ASCRER'S RECKER'S REVIEW

PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Building and Operating a Surgery Center 11 Critical Mistakes

By Scott Becker

his article provides a brief overview of eleven mistakes that ambulatory surgery centers make. These are mistakes that are often made in the development or the operation of surgery centers.

1. Overbuilding. Generally, a surgery center should never have less than two operating rooms. However, it is often the case that the physicians are convinced to build a larger center than needed based on projections of revenues, projections of cases or just the great look that a big center will have. Unfortunately, building big is a cost that one never stops paying for. In a recent project, we witnessed a situation where the center could have readily been completed for 13,000 square feet (the national average size for a surgery center) instead of the 21,000 square feet plan that was developed. This extra 8,000 square feet translates into a significant cost both in building, equipping, and in debt service. The costs are essentially never recovered.

2. Overstaffing. Many management companies and many physicians that operate surgery centers simply don't understand structural means by which staffing costs can be reduced. Essentially there are two ways in which one can go about reducing staffing costs. The first method, if taken too far, is always a losing method. This method relies upon the reducing of wages and trying to be too leanly staffed. Here, one is consistently at odds with employees over their wages. Further, if it is known that you are a lower cost payor for employees in the area, you will almost certainly end up with a worse pool of applicants. The second method to reducing staffing costs is structural in nature. This relies on reducing the number of hours that the surgery center is open to meet the number of cases expected to be done at the surgery center. Here, one pays people

Experts Weigh-In on the Key Elements and Challenges to Overcome in Developing a Successful Spine/Ortho Program

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

ive experts offer tips on how to develop a successful spine/ortho ASC and overcome related inherent challenges. The tips cover, but are not limited to, issues related to managed care contracting, Medicare reimbursement, pain services and hospital partners.

1. What are the key elements to developing a spine ASC?

Teuber: A successful spine ASC ideally merges the specialties of neurosurgery and orthopedics with three key elements. First, comprehensively market the program to include non-invasive conservative care, pain management including all varieties of needle treatment (e.g., injections, diagnostic, therapeutic and ablations) and surgical techniques. Second, standardize surgical treatment including supplies, equipment and implants. Regarding implants, surgeons should use a single approved implant for each application (e.g., cervical plates, pedicle screws and associated hardware and various allograft applications). Third, ensure that all surgeons are trained to use all new devices and perform new techniques keeping in mind that established techniques and implants generally yield greater success, lower complications and minimum cost.

Simmons: A good spine ASC is developed with a mix of orthopedic and neurosurgeons and utilizes two key practices. First, an ASC's surgeons should be accustomed to and comfortable working in an ASC environment. An ASC will find greater success with surgeons who are experienced working in an out-patient setting and with more stringent efficiency controls and fiscal oversight than typically found in a hospital. To ease the transition for hospital surgeons, ASCs must provide fully staffed overnight facilities giving surgeons the option to keep a patient in recovery overnight that is more typical of a hospital. Second, an ASC must not scrimp on equipment and instead invest enough capital in order to obtain state-of-the-art spine equipment for the entire ASC.

Hancock and Kowalski: Four elements must be met in developing a successful spine ASC. First, evaluate the payor market and ensure sufficient reimbursement. If adequate reimbursement is not an option, development of the ASC should be reconsidered. Second, review the start up costs and determine that ample capital is available. Certainly, adding a spine program to an existing orthopedic ASC will be far less costly than building anew. Third, target surgeon partners and hire nurses and technicians comfortable and experienced in an outpatient environment. Surgeons may be uneasy about performing some spine procedures in an ASC and experienced nurses and technicians can help ease their trepidations. Lastly, become involved in patient selection, preparation and education so that patients will be comfortable and knowledgeable about having their surgery in an ASC. One good approach is to educate patients pre-operatively at the surgeons' offices.

Kehayes: The most important issue to resolve is whether payors will contract for the spinal and/or orthopedic services. Private payor reimbursement can be difficult for many reasons. First, many payors are reticent to work with spine ASCs for fear that competing hospitals will demand payors to increase contract rates on other hospital services in order to offset the losses that will result by moving spine cases to the ASC. Second, as many spine and

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Letter from the Editor

his letter highlights several interesting items currently affecting the ambulatory surgical center industry.

1. UnitedHealth Group Takes Aggressive Approach Towards Physicians Regarding Out-of-Network. UnitedHealth Group announced that it has entered into an exclusive national relationship with Laboratory Corporation of America. There, to discourage the use of out-ofnetwork laboratories, United announced that it would adopt a policy whereby physicians who referred to out-of-network laboratories could be (1) terminated from the contracts, (2) required to pay fines, or (3) have their fees reduced. This represents a very aggressive action by UnitedHealth Group. The Wall Street Journal reported that the AMA and a number of state medical societies have demanded that UnitedHealth rescind the policy. One physician noted "This is beyond punitive; it's abusive," says Ted Mazer, an ear, nose and throat doctor in San Diego. "And it makes you wonder, what's next?"

This type of practice as to laboratories is increasingly spilling over into several other areas of care such as ambulatory surgery centers where physicians often use out-of-network providers.

United, in another effort that can harm ambulatory surgery centers, has also increased its efforts to pay physicians extra amounts of monies to do cases in their offices. This often leads to increasingly complex cases being done in an environment that is not certified as a surgery center or otherwise staffed and equipped for more complex cases.

2. Ambulatory Surgical Centers on a Political Roll. The ambulatory surgical center industry has been faced with prospective cuts in reimbursement by Medicare that would set the reimbursement rates at 62.5% of the rates paid to hospitals for the same outpatient surgical services. Recently, a large group of congressmen, representing Republicans and Democrats, introduced a bill that would set this rate at 75%. This type of effort by so many congressmen, at a time when so many other physician owned ancillary facilities are under fire, demonstrates the tremendous effort that the surgery center industry had made, through FASA and the AAASC, to strengthen their case in Washington, D.C. It also reflects the benefits that are derived from the critical mass that surgery centers have started to represent. Each organization should be applauded for their efforts.

3. Ambulatory Surgical Centers -

Publicly Traded Companies. There are currently four publicly traded ambulatory surgical center companies.

An examination of the financial status of the four publicly traded ASC companies provides an interesting overview picture of the industry. Of the four companies, two have traditionally had very distinct strategies. United Surgical Partners (USPI) on joint ventures involving both physicians and hospitals. AMSURG has traditionally focused on surgery centers built around a single specialty such as gastroenterology or ophthalmology. By contrast, two other companies do not tend to have quite as distinct a strategy. NovaMed was originally developed as an ophthalmology practice management company and has done a wonderful transformation to a facility driven ASC company. While a number of its original ASCs were built around ophthalmology, it tends to be focused on a multi-specialty model today with most of its centers not having a hospital partner. Symbion primarily owns and operates multispecialty centers. It has a very effective management team. However, it has shown a tendency recently to invest both in surgery centers with hospital partners and to acquire short stay surgical hospitals.

The financial results of the companies are driven to a great extent by the model that each of these companies has pursued. Currently, for example, AMSURG has profit margins which tend to be among the best in the industry (i.e., 35% operating margins). This is generally driven by the single or limited specialty focus of its centers. This likely allows it to enjoy better staffing ratios and better equipment and planning costs. In contrast, the Wall Street view of the USPI model and of NovaMed's growth prospects appear to be very high. Each one is trading at very price earnings ratios: as of early April, 2007, USPI at 40 and NovaMed at 28. The USPI ratio is partially driven by its current deal to be bought out by Welsh Carson. With that stated, its strategy has been widely praised by the industry and it is viewed as propelling significant growth. Its strategy is also thought to bring stability to its pricing.

