William Kennedy (312) 664-4100
National Surgical Care	Bryan Burgett (312) 419-1033
Nueterra Healthcare	Lynette Ewy (913) 685-2111
PainCare, Inc.	Jeni Williams (407) 367-0944
Physicians RX Network	James Clemens (510) 581-6314
Pinnacle III	Ginger Farquhar (303) 550-1132
PMT Corporation	Jessica Stoneburg (952) 470-0866
Prescient Healthcare Systems	Albert Samaras (203) 488-8470
Provation Medical, Inc.	Laura Gilbert (612) 313-1506
Regent Surgical Health, LLC	Thomas J. Mallon (708) 492-0531
SevenD & Associates, LLC	Ann Deters (217) 342-2255
SG2	Steve Miff (847) 733-9080
Smith & Nephew Endoscopy	Sue Hanlon (508) 261-3701
Source Medical Solutions	Marc Dinkel (205) 972-1222
Stryker	Jennifer Parr (800) 253-3210
Surgery Consultants of America, Inc.	Caryl A. Serbin (239) 482-1777
Surgical Notes	Dennis Blankinship (214) 821-3850
The McShane Companies	Sarah McLain (847) 292-4300
Value Management Group	Greg Koonsman (214) 369-4888
VBM Medical, Inc.	Tina Chen (317) 776-1800
WDM Healthcare Design	Les Mock (316) 262-4700
zChart	Tom Felstead (866) 924-2787
Ziehm Imaging, Inc.	Jayne Miller (951) 781-2020

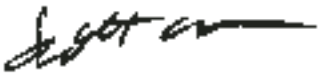
For questions or issues related to the conference, please contact Ken or Michelle Freeland at 858-565-9921

or by email at Ken@pcmisandiego.com or Michelle@pcmisandiego.com.

6. Tom Hui, HST Technologies. We have been informed that Tom Hui is starting a new software and technology firm aimed at servicing the ASC market.

Should you desire more information related to the June ASC conference, to the ASC Review or to other issues, whether related to attending the conference or being an exhibitor or sponsor, please call Michelle Freeland or Ken Freeland at 858-565-9921 or myself at 312-750-6016 or at sbecker@mcguirewoods.com.

Very truly yours,



Scott Becker

The ASC Review is published 6 times per year. It is distributed to approximately 12,000 persons per issue with distribution of 20,000 issues for each the May–June issue and the September–October issue. For information regarding advertising or subscribing, please contact Ken or Michelle Freeland at 858-565-9921 or by email at ken@pcmisandiego.com and michelle@pcmisandiego.com.

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value. The formula amount utilizes a multiple, which we typically see as 3 to 4. A sample formula amount is as follows:

(1) The "formula amount" shall be equal to the product of a multiple, which shall initially be four (4) (the "Multiple") times the average of the Company's net operating income (in accordance with United States generally accepted accounting principles), excluding extraordinary gains and losses, calculated before deduction of interest, taxes, depreciation and amortization ("EBITDA") for the most recent two (2) fully completed prior calendar years, then minus all of the ASC's outstanding long term debt and long term liabilities (including equipment lease financing obligations) as of the date of the withdrawal/resignation determined in accordance with United States generally accepted accounting principles as determined by the Company's accountant.

(2) If any Member's ownership interests are purchased because of the occurrence of a Non-Adverse Terminating Event, the amount the Company shall pay for the ownership interests shall be equal to the formula amount multiplied by the unit proportion.

(3) If any Member's ownership interests are purchased because of the occurrence of an Adverse Terminating Event, the amount the Company shall pay for the ownership interests shall be the formula amount discounted by forty percent (40%) multiplied by the unit proportion.

A formula based on earnings usually uses historical earnings (over one year or an average of two to three years) as its foundation. Where income is relatively steady a formula based on historical earnings provides for a fairly predictable amount. In times where earnings are falling, the formula can overvalue ownership interests, and the opposite is true where earnings are rising. A formula based on earnings may be appropriate for buy-outs but is generally not the final vehicle for a determination of a buy-in price.

B. Appraisal Approach. Another alternative for redemption pricing is fair market value as determined by an appraisal. The logistics of, and cost allocation for, such an appraisal can be structured in numerous ways. For example, the Company could employ an annual appraisal and utilize the findings for any redemptions during the applicable year. The Company could also wait to engage an appraisal only when a redemption situation arises, and in such case, either the Company and the redeemed Member could use a mutually agreeable appraiser or they could engage their own appraisers and employ a third party appraiser in the event the difference between the Company's and the redeemed Member's appraisals differ by a certain margin. The cost for

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Selling an Ambulatory Surgical Center
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B. Improving the Center.

The second core reason why people sell an ambulatory center is to help them improve management and operations. It is often the case that a national third party with good management skills can bring discipline to a center and greatly improve a center's year to year and day to day operations. Here, we have seen companies help centers improve billing and collections, improve recruiting of physicians, manage supply costs and expenses, and take a number of steps to greatly improve the operations of the center. We have seen this happen many times. At the same time, there are a whole number of national management companies that are not qualified and will not offer much help at all. In this regard, it is critical that a center do its due diligence very carefully as to the potential strengths of the management company. Some are good, some are not.

II. Two Types of Buyers.

There are two key types of buyers of surgery centers. These can be broken down simply into those that acquire a majority interest and those that acquire a minority interest.

A. 50% or More.

The majority interest acquiring companies are typically companies attempting to be a consolidator of surgery centers and either trying to become a publicly traded entity or trying to sell themselves to a publicly traded entity. Here, the transactions are often characterized by a deal in which the national company will buy more than 50%, a deal in which there will be a significant management fee, and a deal in which the management company may or may not bring much value as a manager. In many situations, these companies are the companies that pay the highest "multiples." In essence, six to eight times earnings for a majority and controlling interest in a center. There are several major companies that fit this type of category. For example, United Surgical Partners, Symbion, NovaMed, National Surgical Care, Meridian, AMSURG and Medical Facilities Corporation. There are also others.