A few statistics from these four companies as of early April, 2007 are set forth as follows:

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	NovaMed	AMSURG	SYMBION	USPI
Market Cap	157.08M	735.70M	424.95M	1.38B
Qtrly Rev Growth (yoy)	37.50%	16.60%	11.40%	34.20%
Revenue (ttm)	108.43M	464.59M	301.53M	578.83M
EBITDA (ttm)	28.81M	187.54M	81.73M	206.33M
Oper Margins (ttm)	21.96%	35.12%	20.69%	22.03%
Net Income (ttm)	5.70M	38.11M	19.35M	40.08M
P/E (ttm)	28.05	19.73	22.67	40.92

4. New Advertisers. We are delighted to welcome four new advertisers to the *ASC Review*. These include Ventas, a leading healthcare reit visit www.ventasreit.com, HBE, a leading healthcare construction and real estate development firm, contact Lincoln Boschert at 314-567-9000 or visit www.hbecorp.com, OptOr Systems, a leading provider of inventory control systems, visit www.optorsystems.com and KBKG, a leading cost segregation services firm, lead in part by Ray Irving at 866-412-6911 ext 702 or at raymondi@kbkg.com.

5. White Papers. We have recently coauthored two different white papers. First, one paper outlines a number of legal issues and concerns related to integration alternatives between hospitals and physicians. This paper was authored by Bard Walker and Sarah Abraham. Second, a paper outlines investment considerations relating to nine different niches within healthcare. This paper was authored with Amber Walsh and Krist Werling. Should you have an interest in a copy of either of these papers, we would be pleased to provide it to you at no charge. Please email myself or call me at 312-750-6016 and we will provide the same. The paper on investment in different niches within healthcare will be published in the Journal of Health Care Finance. The paper on integration alternatives between hospitals and physicians will be published in the Matthew Bender Health Care Law Monthly.

6. Orthopedic Driven ASC Conference.

We have a terrific conference for June 14th to 16th, 2007. The conference will take place at the Westin Michigan Avenue Hotel in Chicago. We have subjects such as (1) An Overview of the Future of Orthopedics, (2) Turning Around ASCs, (3) Converting an ASC to a Specialty Hospital, (4) A Washington Update and Political Talks from each of Three Leading Trade Associations, (5) Talks on Cutting Costs, (6) A Speech on Effective Staffing of Surgery Centers, (7) Several Discussions on Physicians Hospital Joint Ventures, (8) Two Talks on the Safety and Appropriateness of Providing Spine Services in an Ambulatory Surgery Center. (9) Discussions relating to Building a Surgery Center Around Pain

Management, (10) A Clinical Talk Relating to Orthopedic Knee Procedures in an ASC, (11) a host of other talks relating to improving the profitability of surgery centers, and (12) a pre conference relating to buying and selling ambulatory surgical centers, as well as pre conferences related to Physician Hospital ASCs, Starting a new ASC, and Turning Around an ASC.

Overall, it promises to be a great conference. Should you desire more information on the conference or to register for the conference please visit www.Beckersasc.com or complete the registration form enclosed in this issue. To receive the early registration price for the June 14th to 16th Orthopedic Driven ASC Conference, you must register by May 1st.

7. 50 People to Know. The July/August ASC Review will highlight 50 people to know in the ASC industry. If you have suggestions, please provide to Scott Becker at 312-750-6016 or sbecker@mcguirewoods.com.

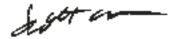
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Should you have any questions on any of the items listed in this letter or any of the articles in this newsletter, please contact myself at 312-750-6016 or by email at sbecker@mcguirewoods.com.

Very truly yours,



Scott Becker sbecker@mcguirewoods.com or 312.750.6016

The ASC Review is published 6 times per year. It is distributed to approximately 20,000 persons per issue.

May 1st is the last day to register for the June 14th to 16th Orthopedic Driven ASC Conference at the reduced rate.

P.P.S May 15th is the last day to sign up to advertise in the July-August issue of the ASC Review.

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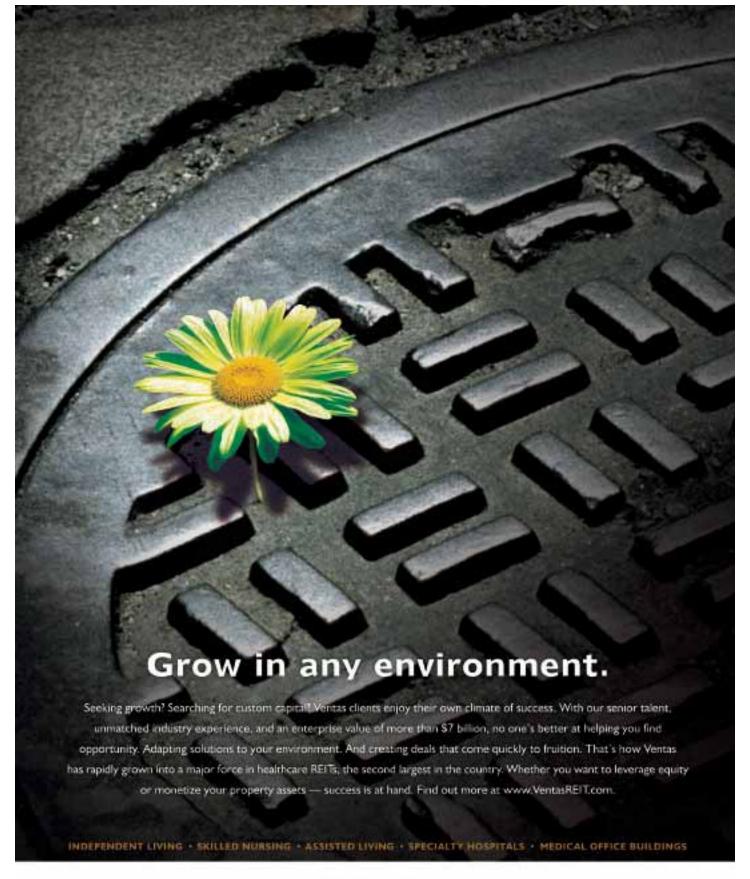
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orthopedic procedures are not included on public and private payor approved lists, payors are concerned about an ASC's ability to meet the payor's credentialing criteria for those particular procedures. Even when an ASC can demonstrate to a payor that is meets the criteria, payors do not want to have inconsistent credentialing policies between ASCs. Some payors fear that credentialing one center to perform spine cases requires them to credential all centers.

2. What are the risks involved in providing pain management?

Teuber: There are no risks in developing centers that also provide pain management services and the best spine centers include them.

Simmons: Pain management services are necessary in a spine ASC and generally have a good profit margin, but there are some risks to avoid. An ASC must adequately balance its pain procedures with other surgeries by providing enough post-operative beds to accommodate all the patients. With an average pain procedure lasting seven minutes, an ASC with a large volume of these procedures and inadequate space can be quickly overwhelmed and left without beds for its recovering surgical patients. Clearly this would result in a logistical and quality of care quandary. In the absence of post-operative bed availability, an ASC can schedule surgeries only in the morning and dedicate the afternoon to pain procedures, freeing up post-surgical beds. Alternatively, the ASC can have a dedicated pain day. This may become more critical as Medicare pain reimbursement decreases.

Hancock and Kowalski: There is no downside to providing pain services and they, in fact, nicely complement spinal surgeries. Injection work in particular is quick, low-cost and effective. However, it will be important to monitor Medicare's reimbursements for pain procedures, as they are expected to decline in the near future.

Kehayes: Pain management reimbursement is expected to decrease as much as thirty percent for a majority of high volume ASC injections under the proposed Outpatient Prospective Payment System ("OPPS") ASC reimbursement methodology, scheduled for implementation by next year. However, there is perhaps worse news. With the implementation of Medicare's site-of-service differentials, physician compensation increases for office-based pain management services. With this financial incentive, physicians may opt to move their pain management cases from the ASC back to the office setting and payors may advance this shift [See Sidebar on page 7].

3. What are the managed care challenges?

Teuber: The greatest payor challenges arise from monopolistic hospitals that, in vie for market control, use their influence and leverage to

exclude competing smaller niche centers from payor contracts.

Simmons: Two main payor challenges exist. First, the multitude of spine procedures not listed on the Medicare grouper list are similarly not provided for in private payor contracts. As such, payors may not reimburse non-grouper procedures or will reimburse them insufficiently. To assure adequate payment, ASCs must negotiate specifically for carve-out payments for procedures not on the grouper list. Second, most payors will not separately reimburse orthopedic and spinal implants. As these implants cost anywhere from \$3,000 to \$25,000, ASCs must carve out their implant reimbursements. Lastly, an ASC should walk away from a contract with an insurer that is unwilling to carve out these reimbursements.

Hancock and Kowalski: One big managed care challenge is non-reimbursable implants. Following Medicare's lead, private payors may not reimburse ASCs for implants making many procedures utilizing implants financially unattractive to perform. While an ASC may sometimes be able to obtain carve-outs for particular implants, it may not be enough. However, relief may be in sight as proposed cost pass-through legislation exists within the Centers for Medicare and Medicaid Service's ("CMS") New Medicare ASC Payment Systems Proposed. For example, CMS proposes including pass-through payments for implantable durable medical equipment and prosthetics (under the existing ASC reimbursement system payment falls under the overall facility fee). In addition under the proposed legislation, orthopedic payments could rise by as much as thirty-eight percent. See the proposed legislation at http://www.cms.hhs.gov/ASCPayment/06_CMS15 06P.asp#TopOfPage and go to www.fasa.org to read further analysis.

Kehayes: Three main challenges exist. First, the Medicare grouper methodology is often used as the basis for private payor reimbursement which does not reasonably group orthopedic and spine procedures for compensation. To be successful, ASCs must negotiate for non-standard options, such as carve-outs, to be sufficiently reimbursed. This usually requires upper level payor approval, which can be difficult to obtain. Second, in the near future as CMS and payors migrate to the OPPS methodology, ASCs will be faced with greater challenges due to the inclusion of prosthetics and implants in global reimbursement under the APC payment. Under OPPS, there are cases where the surgical reimbursement rates are not adequate to cover the cost of the prosthetics and implants. Third, due to prompt payment laws and claims processing challenges that result from prosthetics and implants, many payors are moving to case rate type methodologies that do not provide additional compensation for prosthetics and implants.

4. Clinically, what procedures should be done in an ASC that are now done at hospitals?

Teuber: All pain procedures should and can be done in an ASC. In addition, lumbar discectomy (first time, recurrent or far lateral), lumbar laminectomy, lumbar fusion (with two nights of observation), simple lumbar tumors, ACF, cervical plating and cervical laminectomy can all be performed in an ASC. Due to the risks involved, esoteric procedures and patients with unique anesthetic risk are better served in a hospital.

Simmons: As long as it is performed safely and on a medically safe patient, any procedure that can performed in a hospital in less than twenty-three hours and fifty-nine minutes is clinically appropriate for an ASC. However, the location a procedure is performed is more directly related to reimbursement. For example, Medicare does not reimburse lithotripsy in an ASC and therefore an ASC may not want to perform it on a Medicare patient.

Hancock and Kowalski: While simple discectomies (levels one and two) are commonly performed in ASCs, other multi-level procedures and fusions are still mostly performed in a hospital. This may be related to clinical factors but also often to the level of physician and patient comfort in an out-patient center, as well as reimbursement. With changing technologies, peer education, clinical success and a broader realm of reimbursements, in time more and more spine procedures will be performed in ASCs.

5. Should a spine ASC have a hospital partner?

Teuber: Determining whether an ASC should have a hospital partner requires an analysis of four issues. First, if the political landscape of the local medical community is conducive to joint venturing. Second, whether the hospital has historically demonstrated its willingness and ability to compromise and perform in good faith in a joint venture. Third, if the hospital is able to recognize that an ASC functions differently than a hospital and that an ASC's success is dependent on its operational efficiencies. Lastly, whether the hospitals' interests are aligned with the physicians and that it is not merely interested in controlling the operation.

Simmons: Hospital partners are often advantageous and in fact, about twenty-five percent of Regent Surgical Health's ASCs have them. Partnering with a hospital makes the surgeon's work easier. An ASC surgeon will typically not work solely in an ASC but will also perform surgeries in a hospital. In fact, for every spine surgery performed in an ASC, that surgeon will likely perform three to five spine surgeries in a hospital. By partnering with a hospital, the ASC facilitates an amiable relationship between the surgeon and

the hospital. In order for the arrangement to work for an ASC, the ASC must maintain control of the operation and not permit the hospital to become the majority owner or manager.

Hancock and Kowalski: While partnership with a hospital can be beneficial in regards to physician relations and managed care contracting, it is not always necessary and certainly not wise if the hospital intends to control management of the ASC. If a hospital is not truly motivated to work with the ASC, then the negotiating period is generally a big waste of time. However, in certificate-of-needs ("CON") states where there are enormous barriers to entry to the market, partnering with a hospital is usually essential.

Kehayes: A new spine or orthopedic ASC can pose a financial threat to a hospital and the hospital may employ competitive measures against the ASC to protect itself. Consideration of a hospital partner may eliminate this opposition, especially in a CON state.

6. What specific tips can you provide to those wishing to develop a spine ASC?

Teuber: Assuming that the ASC is providing high quality medicine that exceeds the standard of care, the success of the ASC is ultimately measured by its

profits. To achieve those profits, an ASC must have an adequate number of surgical procedures performed at the center, strong payor contracts, and optimal operational costs. Optimal operational costs are ideally achieved through the standardization of input goods (especially implants) and aggressive vendor negotiation.

Simmons: ASCs should focus on quality care as spine surgery is very complicated. Since it is a high acuity program, only the best surgeons and staff in the community ought to be practicing in the ASC. If the best surgeons are not available as partners, the ASC should not be developed. If necessary, ASCs should recruit experienced nurses and technicians from regional hospitals.

Hancock and Kowalski: An ASC should perform a good financial assessment before developing a program to ensure that there is ample reimbursement available and that the capital and operating costs can be met. In addition, an ASC must not underestimate the pre-operative preparation and education of a patient, who may have unrealistic expectations.

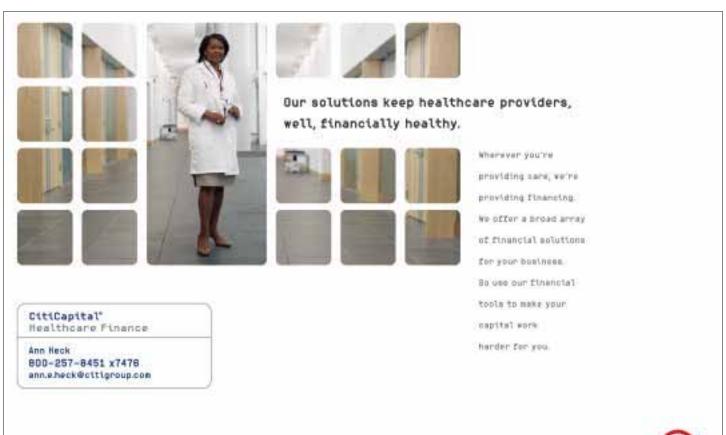
Kehayes: First, ASCs should perform payor due diligence to ensure payors are interested in doing business with the ASC and willing to offer sufficient reimbursement. Six to twelve months prior to opening, ASCs should begin negotiating

with payors because contracting can take time. Second, an ASC should resist pressure to sign an insufficient contract. It is important that *de novo* ASCs have adequate working capital lines of credit to permit the time necessary to negotiate an acceptable contract. The greatest opportunity for maximizing reimbursement rates is at the inception of contracting. Trying to renegotiate later is usually not an effective strategy to maximize reimbursement. Although there is a lot of pressure to finalize contracts, the first contracts negotiated generally set the pace for the ASC's future financial performance. Third, maximize working capital lines of credit in order to cover operating expenses during the start-up year while negotiating contracts.

7. Any other pearls of wisdom?

Teuber: The keys to any successful business are enthusiasm, vision, access to reasonably-priced capital, discipline, risk tolerance, sound execution, the ability to respond to competition and evolve and performance surveillance. Specifically for an ASC to be successful, it must "cross-pollinate" itself with the best business practices of many diverse industries and not rely on the traditional hospital operational methods and corporate culture.

Kehayes: Although Medicare does not cover spine services in ASCs, many private payors have experience with ASCs performing spine surgery



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and see their value. To this end, educate payors on spine surgery in an ASC and the tremendous cost savings that could be obtained. Have the ASC's spine surgeons work with the payor's medical directors when seeking approval for cases. In addition, the new OPPS methodology affords opportunities for increases in orthopedic reimbursement. Understand the future compensation scheme and educate payors so that the ASC can benefit.