B. Minority Interest.

The second type of management company is the type of company that is really brought in to help improve the operations and the results of the center. This company may also help the center improve its operations such that in a couple of years it is also helping the center to be ready to sell to the companies that buy a majority interest. In fact, increasingly, these companies do a terrific job of helping improve the results of centers and then helping them to sell their center to one of the consolidating

national companies. These companies typically attempt to bring smart management and day to day blocking and tackling to the improvement of centers. Often, a third party which is good at what it does, has the ability to provide advice and counsel on decisions to improve results in a manner that a physician colleague does not have the same ability to do. Here, three of the companies that seem to make lots of efforts in this regard include Ambulatory Surgical Centers of America, Regent Surgical Health and Woodrum ASD. There are also others.

With respect to all of these companies, there are two sets of "due diligence" efforts that should be undertaken. First, and most important, it is critical that the physician leaders of the center speak with lots of physicians that work with these companies. Here, the discussions need to be with "non reference" physicians that have worked with these companies. In addition, the parties must attempt to negotiate fair and reasonable legal documents. The documents will differ significantly between a sale to a national consolidator of more than 50% as compared to negotiations with minority interest owners being brought into manage and improve the center. Typically, the rights of a national consolidating company will be much more expansive than the rights of the companies coming in to buy minority interests.

The typical majority interest buyer typically pays 6 to 7 times EBITDA. In contrast, a minority interest buyer may often pay a smaller multiple of EBITDA. Further, in certain situations, a sale to a minority interest buyer may be an intermediate step to a later sale to a majority interest or national company buyer.

III. Know Your Center.

The third important part of the process relative to the sale of a center relates to a center knowing its own business and its own situation. Here, a center typically begins with providing potential buyers with a confidentiality agreement and a small book which provides information relative to the center, including disclosure of financial statements and the typical key facts related to the center. A center should examine issues when it looks at selling its center such as:

A. How is it doing on expense management? Does it have a reasonable amount of staff, supplies and costs for a center with the amount of cases it does?

B. What growth opportunities does the center have? Is there the ability to bring in new physicians, to raise reimbursement rates, or other things that could serve as an advantage to a potential buyer?

C. The center should make sure that in the period of time it starts to look at selling that it keeps its efforts very strong. In most situations, there is no assurance that a center will be able to make a transaction happen between both the buyers on the one hand and the sellers (and the physicians) on the other hand. Thus, it is critical that partners continue to manage the business very well.

SAVE THESE DATES FOR 2006 CONFERENCES—

June 22-24, 2006
Chicago, Illinois

The 4th Annual Ambulatory Surgery Centers Orthopedics, Detailed Program-Ortho, Neurosurgery and Pain Management Driven ASC Conference.

October 26-28, 2006
Chicago, Illinois

The 13th Annual Ambulatory Surgery Centers Business and Legal Issues Conference–Improving, Establishing and Joint Venturing ASCs.

For information, please contact Scott Becker at 312-750-6016, sbecker@mcguirewoods.com; or Ken Freeland at 858-565-9921, ken@pcmisnadiego.com.

D. Does the center know if it has legal or accounting problems? Are the billings and codings being handled correctly?

E. Have there been improper payments or ownership changes made? Have physicians been allowed to buy at below fair market value and have shares been allocated based on how many cases can be performed?

F. Does the center have malpractice coverage?

G. Does it have appropriate reserves for contingencies?

H. Is the center subject to lawsuits? Is there qui tam litigation or problems?

I. Are the physicians bound by non-compete covenants?

J. Is the center overly dependent on any one contract or managed care payor or out of network business?

K. Is the center over reliant on any few physicians?

These are all questions that are aimed at helping a center to understand the kinds of issues that a buyer will want to know about. In almost all situations, a seller is much better off informing a buyer of these types of issues rather than allowing the buyer to discover them through due diligence. The more that a seller is upfront with the buyer the better chance there is that a transaction will be completed in a smooth manner. Further, full disclosure often helps avoid problems between the parties after the transaction.

IV. Negotiation of the Transaction.

The buyer and seller in a typical ASC transaction need to negotiate eight to ten critical issues. Then, in most deals there are a couple of issues that are specific to that deal. This may include the need for the extension of a lease, the need for a specific physician to have a covenant against competition carved out or other particular issues related to that transaction.

The key issues often include the following:

A. Price.

Obviously, in any transaction, particularly one involving the intent to take cash off of the table, the purchase price and total valuation for the center will be a critical issue. There, prices range for mature centers from four to eight times EBITDA. Further, the six to seven times multiple range is often paid where a party is buying a majority interest in a mature center. One can expect a lower price where someone is not selling a majority interest or entering into a long term management contract. Typically, a minority interest buyer will pay a reduced price or a price that is lower by 30 to 40%.

B. Percent to be Sold.

The parties must decide how much of the center the buyer will acquire. Will they require a majority percentage or a minority percentage? This will impact a number of issues from voting rights to pricing of the transaction to a number of other issues.

C. Split of Board of Managers.

A national party or buyer of a majority of interest typically expects almost complete control of the Board of Managers. In contrast, a minority ownership buyer will often have a smaller role on the Board of Managers but will also have a management contract and will have reserve rights. With respect to Board split, the parties must also decide whether the Board votes will be one vote per manager or whether votes will be allocated vote based on the number of shares held by the parties that appoint the Board members.

D. Reserve Powers.

The party which controls the Board will often have to share rights and control with the parties that do not share control of the Board. This is often accomplished through "reserve rights." Reserve rights provide a class of shareholders the right to approve or veto certain transactions. These might include, amending the agreement, a self dealing transaction, a merger, an expenditure over certain amount, a certain amount of dilution of ownership, and certain other issues. For example, Party A may control the Board but Party B may have to approve of these actions in order for Party A and the center to take these actions.