SOURCES:

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[SIDEBAR]

Pain Management Rewarded for Migration From the ASC and Hospital

Due to the 2002 implementation of Medicare's 1999 site-of-service differentials that have also been adopted by private payors, ASC physicians may opt to perform pain procedures in their offices rather than in ASCs. I. Naya Kehayes of Eveia Health Consulting & Management provides the following example: the 2007 Medicare reimbursement rate for a physician providing injection code 64483 in the office is approximately \$336.00, while this injection in an ASC or hospital only reaps \$107.00 for the physician. "The additional compensation of \$229.00 for provision of services in the office setting offers physicians an opportunity to realize increased revenue if their offices are already equipped and staffed to provide these services. However, many physicians do not desire to incur the additional expenses associated with the provision of

services in the office. With the significant compensation reductions proposed for ASCs, these cases will no longer be financially attractive to the ASC but may be more advantageous in the hospital setting if the physician cannot move them back to the office because the hospital is already equipped and staffed to perform the services, receives OPPS reimbursement that may be higher and has other ancillary services reimbursed. Further, when comparing the \$229.00 site-of-service amount to the proposed OPPS ASC reimbursement amount of approximately \$253.00, payors may not want to compensate more for the services performed in an ASC. Payors want to pay the same amount for the services regardless of the setting," Kehayes surmises. This is especially true if the services are provided in a group practice based ASC, she adds.



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Building and Operating a Surgery Center - 11 Critical Mistakes continued from page 1

better per hour for the hours that they do work. In essence, it relies on a structurally different view of how to operate a surgery center. Rather than be open five days and paying a staff for five days and operating at 30% capacity, the concept is to be open three days a week and operate at 70% capacity and pay the staff very well for those three days. Staffing costs may be targeted at 25 to 30% of collections.

3. Signing Bad Managed Care Contracts. We have seen countless surgery centers fail due to signing managed care contracts that are not profitable. In essence, no matter how many cases one does at the rates being paid by the managed care company, there is no way to make money. These centers are much better off taking a chance to operate for some payers on an "out of network basis" or simply not to serve patients of those payors. The increased number of cases at too low of rates to be profitable leads to increased staffing and equipment needs, numerous scheduling headaches and often worse service.

4. Not Hiring Professional Management Help. Many physician owned surgery centers thrive. However, with an experienced management company, the chances for success improve,

even if you are giving away a small percentage of revenues and a small percentage of the profits. In essence, you significantly increase your chance of success even though you give up a piece of the profitability. The only thing worse than not hiring a management company is discussed next.

5. Hiring Bad Management. Perhaps the only thing worse than not having a management company is to hire one that is not good and does not provide good efforts and intelligent help. In a mom and pop industry, like the surgery center industry, every day there is a new company that professes to be in the ASC management business. These companies often do not have sufficient staff or support to render good services on a systematic ongoing basis. Before hiring any management company, check their references very thoroughly. Further, try to find several physicians that have worked with them that are not references and can speak about their services and quality. The amount of money that is spent on trying to separate from management companies that have underperformed is immense.

6. Dependent on too Few Physicians.

Generally, surgery centers can find themselves at significant risk if they are overly dependent upon two to three physicians versus a larger group. In

contrast, they can also find themselves in trouble if they have so many owners that there is a diffusion of responsibility and no one takes great care or concern about the surgery center.

7. One Bad Partner.

There is an old saying for lawyers - "bad people cannot make a good deal." The corollary to this statement is that good people can make a good deal without legal documents. In a surgery center, all it takes is one poorly behaving partner, whether a management company or an individual, to spoil the whole fun. Countless hours can be spent on political problems as opposed to trying to constructively move the center forward. We witnessed, for example, one physician lead eight key orthopedic physicians out of a hospital project. Here, all it takes is one strong minded confrontational physician, particularly in situations where many other physicians don't want to spend their time fighting or combating.

8. Lack of Compliance Efforts. Over the past few years, the Offices of Inspector General has not appeared to be overly aggressive in pursuing surgery center joint ventures and transactions. This often leads people to a false sense of comfort regarding their need for compliance efforts and regarding their need for concerns in measuring their efforts against the Anti Kickback Statute. We believe that this can lead to bad business practices and extreme vulnerability when and if your surgery center is investigated or prosecuted. Again, we are seeing a reloading of resources into investigating healthcare fraud and improper relationships. The surgery center business industry is certainly not immune from these efforts.

The DHHS Inspector General recently testified that from 2003 to 2006 the OIG recouped \$13 for every \$1 invested in prosecution and investigation.

9. Lack of A Core Base. Successful surgery centers are often built around a core practice and a core base of physicians. A center that is built around a whole number of unrelated parties where there is not a single coherent base of viability to the center often spells long term challenges and problems. Where you have a core base, whether a practice or core group of physicians that are devoted to the center, viability is often assured and you can spend your time trying to improve operations and profitability. Where you don't have this core base, it can be a long term game of catch up just to survive.

10. Hospital Partner. Often physicians judge success in a hospital negotiation based on how small an ownership position the hospital will be granted. We often find if a hospital owns less than at least 20 to 30%, its interest in the project's success is very low. Conversely, the project performs well when the hospital has a sincere interest in the project's success.

11. Billing and Collections. There is probably no issue more fatal than not focusing appropriate efforts and resources on billing and collections.





Nine (9) Things to Know About Imaging and Radiation Therapy

By Scott Becker

he imaging industry is currently under a great deal of pressure. This outlines some of the current issues and observations relating to imaging.

1. Technology and Innovation. Notwithstanding the scrutiny being levied upon the imaging industry, the improvements in technology and innovation continue to be amazing. This point is often lost in the face of the numerous different complaints coming from regulators and payors related to the increase in imaging supply.

2. Governmental and Payor Perspective.

There is widespread belief amongst payors and the federal government that two things occur with the development of imaging. First, that improvements to technology add cost to the health care system. Second, that the increase in supply drives demand. In essence, the more imaging facilities that are in business, the more imaging procedures are provided. The belief is that the

demand of patients for better diagnostics does not lead to more demand. Rather, it is more owners of the imaging technology that are out pushing hard to sell imaging that leads to greater cost and greater use of imaging technology. Further, they do not see the increase in imaging facilities leading to any price erosion or price competition. This last point, to date, is largely true.

3. Government Perception of Legitimacy.

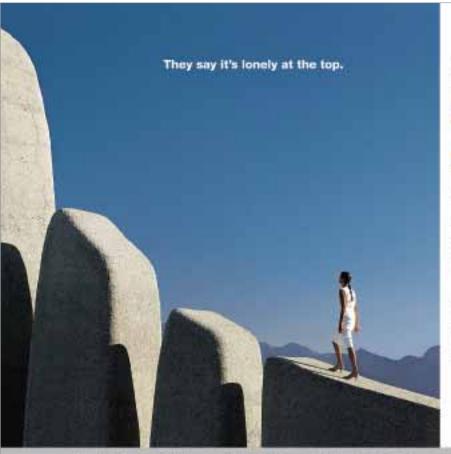
The government does not perceive that every provider of imaging is involved in an improper scheme or some method to simply reap profits. They tend to perceive that there are a handful of providers that are legitimate providers not interested in simply reaping profits.

4. Stark Services. Imaging providers and radiation therapy providers are Stark services. This means that they can only be provided and owned by physician owned groups, unless in a

rural area, through a group practice exception. We would be very mindful of situations in which lawyers or consultants provide physicians and providers with "creative" schemes or models aimed at allowing physicians to access profits from imaging. Here, we would aim to stay on the more conservative side of the line as to the method by which to provide services.

5. Best of Times and Worst of Times.

It appears to be essentially the best of times for radiation therapy providers. There seems to be great interest in development of radiation therapy facilities. There also seems to be a window of time in which this will be a very profitable business. In contrast, for imaging providers, particularly MRI and CT, this no longer seems to be the best of times. As measured by the number of inquires we get from people at national companies looking to either sell their companies or engage in a job search to find a job outside the imaging industry, it is becoming a challenging time in this industry.



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6. The Check is in the Mail. One common perception that is proving to be untrue is the concept that as long as you serve "commercial pay" patients only you have great freedom to do whatever you want. In fact, as we are witnessing increasingly, state attorney generals and managed care payors are attacking commercial pay ventures based on the concept that such ventures violate other state laws whether they be consumer practices laws, deceptive trade practice laws or state anti-kickback laws. When someone says to you that "it is commercial pay only, don't worry," that is a good time to ask for a legal opinion.

7. Per Click. Increasingly, states and payors are attacking per click efforts. These are situations in which a referring physician buys an image from a facility and then resells it or bills it himself to a payor or payors. Here, a business practice like this was recently attacked by the State of Illinois as it brought actions against several different imaging providers. Here, the more that the referring practice can be shown to actually be the provider of services as opposed to simply a buyer and reseller, the more likely it is that this practice may survive scrutiny. The federal "purchased diagnostics rule" does not allow the mark up of imaging services and reselling of the same. In any event, there are a whole number of rules that one can adopt to do "block leasing" as opposed to per click leasing. Here, the practice wants to show that they are truly the provider of services. In all these efforts, full disclosure to the payor, if one is not the provider, may go a long way towards avoiding a suit or claim based on fraud and misrepresentation. For a list of core rules regarding block leasing, please email me at sbecker@mcguirewoods.com.

8. Raising the Bar. Increasingly, payors are setting new requirements such that a party cannot provide and bill for imaging services unless they provide a full array of imaging services. Further, the government has introduced rules that have now been put on hold that would have provided numerous different additional requirements for imaging providers to meet in order to provide imaging services as an independent diagnostic testing facility.

9. Radiation Therapy - The 4th Wave.

Over the last several years, urologists, who receive relatively lower reimbursement for their core professional services have tended to earn a great deal of their income from ancillary ventures. These ancillary ventures in waves have included the provision of lupron (now no longer profitable to practices), the provision of lithotripsy services, the provision of prostate bratherapy services and now the provision of radiation therapy services.

Radiation therapy has the potential to be the most profitable of all of these services. This is particularly true given the combination of reimbursement for the services plus the fact a great percentage of men above a certain age test positive for some level of prostate cancer or exposure to potential prostate cancer. In fact, the development of radiation therapy looks so profitable to some that it is leading to an unusual alliance in practice between radiation oncologists and urologists. For example, because radiation therapy can only be provided and owned by a practice per the group practice exception, and it requires the help of radiation oncologists and urologists, we are seeing practices examine mergers between radiation oncologists and urologists that we would have never expected.

Should you desire a copy of an article authored by two of our lawyers, Ron Lundeen and Sarah Abraham regarding business and legal issues related to radiation therapy, please contact myself at sbecker@mcguirewoods.com or through www.Beckersasc.com.





IT'S TIME POTENTIAL BECAME A LINE ON A BALANCE SHEET.



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Acquisition Finance

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Ask the Expert

Jim Freund, HELP International at j.freund@snet.net or 203-733-8818.

The following question was asked of Jim Freund at HELP International.

What are the three things you should know when buying or planning equipment for an ASC?

- 1. Start detailed equipment planning/ budgeting immediately after the architect presents preliminary schematic drawings. The importance of this is that equipment dictates design and design dictates equipment, so any time that is spent designing the architectural floor plans without the consideration of the equipment will be potentially lost, if later equipment decisions cause redesign or delays. Not only must the equipment fit the space but it also must fit the building, from the standpoint of being able to get the equipment into the space through narrow doors or hallways, inside elevators, etc. The utilization of the equipment with regard to materials, personnel, and/or patient flow is also critical. There are all too many instances throughout the industry where designs are finalized and construction started only to find a required change due to the late selection of equipment.
- 2. Finalize fixed equipment specifications and documentation prior to construction documents. There are two primary reasons to finalize fixed equipment specifications and their respective documentation, prior to construction documents. First, the typical construction duration of an ambulatory surgery center is relatively short, measured in months not years. If the fixed equipment is not finalized and, in some cases, ordered prior to construction starting, the building will be finished before the equipment can be finished and received. Secondly, if all the fixed equipment is specified and the documentation incorporated into the construction documents, then there is no room for equipment related construction change orders. If the construction documentation includes all the equipment mechanical, electrical, plumbing, structural requirements, then the contractor and/or architect cannot come back and say that they were unaware of a particular need. As we all know, construction change orders are very expensive both in cost and time.
- **3. Finalize equipment financing and enter purchase orders 120 days prior to required installation date.** As previously mentioned, the construction duration, particularly of a tenant "tenant improvement" space can be very short and actually take less time than the normal manufacturing lead time of certain pieces of equipment. A good rule of thumb is to order all equipment at least 120 days prior to the required installation date to allow time for manufacture,

shipping, installation, and training prior to use. What holds up the purchase of equipment in the proper time frame, more often than not, is failure to obtain financing for the equipment. In developing a new facility, credit worthiness will need to be established with each and every vendor because there is no existing entity with no existing credit score. Seeking out and finalizing competitive financing, for capital medical equipment on a start-up project, is a difficult and time consuming process. There is a "pumpkin point" after which, if equipment is not ordered, it will simply not arrive in time to open the facility. Obviously, every day the facility is finished and not open is a day of lost revenue and, more important than that, lost confidence on the part of the medical staff. In summary, the averaging manufacturing and shipping lead time for capital medical equipment is 120 days and some items can be substantially longer. Equipment planning and procurement cannot wait until the building is half finished.

Selling a Physician Owned Hospital or **Surgery Center.** We have reported that we have seen a slight decrease in the pricing of surgery centers and physician owned hospitals. As this quarter evolves, it is probably fairer to reflect as follows. First, for outstanding centers that have some sort of protective moat, and significant prospects for long term stability (for example, a certificate of need, and limited out of network reimbursements) we are seeing very, very high prices. Second, in contrast, for surgery centers who rely heavily on out of network patients or are heavily dependent on one to three physicians, and do not have some sort of special protective moat, we are seeing significant reductions in the pool of purchasers and in potential purchase price. Elissa Moore of our office, with myself, just completed an article entitled "Selling Your Physician Owned Hospital - A 15 Point Primer." For a copy of the article please email myself at sbecker@mcguirewoods.com or Elissa Moore at emoore@mcguirewoods.com. The article should be posted shortly at www.beckersasc.com under Hot Topics as well.

Ask the Expert part two

Anthony Mai, CIT Healthcare at 201-750-5155.

We posted the following question to Anthony Mai of CIT Healthcare.

What is the most critical items that scare a lender away from financing an ASC project?

1. Not enough equity to cover monthly expenses during pre and post opening.

Something always goes wrong with the ASC timeline from the contractor needing more time, to Medicare taking longer to certify the center. Investors in ASCs need to have the capital available to cover these potential problems.

2. Not enough cases to make the center cash flow

3. Not having an experienced developer in the process. The only deals that I remember not being able to get done are the ones in which the physician leaders tried to do everything themselves. They are trying to treat patients, form the LLC, hire a contractor and find space, and play politics with the other investors. Something will slip through the cracks.

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

"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."

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– Jeff Simmons, President, Western Region, Regent Surgical Health, LLC.

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- Jon Vick, President, ASCs Inc.

Quality Imaging Services: Essential For Ortho-Pain-Spine Programs

By Susan Hollander, BSN, MBA, FACHE, Vice-President National Surgical Care

Susan Hollander is a senior executive who is extremely experienced in the operations of ASCs. She can be reached at 303-249-2388.

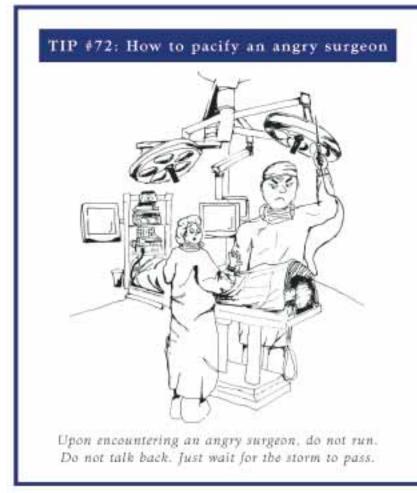
Imaging or radiology services are essential if your ambulatory surgery center is performing neurospine, pain management, orthopaedic or podiatric cases. The manner in which your imaging services are delivered will either make or break the surgeon's experience at your facility and can drive him away or gain his support. In addition to the surgeon, there are other constituents important to imaging services, namely state regulatory and accreditation agencies. The development of a technically sound imaging service along with a radiology protection plan can ensure your center has not only a safe, but a quality ancillary program for the operative procedure.