E. Non Compete Covenants.
Negotiated issues related to the non-compete covenants include their duration and the geographic area that they cover. In most transactions, where a majority buyer is buying a great deal of control and paying a great deal of money, they will want extensive non-compete covenants. Here, further issues that need to be taken into account include whether physicians will be able to operate and do surgery in their own offices and whether or not certain existing ownership in other ASCs will be "grandfathered."

F. Further Dilution.
The parties must determine how further dilution will be accomplished. Are there going to be certain protections for the physicians against too much dilution without their vote?

G. Redemption Rights.
The parties must assess how physicians may be later redeemed from the venture. First there are often involuntary events upon which a physician must redeem his or her units. These include, for example, loss of privileges, death, retirement, and certain other items. A second question relates to whether the physicians have the right to unilaterally refuse to walk away from the deal. Many national companies are reluctant to provide this right. Further, parties must look at what price will be paid upon redemption.

H. Management Agreement.
The parties must negotiate the length of the management agreement and the Management Fee. For example, is there a limit to the fee, does the percentage fee go down after a certain amount of revenues, are there limits to the out of pocket expenses that can be reimbursed.

I. Current Receivables and Payables.
Another key issue arises as to who will be responsible for and/or be able to keep the current accounts receivable and accounts payable. This issue really relates in part to the value of the center. For example, if the Seller can leave all payables with the center but keep all receivables, they for all practical purposes receive a higher purchase price. In contrast, if the Seller must keep receivables in the business and also be responsible for all liabilities and payables, this for all practicable purposes means that the price is actually lower.

J. Process.
A last set of key issues that need to be negotiated include the timing of closing, the due diligence that must be completed, and the type of after transaction

responsibility that the Sellers have for problems that arise with respect to the center. These types of concepts are often found in the representations and warranties sections, the closing sections, and the indemnification sections of the purchase agreement. These are very important as well.

This article is intended to provide an overview of the issues that are faced when a party is selling a surgery center. It attempts to provide information as to each of the reasons for selling, the types of buyers, the types of issues that need to be negotiated, and the diligence that a seller should have in determining to sell its center.

Should you have any questions, please contact Scott Becker at 312-750-6016 or at sbecker@mcguirewoods.com. ■

$7,300,000
Term Loan used for the acquisition of four MRI centers in Texas

CIT Healthcare
Sole Lender

AMERICAN HEALTH IMAGING

$38,500,000
First Mortgage Loan and Revolving Line of Credit

CIT Healthcare
Sole Lender

Ruxton

$14,000,000
Accounts Receivable backed Senior Secured Revolving Credit Facility along with working capital and liquidity

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c it deliver solutions.

$30,000,000
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Sole Lender
Administrative Agent
Collateral Agent

NATIONAL RENAL ALLIANCE

$5,500,000
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CIT Healthcare
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$135,000,000
Senior Secured Credit Facilities provided to Diagnostic Imaging Group, LLC for recapitalization led by Evercore Capital Partners

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The 4th Annual

Orthopedics, Neurosurgery and Pain Management Driven ASCs

Ambulatory Surgery Center Conference and Exhibits

Improving the Profitability of, Developing and Operating ASC's

June 22–24, 2006

Hilton Chicago, Chicago IL

PRELIMINARY PRE & MAIN CONFERENCE PROGRAM

THURSDAY, JUNE 22, 2006

12:00–2:00pm REGISTRATION

PRE-CONFERENCE CONCURRENT SESSIONS

2:00–2:35pm

A. TURNING AROUND ASC'S, BRINGING AN ASC BACK TO PROFITABILITY
Thomas Mallon, Chief Executive Officer; W. Michael Karnes, Chief Financial Officer Regent Surgical Health, LLC

B. BUILDING AN ORTHO DRIVEN ASC, TEN KEYS TO IMMEDIATE SUCCESS
Brent Lambert MD, Founder Ambulatory Surgical Centers of America (ASCOA)

C. BUILDING A PHYSICIAN HOSPITAL JOINT VENTURE AROUND ORTHOPEDICS
Robert J. Zasa, MSHHA, FACMPE, Founder; Joesph Zasa JD, Partner—Woodrum/ASD

2:40–3:15pm

A. TURNING AROUND ASC'S, BRINGING AN ASC BACK TO PROFITABILITY
Thomas Mallon, Chief Executive Officer; W. Michael Karnes, Chief Financial Officer Regent Surgical Health, LLC

B. BUILDING AN ORTHO DRIVEN ASC, TEN KEYS TO IMMEDIATE SUCCESS
Brent Lambert MD, Founder Ambulatory Surgical Centers of America (ASCOA)

C. BUILDING A PHYSICIAN HOSPITAL JOINT VENTURE AROUND ORTHOPEDICS
Robert J. Zasa, MSHHA, FACMPE, Founder; Joesph Zasa JD, Partner—Woodrum/ASD

3:15–3:30pm BREAK

3:30–4:10pm

A. TURNING AROUND ASC'S, BRINGING AN ASC BACK TO PROFITABILITY
Thomas Mallon, Chief Executive Officer; W. Michael Karnes, Chief Financial Officer Regent Surgical Health, LLC

B. BUILDING AN ORTHO DRIVEN ASC, TEN KEYS TO IMMEDIATE SUCCESS
Brent Lambert MD, Founder Ambulatory Surgical Centers of America (ASCOA)

C. KEY ISSUES TO OPERATING A PHYSICIAN HOSPITAL ASC SUCCESSFULLY
Caryl Serbin, RN, BSN, LHRM Surgery Consultants of America, LLC