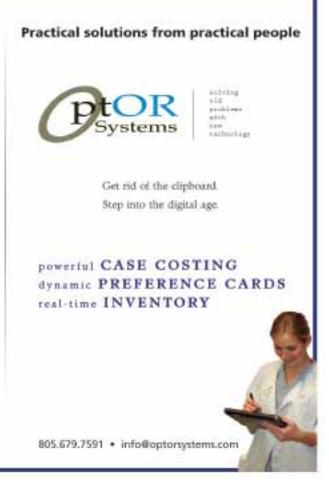
Physician Satisfaction: How many times has your scheduler had to reschedule a physician's case because there was no radiology technologist available or the C-arm was down or already in use? Time and time again surgery centers find themselves in a quandary because of two reasons: expense of the equipment and expense of the specialized staff. C-

arms are not inexpensive, typically costing \$100,000-\$125,000. The pricing and reliability of refurbished C-arms at times has been questionable, leading the center to a significant capital investment. The payors typically do not reimburse for fluoroscopy claims unless the contract is based on a discount from charges or the administrator has successfully negotiated rates for the 70000 codes. In spite of the low occurrence of reimbursement, it is prudent to establish a fixed price for fluoroscopy services, typically seen at \$250-\$500. The surgery center should always file a claim when it is used, as it verifies the frequency and circumstances in which the equipment is utilized to establish data for re-negotiations with the payor. In addition to the equipment cost, the trained operator is a high-priced employee paid at the same hourly rate as a registered nurse. This fact should also be included when discussing payment for radiology services with the payors.

If you want to develop your orthopaedic or pain management service line, then a reliable C-arm and an experienced radiology technologist must be readily available. The options to meet staffing needs are to establish a relationship with several radiology

technologist agencies, if you are located in an urban area, or to hire a radiology technologist. The latter approach is the fail-proof way to control access to expertise. The downside is arranging for coverage during vacation time. Alerting your physicians and their schedulers as to the technologist's planned absences can oftentimes cancel the need for agency relief if the case load is light. If you choose to employ the radiology technologist full-time for a part-time need, this person will oftentimes require direction to succeed as a member of your team. The applicant for this position should be aware there will be "all other duties as assigned" when his technology services are not required. These other duties can be diverse, depending on skill and interest levels. Radiology technologists can be taught patient registration, medical records management, sterile processing and even function as materials management assistants. This keeps their productivity high, possibly negating hiring a nursing assistant or supply clerk. It takes the right attitude and mindset of the radiology technologist to perform the off-duty tasks. However, the flexibility the surgery center gains in scheduling cases is irreplaceable.





Regulatory: Each state has its own regulations it expects healthcare facilities to follow if using radiation emitting machines. The following website provides links for the reader to the radiation control agency in 43 different states: www.iem-inc.com/linkstdr.html. The remaining states' information can be found using Google, then entering the state under search and "radiation control regulations." In a few states, the radiation regulations are written as part of the environmental protection regulations or hazardous materials regulations. There are peculiarities of note, such as Oregon includes registration of tanning facilities in its radiology plan and Texas includes laser equipment registration along with X-ray machines.

There are two main subjects covered in the regulations-radioactive materials and radiation equipment. Some states distinguish between use in industry and use in the healing arts or healthcare. These regulations are lengthy, so searching on key words, such as "healing arts," "healthcare," "fluoroscopy," "healthcare facility" may speed the search through the document to the chapters pertinent to the surgery center.

The controlling agency provides details as to what type of equipment is covered, submission of registration application, registration fee schedule, and in some cases, designation and qualifications for a Radiation Safety Officer (RSO). For example, the Texas Department of State Health Services and the North Carolina Radiation Protection Section require a Radiation Safety Officer to be designated

for the facility. This person is responsible for the following components:

- a. updating of the radiation safety program
- b. assuring personal protection devices are checked annually
- c. replacing darkroom chemicals
- d. assuring equipment preventative maintenance performed and reported
- e. ensuring physicist analysis performed and reported
- f. providing staff education
- g. monitoring, reporting and posting radiation exposure
- h. verifying safety precautions are followed by the physicians and staff

Facilities are typically required to post on its employee bulletin board an informative notice to employees as to standards for their protection against radiation, their responsibility as a worker and what is covered by the rules, including their rights to reports on their personnel monitoring devices.

Accreditation: In 2007 AAAHC renamed Chapter 17 "Diagnostic and Other Imaging Services" and organized it such that Standards A-E are applied to organizations that provide imaging services used for diagnosing, monitoring or assisting with procedures. The remaining standards are targeted to organizations dedicated to diagnostic imaging services. Surgery centers need to check their credentialing policies to ensure they define who can be credentialed

to interpret results of the imaging services. Medical records staff or coding staff should audit the operative note for documentation of the interpretation of the X-ray examination. Other accreditation standards cover safety training to the staff, hazard precautions, personal protective device testing along with proper shielding and monitoring. Warning signs should be in place when X-ray equipment is in use and facilities should be screening for possible pregnant females whether employees or patients. The organization should have policies on protection for the pregnant employee and monitoring of the fetus. Some organizations have replaced individual monitoring with area monitoring, especially for those facilities using radiology equipment on an infrequent basis.

Most physicians use the mini C-arm without the guidance of a radiology technologist, but hospitals have started to provide radiology self-learning modules with competency testing of the physician prior to credentialing him to operate the mini C-arm to meet their respective accreditation standards.

In summary, imaging services are critical to support the growth of pain management, neurospine and orthopaedic services. Providing radiology services as an organized ancillary program is the responsibility of the surgery center administrator and clinical director. Understanding all components of a radiation protection program in addition to staffing the program will lead to a safe service for your patients and physicians.



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- To help such surgeons as well as hospital and management company leaders to assess the latest trends and current issues in ambulatory surgery centers.
- To help such parties understand their choices as to development models, hospitals as opposed to surgery centers, single- as opposed to multi-specialty, and several other key strategic and business issues.
- To enable participants to incorporate innovative business and strategic strategies into their ambulatory surgery centers.
- To identify the key business, clinical and staffing issues involved in an ambulatory surgery center.

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CONFERENCE PROGRAM

THURSDAY, JUNE 14, 2007

12:00 – 2:00 pm Registration

Pre-Conference Workshop - Concurrent Sessions A, B, C

2:00 - 3:30 pm

A. Turning Around an ASC – Tested Methods for Financial Improvement – Case Studies and Analytical Tools

Thomas J. Mallon, CEO & Jeffrey Simmons, President Western Region Regent Surgical Health, LLC

Jim Lynch, MD - Surgery Centers of Reno, LLC

B. Establishing an Ortho-Spine-Pain Driven ASC

Brent Lambert, MD, FACS, Founder Ambulatory Surgical Centers of America

C. Establishing Physician Hospital Joint Ventures for Long Term Success

Bill Southwick, CEO - Healthmark Surgical Partners

3:30 – 3:45 pm Break

3:45 – 5:00 pm

A. Selling Your ASC or Physician Owned Hospital – The Pros and Cons, What to Expect in Terms of Price and Terms, Understanding the Entire Process

Scott Becker, JD, CPA, Partner; Scott Downing, JD, Partner; Elissa Moore, Associate & Sarah Abrahams, Associate – McGuireWoods

B. A Detailed Blue Print for Developing the Orthopedic Driven ASC

Steve Dobias, Founder and Principal – Somerset Financial Services, Joseph Zasa, CEO and Principal – Woodrum ASD

C. Transitioning to a Physician Owned Hospital – A Primer from A to Z

Ajay Mangal, MD, MBA, President; Donald J. Jansen, MHA, VP Marketing; Development & Mary Ann Gellenbeck, RN, CASC, COO; Michael L. Griffin, CPA, MBA, VP for Finance Prexus Health Partners