4:15–5:00pm

A. TURNING AROUND ASC'S, BRINGING AN ASC BACK TO PROFITABILITY
Thomas Mallon, Chief Executive Officer; W. Michael Karnes, Chief Financial Officer Regent Surgical Health, LLC

B. BUILDING AN ORTHO DRIVEN ASC, TEN KEYS TO IMMEDIATE SUCCESS
Brent Lambert MD, Founder Ambulatory Surgical Centers of America (ASCOA)

C. KEY ISSUES TO OPERATING A PHYSICIAN HOSPITAL ASC SUCCESSFULLY
Caryl Serbin, RN, BSN, LHRM Surgery Consultants of America, LLC

FRIDAY, JUNE 23, 2006

7:15–8:00am
REGISTRATION & NETWORKING CONTINENTAL BREAKFAST

8:00–8:15am
WELCOME & INTRODUCTIONS
Scott Becker JD, CPA, Partner McGuireWoods, LLP

GENERAL SESSION

8:15–9:00am
SEVEN BUSINESS AND OPERATIONAL PROBLEMS ORTHOPEDIC AND PAIN MANAGEMENT ASCS FACE AND HOW TO SOLVE THEM
Brent Lambert MD, Founder Ambulatory Surgical Centers of America (ASCOA)

9:05–9:50am
KEY STEPS TO RESURRECTING A CENTER BY USING ORTHOPEDICS OR PAIN MANAGEMENT AS A BASE
Robert J. Zasa, MSHHA, FACMPE, Founder; Joesph Zasa, JD, Partner—Woodrum/ASD

Preliminary Pre & Main Conference Program

9:55–10:30am
KEY TRENDS IMPACTING ORTHOPEDICS, PAIN MANAGEMENT AND NEUROSURGICAL DRIVEN ASC'S
Thomas Mallon, Chief Executive Officer Regent Surgical Health, LLC

10:30–10:35am BREAK

CONCURRENT SESSIONS

10:35–11:05am
A. THE EVOLUTION OF A SPINE ASC IN A DIVERSE SINGLE SPECIALTY GROUP
Thomas Saul MD, Neurosurgeon Mayfield Clinic; Beth Atkinson, RN, Vice President Clinical Services Blue Chip Surgical Center Partners

B. KEY PROBLEMS IN PHYSICIAN HOSPITAL VENTURES
Caryl Sexton, RN, BSN, LHRM—Surgery Consultants of America, LLC; Mike Fawley, Administrator; Steve Karia, MD—Spartanburg Hospital

C. THE PROS AND CONS AND THE KEY STEPS OF DEVELOPING AN IN-OFFICE PRACTICE BASED PAIN CENTER
Amy Mawles, President—Mawles Medical Practice Management

11:05–11:35am
A. WASHINGTON UPDATE
Kathy Bryant, Executive Vice President Federated Ambulatory Surgery Association

B. ESTABLISHING SUCCESSFUL PHYSICIAN HOSPITAL VENTURES
Thomas R. Verdon Chief Executive Officer TRY Health Care Solutions, LLC

C. THE FUTURE OF ORTHOPEDICS—A CHALLENGING FORECAST
John Chorl, MD, MPH, MBA The Neurological and Orthopedic Institute of Chicago (a SgC)

11:35–7:00pm EXHIBITS OPEN

12:30–1:30pm
NETWORKING LUNCH—THE FOURTH ANNUAL ASC SURVEY, HOW THE ASC COMPANIES ASSESS VALUATION
Todd J. Mako, MBA, AVA, Principal HealthCare Appraisers, Inc.

CONCURRENT SESSIONS

1:30–2:05pm
A. CARTILAGE RESTORATION OF THE KNEE IN AN ASC-FOCUS ON BIOLOGICAL SCAFFOLDS
Philip Davidson MD—Tampa Bay Orthopedics; Bryan R. Smith, Vice President—National Surgical Care

B. CORPORATE PARTNERS—WHAT DO THEY BRING TO THE TABLE & HOW TO MAXIMIZE THE VALUE OF YOUR ASC PRIOR TO SELLING
David J. Abraham MD, Spinal Surgeon The Rewalg Neck and Spine Center; Jonathan E. Volk, President ASC's, Inc.

C. THE WALL STREET PERSPECTIVE ON ASC'S—THE TOP COMPANIES AND THEIR STRENGTHS AND WEAKNESSES
Carsten Beth, MBA, Managing Director—Cain Brothers

2:10–2:45pm
A. OPERATIONAL KEYS TO A PHYSICIAN HOSPITAL ASC
Don Schreiner—Rockford Orthopedic Surgery Center

B. "PHYSICIANS—AN ASC'S NUMBER 1 CUSTOMER, ALLOCATING BLOCK TIME, HANDLING DIFFICULT PHYSICIANS, BUYING OUT PHYSICIANS, ATTRACTING NEW PHYSICIANS AND ADDING SERVICE LINES"
Ajay K. Mangal, MD, MBA, Chief Executive Officer; Donald J. Jansen MHA, Vice President Marketing & Development—Provus Health Partners

C. A PHYSICIANS PERSPECTIVE ON DEVELOPING, PARTNERING, PLANNING AND OPERATING AN AMBULATORY SURGERY CENTER
Scott D. Holly, MD—Surgery Center of Kalamazoo, LLC & Brookside Surgery Center

2:50–3:20pm
A. A CASE STUDY—THE BEFORE AND AFTER OF BRINGING IN A NATIONAL PARTNER
George Goodwin, Vice President Mergers & Acquisitions; Michael Weaver, Vice President Acquisitions & Development—Symbion Healthcare

B. "OUT VS IN", NETWORK PROS AND CONS AND STAFFING AN ASC—A PLAN FOR HOURS, WAGES AND RETENTION
Greg Gaviff, Vice President Finance/Treasurer; Dawn McLane, Vice President—National Surgical Care

C. MANAGED CARE CONTRACTING FOR ASC'S AND SMALL HOSPITALS—KEY SUGGESTIONS FOR PRICING, COSTING AND CARVEOUTS
L. Nava Kenayes, MPH, Chief Executive Officer Momentum Health Consulting, LLC

3:25–3:55pm
A. METHODS TO IMPROVE PROFITS—A FEW GOOD STEPS
Thomas Mallon, Chief Executive Officer—Regent Surgical Health, LLC

B. ESTABLISHING AND OPERATING AN ORTHOPEDIC DRIVEN HOSPITAL
B. Dan Berman, Chief Executive Officer Pinnacle Healthcare

C. PHYSICIAN HOSPITAL ORTHO DRIVEN JOINT VENTURE—WHAT WORKS, WHAT DOESN'T
Charles Bush Joseph MD Midwest Orthopaedics at Rush

4:00–4:30pm
A. KEY MEANS AND TESTS TO MONITOR THE ECONOMIC HEALTH OF YOUR ASC
Daren R. Tasset, Chief Executive Officer; Nuetarra Healthcare; Mark Adams MD, Board Chair, Institute for Outpatient Surgery

B. UNIQUE EXIT STRATEGIES FOR ASC'S
Larry Tauber MD, President Black Hills Surgery Center/Medical Facilities Corporation

C. POLITICAL SURVIVAL STRATEGIES FOR AN ASC
Robert Carnes, President—Pinnacle III

4:35–5:05pm
A. THE ASC BENCHMARKING STUDY 2006, ARE YOU CHARGING AND COLLECTING ENOUGH PER CASE AND SPECIALTY, IS YOUR STAFFING LEVEL APPROPRIATE, ARE YOU PAYING TOO MUCH FOR SUPPLIES
Gregory Koohsnan, Principal, Founder Value Management Group, LLC

B. LEGISLATIVE VICTORIES AND CHALLENGES, THE EFFORTS OF AAASC AT THE ALL IMPORTANT STATE AND FEDERAL LEVEL
Mark Mayo, Mako Consulting American Association of Ambulatory Surgery Centers

C. FINANCING AN ASC—WHAT LENDERS LOOK FOR—WHAT KIND OF PROPOSALS YOU CAN EXPECT
Ken Seip, Vice President CitiCapital; Jeff Fox, Senior Vice President—CIT Healthcare

5:10–7:00pm
NETWORKING RECEPTION & EXHIBITS

Saturday, June 24, 2006

7:45–9:00am
NETWORKING CONTINENTAL BREAKFAST

CONCURRENT SESSIONS

9:00–9:40am
A. SELLING YOUR ASC, THE KEY STEPS AND ISSUES
Scott Becker, JD, CPA, Partner; Scott Downing, JD, Partner McGuireWoods, LLP

B. ADDING ORTHOPEDICS AND PAIN MANAGEMENT TO A CENTER AND UNDERSTANDING THE ECONOMICS OF ORTHOPEDICS, PAIN MANAGEMENT AND NEUROSURGERY IN AN ASC
Luke M. Lambert, CPA, Chief Executive Officer—Ambulatory Surgical Centers of America (ASCOA)

C. EFFICIENCY IN SPINE AND NEUROSURGERY IN AN ASC, MAXIMIZING OPERATIONAL EXCELLENCE
Larry Tauber MD, President Black Hills Surgery Center/Medical Facilities Corporation

9:45–10:25am
A. ASSESSING THE FEASIBILITY OF AND OPERATING ANCILLARY SERVICES IN AN ORTHOPEDIC PRACTICE—ASC'S, MRI AND PT
Rick DeHart, Chief Executive Officer Pinnacle III

B. SURGERY CENTER DEVELOPMENT AND OPERATIONS
Charles Ross, MD; Peggy Zampetti, RN, Vice President of Facility Development Titan Health Corporation

C. CONSTRUCTION ISSUES AND PLANNING ISSUES FOR ORTHOPEDIC DRIVEN ASC'S AND MOB'S
John C. Daly, AIA, Vice President Healthcare Services—McShane Construction Corporation; Jack Ammirato, President/Chief Executive Officer—AMB Development Group

10:30–11:10am
A. "NO MORE WIGGING—TAKE CONTROL"—A SPINE SURGERY CENTER IS ONE OF THE SEVEN STEPS TO CREATE A COMPREHENSIVE SPINE PROGRAM
John Caruso, MD, Neurosurgeon Neurological Associates of Hagerstown; Jeff Leland, Managing Partner—Blue Chip Surgical Center Partners

B. KEY REGULATORY ISSUES FOR ASC'S
Scott Becker, JD, CPA, Partner; Ronald Landever, Jr., Associate McGuireWoods, LLP

C. KEY TIPS FOR SUCCESSFUL BILLING, CODING AND COLLECTING
Caryl Sexton, RN, BSN, LHRM—Surgery Consultants of America, LLC

11:15–11:45am
A. TIPS FOR ENCOURAGING PHYSICIAN LOYALTY AND RECRUITING PHYSICIANS TO ASC'S
Thomas R. Verdon Chief Executive Officer TRY Health Care Solutions, LLC

B. CODING AND BILLING ISSUES FOR ORTHOPEDIC, PAIN MANAGEMENT AND NEURO DRIVEN ASC'S
Ellen Swan, MBA, MSN, RN, President Advanced Practice

C. MAKING FULL USE OF YOUR INFORMATION SYSTEM IN AN ASC
Mark Cambe, Vice President Marketing & Account Management Cypress Systems Consulting

11:50–12:30pm
A. MANAGED CARE PROBLEMS, ASSESSING IN VS. OUT OF NETWORK AND NEGOTIATING WINNING MANAGED CARE CONTRACTS
Robyn Finnegan, Vice President Managed Care—Provus Health Partners

B. 5 KEYS TO AN ASC'S SUCCESS, A LENDERS PERSPECTIVE
Peter Myhre, President MarCap Corporation

C. CRITICAL ACCOUNTING AND FINANCIAL MANAGEMENT ISSUES FOR PHYSICIAN LEADERS AND ASC ADMINISTRATORS
Michael J. McCaslin CPA, Principal Somerset CPA II, P.C.