5:00 – 7:00 pm Networking Reception & Exhibits

FRIDAY, JUNE 15, 2007

7:00 – 8:00 am
Registration & Continental Breakfast

8:00 – 8:15 am Welcome & Introductions

8:15 - 8:45 am

Orthopedics and Spine – A Forecast for the Next Ten Years *John Cherf, MD, SG2*

8:50 - 9:20 am

Key Tips for Retaining and Recruiting Physicians

Thomas R. Yerden, CEO - TRY Health Care Solutions, LLC

9:25 - 9:55 am

Snatching Victory from Defeat, A Case Study View of Turning Around ASCs

Brent Lambert, MD, FACS, Founder Ambulatory Surgical Centers of America

10:00 - 10:30 am

Selling an ASC – A Buyer's Perspective

Evelyn Miller, Director of Acquisitions – United Surgical Partners International

FRIDAY, JUNE 15, 2007

10:30 - 10:40 am

Break

10:40 - 11:10 am

Critical Times in Government – A Washington Update for ASCs

Craig Jeffries, Executive Director – AAASC

11:15 – 11:45 am

Improving Your ASC, The Five Things You Should Do Starting on Monday, June 17th

Thomas J. Mallon, CEO - Regent Surgical Health, LLC

11:45 - 12:30 pm

Exhibit Viewing

12:30 - 1:30 pm

Lunch

1:30 - 2:05 pm

(Concurrent Sessions A – Orthopedics and Spine, B – Spine and Pain Management, C – Physician Hospital Joint Ventures and Physician Owned Hospitals, & D – Strictly Business)

A. Managed Care Contracting for ASCs – Contracting with Commercial Payors for Complex Cases

I. Naya Kehayes, MPH, CEO – Eveia Health Consulting & Management, LLC

B. Building a Center Around Pain Management

Charles Tadlock, MD, Founder – Surgery Center of Southern Nevada, CEO – Epiphany Surgical Solutions

C. Establishing Winning Physician Hospital Joint Ventures an Ortho Driven Example

Caryl A. Serbin, RN, BSN, LHRM, Founder/President Surgery Consultants of America, Inc.

D. Developing Real Estate Plans for an Ortho Driven ASC, A Case Study Approach

Jack Amormino, President, CEO – AMB Development Group Steve Goodman, VP New Business Development – Irmscher Construction, Inc.

2:10 - 2:45 pm

A. Building a Very Profitable Project Around a Top Flight Spine Program

Larry Teuber, MD, Founder

Black Hills Surgery Center & Medical Facilities Corporation

B. Pain Management, Understanding What Works and What Doesn't in ASCs and Practice Offices

Amy Mowles, CEO – Mowles Medical Practice Management, LLC

C. Turning Around an ASC with Orthopedics, A Case Study
Bill Southwick, CEO – HealthMark Partners

D. Five Vove to a Successful Polationship and Future wit

D. Five Keys to a Successful Relationship and Future with Lenders

Ken Seip, Vice President – CitiCapital

2:50 – 3:20 pm

A. What to Expect When You Convert from an ASC to an Ortho and Surgical Driven Hospital

Brett Gosney, Founder/CEO – Animas Surgical Hospital & President Elect – Physician Hospitals of America

B. A Study on the Safety and Efficacy of Spine Procedures Performed in an ASC vs a Hospital

Ken Pettine, MD, Founder - Loveland Surgery Center, LLC

C. How to Effectively and Successfully Staff Your ASC – Keeping the ASC Humming Without Breaking the Bank

Ann Geier, RN, MS, CNOR, Vice President Operations Ambulatory Surgical Centers of America

CONFERENCE PROGRAM

FRIDAY, JUNE 15, 2007

D. How to Cut the Costs of Implants and Expensive Supplies and Equipment in an Orthopedic or Neurosurgical ASC or Hospital

Larry Teuber, MD, Founder – Black Hills Surgery Center & Medical Facilities Corporation

3:20 - 3:50 pm

Break in Exhibit Hall

3:50 - 4:20 pm

A. Bringing a Sense of Urgency to Growing the Orthopedic and Pain Driven ASC

William Kennedy, Senior Vice President - Novamed

B. Five Key Steps to Mixing Spine and Orthopedics for Success – A Case Study

Susan Pieper, Chief Development Officer – Neospine, LLC Dr. Richard Wohns, MD, MBA, Founder & President – South Sound Neurosurgery

C. Bringing in a National Partner for Your ASC – Making the ASC and Partnership Successful After the Deal is Closed and Checks are Cashed

George Goodwin, VP Mergers & Acquistions & Michael Weaver, VP Acquistions & Development – Symbion Healthcare, Inc.

D. Examining Your Financial Statements to Fine Tune and Improve Your ASCs Results

John Goehel, Vice President - Surgery Consultants of America

4:25 - 4:55 pm

A. The Ortho Driven ASC – How to Manage Costs, Egos, Schedules and Improve Profits

Rick Pence, President - National Surgical Care

B. Spine Surgery Centers - Lessons Learned

Jeff Leland, Managing Partner – Blue Chip Surgical Center Partners Richard Roski, MD, CMO – Blue Chip Surgical Center Partners

C. Developing a Physician Hospital ASC Around Orthopedics, A Plan for Success

Robert Carrera, President – Pinnacle III, LLC

D. 7 Keys to Cutting Costs

Dave Moody, Administrator – Knightsbridge Surgical Center, LLC

5:00 - 5:30 pm

A. Handling Complex Orthopedic Procedures in an ASC, What is Appropriate and What is Not

Phillip A. Davidson, MD – Tampa Bay Orthopaedic Specialists

B. Five Key Legal Issues for ASCs

Scott Becker, JD, CPA, Partner; Alison Mikula, Associate & Ronald Lundeen, Associate – McGuireWoods, LLP

C. Physician Owned Hospitals, a National Legislative Perspective

Molly Gutierrez, JD, Executive Director – Physician Hospitals of America Brett Gosney, Founder/CEO – Animas Surgical Hospital & President Elect – Physician Hospitals of America

D. Billing and Collecting, An Aspect of Operations that can Make or Break You

Caryl A. Serbin, RN, BSN, LHRM, Founder/President Surgery Consultants of America, Inc.

5:30 - 7:30 pm

Networking Reception & Exhibits

SATURDAY, JUNE 16, 2007

7:00 – 8:00 am Continental Breakfast

SATURDAY, JUNE 16, 2007

8:00 - 8:35 am

The World's Largest Operator of ASCs, Bringing an Assessment of What Works from a Macro Perspective to an Individual Center Perspective

Joseph Clark, President Ambulatory Surgery Division – HealthSouth

8:40 - 9:15 am

How a Higher Acuity Neurosurgery/Spine Program can Achieve Wonderful Clinical and Financial Results for an ASC

Jeffrey Simmons, President Western Region – Regent Surgical Health, LLC Jim Lynch, MD, Founder – Surgery Center of Reno, LLC

9:20 - 9:55 am

The Three Things the ASC Industry has to do in DC and in the States to Thrive as Climate Shifts in Washington DC

Kathy Bryant, JD, President – FASA Rob Schwartz, Executive Director – WASCA

9:55 - 10:25 am

Understanding Your Top Five Costs in an ASC – How to Assess if They are in Line with Expectations or if They Need Improvement

Luke Lambert, CFA, CEO - Ambulatory Surgical Centers of America

10:30 - 11:05 am

Conducting an Operational Audit of your ASC

Robert J. Zasa, MSHHA, Founder – Woodrum/ASD

11:05 - 11:20 am

Break

11:20 - 11:55 am

(Concurrent Sessions A, B, C & D)

A. Five Keys to Developing a Winning Orthopedic Driven ASC

Jeff Peo, Vice President - Ambulatory Surgical Centers of America

B. Developing a Physician Owned Hospital – 5 Core Considerations

Douglas V. Johnson, President - Surgical Management Professionals

C. Outsourcing the Back Office Functions of Your ASC, a Plan for Simplification and Effectiveness

Tom Jacobs, President/CEO - MedHQ

D. Staffing and Scheduling – Hiring and Keeping a Great Staff

Dawn McLane, RN, MSA, Chief Development Officer Nikitis Resource Group

12:00 – 12:35 pm

A. Our Approach to Assisting an Underperforming Center

Donald J. Jansen, MHA, VP Development & Michael L. Griffin, CPA, MBA, VP for Finance – Prexus Health Partners

B. Coordinating the Development of Your ASC With Construction and Financing

Jeff Fox – MarCap & John A. Marasco, AIA, NCARB, Principal Marasco & Associates

John C. Daly, AIA, VP Health Care Services – McShane Construction Corporation

C. Adding Procedures and Specialties

Gregory R. Cuniff, Chief Financial Officer – National Surgical Care

D. Valuation Issues for ASCs

Gregory Koonsman, Founding Principal – VMG Health Todd J. Mello, MBA, AVA, Principal – HealthCare Appraisers, Inc.