12:30pm
MEETING ADJOURN

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Changes to Reimbursement for Imaging Services Under the Deficit Reduction Act

By Ron Lundeen and Scott Becker

I. Status of the Deficit Reduction Act

S. 1932, the 2005 deficit reduction bill (the "Deficit Reduction Act") was designed to save up to $40 billion over fiscal years 2006 to 2010. Almost a third of these savings–approximately $11-12 billion–will result from cuts to Medicare and Medicaid. The Deficit Reduction Act has a significant effect upon Medicare and Medicaid reimbursement.

The Deficit Reduction Act was narrowly passed by the House of Representatives on December 19, 2005 by a vote of 212 to 206. The Senate approved the bill on December 21, 2005 by a vote of 51 to 50, with Vice-President Cheney casting the tie-breaking vote, but only after deleting three provisions from the proposed bill. The House passed the amended bill on February 1, 2006. President Bush signed the Deficit Reduction Act into law on February 8, 2006.

II. Imaging Billing Changes under the Deficit Reduction Act

The Deficit Reduction Act enacted two key changes to Medicare reimbursement of imaging services. These changes will go into effect on January 1, 2007.

A. Multiple Imaging Procedures No Longer Budget-Neutral

In November 2005, CMS published a final rule which reduced payment for multiple imaging procedures furnished in a single session and for multiple images performed on contiguous body parts. This November 2005 reduction was budget-neutral, however, in that the payment reduction was offset by upward adjustments in practice expense values for other physician services.

The Deficit Reduction Act eliminated the budget-neutrality of these multiple imaging procedures. Starting in 2007, the savings from the reduction in reimbursement for multiple imaging procedures will not be offset by other upward adjustments, but will instead be retained by the Medicare program.

B. New Reimbursement Limits – Capped at HOPD Rates

Medicare reimbursement is made on the basis of a fee schedule for physician provision of services in physicians offices or in independent diagnostic testing facilities ("IDTFs"). The fee schedule amount is based on survey data over several years that reflect the costs of providing such services. Imaging and certain other services are reimbursed through two components: a professional component and a technical component. Some imaging services, particularly those provided in IDTFs, are reimbursed by a single global rate which combines the professional and technical components together.

Medicare also has a reimbursement program in place for imaging and certain other services provided in a hospital outpatient setting. This payment structure differs from the physician fee schedule structure. The Hospital Outpatient Prospective Payment System ("HOPPS") rates are calculated by allocation of department-wide costs, based on hospital claims and cost report data, among specific services. This rate structure has received criticism based on the inability to accurately allocate or reflect the costs of services.

The physician fee schedule reimburses at a higher rate for imaging services performed in physicians offices and in IDTFs because physicians use their own equipment and staff in the provision of services. Therefore, the physician fee schedule generally provides for higher reimbursement for imaging services than the HOPPS rate.

As of January 1, 2007, the Deficit Reduction Act will set reimbursement for the technical component of imaging services to the lower of the HOPPS rate or the physician fee schedule rate. This lower reimbursement applies to the technical component of global fees as well. This reimbursement limitation ensures that payment rates for imaging services provided in physician offices and IDTFs do not exceed payment rates for identical imaging services provided in hospital outpatient departments.

Nearly all imaging services reimbursed by Medicare are impacted by this new reimbursement limitation. The Deficit Reduction Act describes imaging services as "imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography."

The effect of this rule is to dramatically reduce reimbursement for many imaging services provided in physician offices or IDTFs. Reimbursement for certain ultrasound CPT codes will be reduced by as much as 76%. For example, the technical component of intravascular ultrasound (CPT 75945) is reimbursed under the HOPPS rate at $138.18; the technical component of the same CPT code is reimbursed under the physician fee schedule at $208.63. The technical component of ultrasound guided compression repair (CPT 76936) is reimbursed under the HOPPS rate at $67.44 and reimbursed under the physician fee schedule at $288.41. For many ultrasound codes, the physician fee schedule provides for lower reimbursement than the HOPPS rate. For example, the technical component of echoencephalography (CPT 76506) is reimbursed under the HOPPS rate at $92.74; the technical component of the same CPT code is reimbursed under the physician fee schedule at $65.34.

HOPPS rates for CPT codes for certain MRI services are between 46-75% of physician fee schedule rates for identical CPT codes. For example, the technical component of brain and brain stem proton imaging (CPT 70553) is reimbursed under the HOPPS rate at $522.54; the technical component of the same CPT code is reimbursed under the physician fee schedule at $1,138.35. The technical component of thoracic spinal canal imaging (CPT 72147) is reimbursed under the HOPPS rate at $386.64 and reimbursed under the physician fee schedule at $614.39.

Certain PET CPT codes are reimbursed by the HOPPS rate at only 30-40% of the physician fee schedule rate. For example, the technical component of PET myocardial imaging with metabolic evaluation (CPT 78459) is reimbursed under the HOPPS rate at $735.77; the technical component of the same CPT code is reimbursed under the physician fee schedule at $2445.84. The technical component of PET brain imaging with metabolic evaluation (CPT 78608) is reimbursed under the HOPPS rate at $1,150 and reimbursed under the physician fee schedule at $2445.84.

If you have comments or questions regarding the issues described above, please contact Scott Becker at (312) 750-6016 or Ron Lundeen at (312) 849-8106. ■

HR Administrative Service Providers Can Enhance the Efficiency of an ASC

By: Ryan Stoneburner,
President/CEO, HR America

Along with the core challenges of an ASC in providing patient care and meeting professional regulatory standards come employment related administrative responsibilities. These administrative burdens carry their own set of risks and utilize the time of staff that can be more effectively dispensed to productive initiatives.

HR administrative service providers are generally cost effective for an ASC. They deliver a higher level of applicable expertise, support and technology that is not efficiently replicable within the small business environment of the typical surgery center.

There are many providers who deliver a single administrative service. They include: payroll processors, health insurance agents, HR consultants, 401k/retirement plan advisors, COBRA administrators, Section 125 FSA providers, workers' compensation representatives, and a few other specialty providers.

In a traditional ASC environment, administrators/staff will handle some of these services in-house and work with a few of the aforementioned provider organizations to complete requirements. Many surgery centers individually contract for most, if not all of these services. However, only a small percentage of ASC's use a program that efficiently combines these services together with one company.

There are two primary service models available that can effectively combine the multitude of employment related administrative services within one relationship.

A. Professional Employer Organization (PEO) – This model relies on the basis of a co-employment relationship. I.E. the ASC and the PEO become employers together and the result is a comprehensive service arrangement for employment related administration. The payroll is completed by the PEO and the taxes are filed under their FEIN, which allows the ASC to participate in the HR and benefits infrastructure of the PEO. It is important to note that there are large group benefit plans with most PEO's. However, the health insurance and 401k plan, although coordinated by the PEO, are often structured based on the employee composition of the ASC.

B. Administrative Services Organization (ASO) – This model does not have a co-employment relationship, but offers most of the same services as the PEO in the general areas of payroll, employee benefits and human resources. With the ASO there are no large group benefit plans, but the scope of benefit offerings remains comprehensive. An advantage of the ASO program is the ability of the ASC to have the program selections on an a la carte basis to customize the application to their specific requirements.

Both models can bring the desired result of efficiency to a surgery center. The selection of one program over the other would depend on many factors that should be addressed in a preliminary review of the ASC's requirements.

I have mentioned efficiency and cost effectiveness several times. The following are some the reasons why the PEO and ASO are successful programs for surgery centers.

1. Surgery centers are typically small businesses with 10-80 full time equivalent employees (around 20 EE's is common). Most, if not all employment laws/requirements, will be applicable to this size of business. However, it is not practical, from a cost perspective, to hire a human resources professional. Using another staff person with "some HR background" usually indicates wages and benefits are being paid to a person for skills that may not be adequate to safely manage the workforce with in the guidelines of the law. A poor quality decision affecting an employee can be very costly.

   With a PEO or ASO service, the ASC will have access to human resource professionals with extensive skill sets in technical areas such as FMLA, ADA, FLSA, and the myriad of other employment regulations. The best way to limit risk in the HR area is to be proactive and have appropriate measures in place and take the

proper steps to limit adverse action.

Another advantage is the consistent availability of the HR professionals with a PEO or ASO. They will not call in sick, take vacations or leave for a position with better benefits.

2. Enhanced employee benefit options are another important consideration. Often a surgery center must compete with hospitals and other companies for good employees and a high quality benefit package is needed for effective recruitment. With a PEO's group plan design, the cost/benefit relationship is favorable to the ASC. With the ASO program, the aggregated benefit plans are not in place. However, due to the benefits procurement experience of the ASO, they bring advantages in plan design and flexibility. An ASO also has many pre-set options they can readily implement or customize to the specific needs of the ASC.
3. The consolidation of vendors is another practical measure that removes administrative burden from the ASC. Each vendor relationship an administrator/staff maintains takes time away from other core operational duties. It would not be prudent to have vendor consolidation for unrelated items like surgical supplies and payroll, but within the PEO or ASO, the service areas are related and under the umbrella of employment administration.

Utilizing the services of a PEO or ASO allows ASC staff to focus their time on core business instead of administrative tasks, while concurrently lowering employment related risks and providing enhanced benefits to recruit and retain great employees. An ASO or PEO that has experience working with surgery centers brings additional value. In summary, these are cost effective programs to make an ASC more efficient. ■

Pricing for Redemption – Two Key Options
continued from page 3

such an appraisal could be allocated equally among the Company and the Member or in some other manner.

A typical appraisal method, as opposed to a historical earnings approach, examines estimated future cash flows and does a better job of taking into account potential changes in the business. To help address such problems in a formula approach partners often use (a) a relatively low multiple (3, for example), (b) payouts over time, or (c) limits on payouts (e.g. no more than 7.5% of collections or 20% of net income).

C. Agreed Price. A final alternative is to allow the Company and the Members, acting by some specified vote, to annually agree as to the buyout valuation amount of the ownership interest based on the respective parties' determinations thereof with a default to an appraisal if the parties cannot agree on the fair market value within a set period of time.

II. Adverse Terminating Event Options. Options for redemption pricing for Adverse Terminating Events include the following, which options should appropriately tie in to the Non-Adverse Terminating Event price selected:

A. One option for an Adverse Terminating Event redemption price is to pay the redeemed Member the book value of the Member's ownership interest. This methodology typically results in a low redemption price as such amount will be tied to the book value of the assets owned by the Company, equipment, cash on hand, etc. without taking into account the goodwill of the ASC.

B. Alternatively, the Adverse Terminating Event redemption price could equal the amount of the Member's capital account, which is often simply the Member's capital contribution. Depending on when the ASC assets were purchased and the depreciation thereof, this amount may be comparatively higher or lower than the book value of the ownership interest but will typically be significantly less than basing the redemption price on a discount of the formula amount as described below.

C. A final option is to utilize the methodology chosen for the Non-Adverse Terminating Event redemption price and give the Member a discount from such calculated price (i.e., a 30% to 50% discount of the amount determined under the formula amount or by an appraiser). ■

Six Steps That Can Help Boost Profits at a Struggling ASC

By: Dana Kulvin

Many factors can contribute to low profits at an ASC. Fortunately, if an ASC recognizes the causes and acts accordingly, it can improve its economic outlook. To help accomplish increased profits, ASC experts suggest six steps an ASC can take to boost its profits. The steps can be categorized in two areas: revenue and operations.

Revenue

1. Add New Procedures and Equipment

One way to build up an ASC's revenues is to increase the types of procedures being performed at the ASC. "Expanding the types of procedures currently being performed at an ASC provides the ASC with a greater variety of reimbursement opportunities," says Joe Zasa of Woodrum Ambulatory Systems Development. It can also serve as a way to recruit more active physician investors who will perform more of their procedures at the ASC, he adds. However, adding new procedures often means that the ASC must invest in additional space or equipment. "If the costs and benefits are evaluated properly, a capital investment that will permit an ASC to provide more services will pay off long term. Be sure that you review all state licensure requirements before adding procedures and/or space at your ASC," Zasa notes. "With the new technology in implants and anesthesia, neurosurgery has become an area of focus for our multi-specialty centers," says Mallon.

2. Teach Physician Investors How Processes Impact the Bottom Line

Almost every aspect of an ASC's operations effects its bottom line. However, the connection between an ASC's processes and its profits is not always obvious to physician investors. "Clarifying the process-profit connection to an ASC's physician investors ultimately helps build a stronger and more profitable ASC," says Tanner. For example, once a physician knows how supply costs impact case revenue and the overall ASC profits, he will likely be more willing to streamline his supply requests. Tanner suggests that a non-physician investor with specific management experience may be better equipped to teach physicians investors by building a bridge between the business, revenue, operations and medical aspects of the ASC. Once all of an ASC's investors have a common understanding about how the ASC profits, their interests in quality care and a return on their investment can be aligned, then they can work collectively to increase the ASC's profits.

3. Recruit Physician Investors

Active investors are vital to a successful ASC. "Investors with their 'skin in the game' will pay attention to details, and focus on the ASC's long-term success. With investors' dedicated energy and attention, an ASC will generally see increased profits," says President and CEO of Physician's Endoscopy Barry Tanner. Investors with substantial capital at risk are often more active participants in the ASC, he adds. For this reason, an ASC may want to recruit investors willing to put up larger amounts of capital. "From an operating and financial standpoint, it is often better to have eight to twelve committed members using a smaller facility than twenty-five members in a larger facility," says Tom Mallon of Regent Surgical Health. In addition, an ASC will likely have an easier time recruiting active physician investors if the ASC is equipped with the technology and equipment those physician investors need to perform their procedures, adds ASC consultant at Woodrum Ambulatory Systems Development, Joe Zasa.

Operations

4. Maximize Operating Room Utilization

Unused or underutilized operating rooms can deplete an ASC's profits. "Every hour that an operating room sits unused costs an ASC an extraordinary amount of money because the ASC still pays for the overhead, equipment and staff time–without gaining any revenue," says Tanner. It is imperative that an ASC properly manage the operating rooms' block time in order to avoid unused or underutilized operating rooms. This means scheduling as much of any unused block time as possible, he adds. For example, in an effort to be overly accommodating to a physician or a patient, an ASC may schedule two, one hour time blocks with an empty one hour block in between them. It is also not uncommon to have a patient cancel a surgery, leaving the ASC with an unused time block. To avoid having the unused time block cost the ASC revenue and profits, fill in that time by moving surgery times around, adding surgeries into unused times, or even changing the surgery times so that they are all done earlier and then having staff go home early, Tanner suggests. In addition, an ASC should train its schedulers to anticipate holes in the schedule, says Zasa. "Make sure schedulers know when the physicians will be vacationing or out of the office so that their time blocks can be filled with other physicians' cases. The earlier an ASC's schedulers are aware of potential gaps, the easier it will be for them to fill those gaps, and the ASC can better profit," he explains.

5. Improve Management of Staff Time

High staffing costs without an accompanying high level of revenue is often an indicator of an ASC's decreasing profits. To cut costs and maximize revenues, an ASC must improve its staff time management, says Zasa. This usually means better aligning staffing levels with expected utilization, adds Tanner. For example, many ASCs employ a full-time eight hour a day staff for all positions, even when the ASCs are not operating at capacity. "This is overkill. An ASC should instead be flexible and hire part-time staffers, cross-train staff or send staff home when they are not needed, otherwise the ASC's costs will overrun their revenues" explains Tanner. Should utilization change, the staffing levels should change accordingly. Zasa also suggests that ASCs compare their staffing hours per case with regional or national benchmarks in an effort to identify opportunities to improve their efficiency and increase their profits.

6. Ensure Physicians Show Up and Show Up on Time

Ensuring that physicians show up on time is an important factor in increasing ASC profits. "Physicians who fail to show up for surgeries or show up late can cost an ASC thousands of dollars per case," says Tanner. Underutilized operating rooms present a great opportunity to fully recognize a revenue opportunity. As mentioned above, the ASC pays for the overhead, equipment and staff time for every scheduled surgery. If a physician fails to show up for the surgery, the ASC must still pay those costs but without the benefit of any revenue. A late-arriving physician can push the surgery schedule back, potentially resulting in cancelled or after-hours surgery, both of which can cost the ASC a lot of money in lost revenue and overtime wages, adds Tanner. Educating the physician investors about how their absence or tardiness affects the case profits may help ensure a change in behavior. Making physicians accountable for their absence or tardiness can help, too. For example, Mallon suggests forbidding habitually late physicians from scheduling early start times. "ASCs should also develop and utilize a protocol of calling physicians prior to their scheduled surgeries to determine if the physician will be late," he adds. This way schedulers, where possible, can proactively fill in empty surgery time blocks. ■

[Sources]

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