12:35 pm

Meeting Adjourn

ASC COMMUNICATIONS, INC. PRESENTS

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OPTIONAL					Email: chris@bluehouse.us	
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(Published six (6) times	a year)		\$225 (for 2 years)	\$	McGuireWoods, LLP	
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Using Technology: Automate Your Workflow to Cut Costs

By David W. Odell, Founder and CEO of MedBridge Development

SCs do not operate in the traditional 'fee for service' world. Although medical services are performed, rarely is a center paid in full. Providers are significantly limited in what steps they can take to improve the reimbursements they receive. In an increasingly competitive industry this requires that all costs be tightly controlled. Even then, volume needs to be high and costs need to be low. In addition, without the staff working at peak efficiency a surgery center will not turn a profit from one month to the next.

Certain costs incurred by the center, although quite substantial, are necessary for an ASC to succeed. Expensive equipment needs to be secured, everincreasing staff salaries and benefits must be paid, and disposable supplies have to be purchased and used. Creative loaner/lease options can help shoulder the heavy equipment load. Hiring employees who value flexibility, and will accept this in exchange for not being given the benefits of an FTE, can eliminate a costly expense. However, focus is rarely given to the importance of establishing tight inventory controls, or to establishing ways to see disposable supplies as more than simply sunken surgery costs.

From the beginning, opening a surgery center is no small task: physician partners must be found, brought together and pass the feasibility test. Land must be secured and permits to build a facility need to be obtained. Staff must be hired and trained. All of these hurdles and more must be overcome well before a center can open its doors. Quite often, the fact that surgery supplies must be purchased before cases begin is a mere afterthought. It is not uncommon, amid the chaos of an impending opening date, for a price to be quoted and paid without ever shopping around. With numerous GPOs (group purchasing organizations) eager to increase their purchasing power and vendors needing to match their competitors' prices, neglecting this step is a missed opportunity to save thousands of dollars each month. Once a price agreement is reached, renegotiation should occur at least once per calendar year.

Once equitable supply procurement contracts are reached, a method for tracking items ordered, and their unit of measure price, is an absolute must. Tracking the issuance and receipt of all purchase orders guarantees that negotiated contract pricing is, in fact, what is being billed. Centers frequently realize that contract pricing will mysteriously disappear, and a center will be charged for months at a vendor's retail price. A system to cross-check invoices will help eliminate expensive and time consuming vendor mistakes. In addition, without a system

to track all issued POs, a center is left with nothing to verify that every order was fully received.

Although a surgery center may pride itself on negotiating rock bottom prices, inventory control should never end there. The efficient use of disposable supplies is just as important, if not more, than purchasing them at the lowest available prices. If inventory is being wasted without restraint, purchase price only serves to show how much money is being needlessly thrown away.

Purchasing supplies is a cost of doing business at every ASC. However, supplies that sit on the shelf are simply wasted capital. Without direct communication between surgery staff and ordering personnel, an excessive amount of stock will be purchased without need. Conversely, if necessary items are somehow overlooked, someone will have to answer to the displeased surgeon asking for the supplies needed to finish the case. A center must devise an efficient system to capture all inventory items used in each and every case as well as report the total amount of inventory simply sitting on the shelf. Staff in all phases of care must be responsible for recording inventory use. This will ensure that ordering personnel purchase only what will be needed and used.

Case costing is an incredibly valuable exercise that



is all too often overlooked. Either due to a lack of information or too little time, a surgery center will neglect one of the most effective cost-cutting procedures in the ASC field. Case costing is most commonly done by totaling up the line items on a surgeon's preference card. However, this is not a truly accurate 'real-cost' reflection because a preference card lists only a procedure's projected use. Without an actual report of used disposable supplies, case costing will be a rough estimate, at best. Capturing each disposable or implantable item as it is opened and used is necessary to report on the actual cost of a case. This information should then be documented in reports to compare and contrast inventory use with all surgeons for each surgery type. By accumulating surgery summary reports that document each item used in every case, a real number average can be calculated and discussed. Case costing is only effective if it motivates surgeons and staff to cut costs and eliminate waste.

A report of all items used in a case can also be a valuable collections tool. A surgery summary report sent alongside the claim and Op Report is an effective cost justification piece. Doing so not only increases reimbursements for out-of-network claims, but also provides a significant reduction in back-end work for the A/R department. One of the most challenging issues facing surgery centers today is collecting cash on the claims that they send. When the workload of the collections staff can be lightened, the bottom line is positively affected.

Though these tasks can be completed with pen and paper in-hand, with all of the new technology available today there certainly is a better way. Finding a software system that will assist employees in completing these tasks without significantly altering their daily workflow is an efficient alternative. Although the implementation of such a system may take a substantial amount of work at the onset, the payoff is both long-lasting and lucrative. When used correctly, current software tools will significantly increase the efficiency and profitability of your ASC.

Dave Odell is President of MedBridge Development, a medical facility development and management company. He can be reached at dodell@medbridgedevelopment.com or by telephone at (805) 679-7560. ■





Are You Making the Best Use of Your Invested Capital?

By Raymond N. Irving

f you are a "for-profit" healthcare entity who owns healthcare real estate, are you using every asset to its optimum advantage? If you are not familiar with the term "cost segregation" nor employ it as a part of your everyday operating strategy, there is considerable value on your Balance Sheet which has not been put to proper use. Cost segregation is a strategic tax savings tool that allows companies (and individuals for that matter) who have constructed, purchased, expanded or remodeled investment or commercial real estate (healthcare facilities being the focus here) to increase their cash flow by accelerating depreciation deductions and deferring federal and state income taxes.

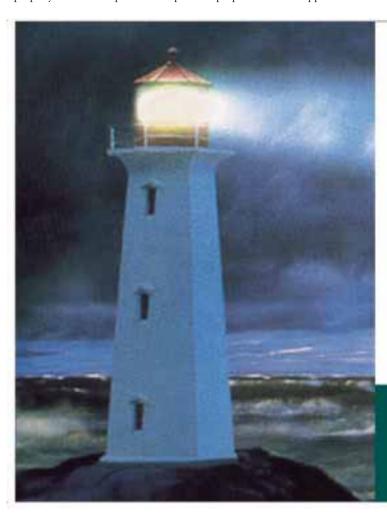
The application has been around since the 1960's but thought to have been disallowed by the Tax Reform Act of 1986. It was not and there are now over 200 court cases and IRS rulings supporting the benefits of cost segregation. In the landmark Hospital Corporation of America Case 109 TC 21 in 1997, the Federal Court further expanded the benefits of cost segregation by allowing property owners to separate 1245 personal prop-

erty from 1250 real property thus allowing specific non-structural assets to be correctly identified and classified so they could now be depreciated over their more appropriate lives of 5, 7 or 15-years rather than the usual 39-year life. (It might surprise you to learn that there are over 135 classifications of assets on the IRS books.) And when the IRS did not appeal the Federal Court's ruling on this \$800 million tax benefit taken by HCA, the application of cost segregation started to be embraced by very insightful industry leaders in the legal and tax communities.

Surprisingly, and even with the whitepapers being written by the American Institute of Certified Public Accountants (AICPA) touting cost seg and advocating that their members become knowledgeable so they in turn may introduce it to clients who would benefit from such a strategy, it is still relatively unknown in the general marketplace. On the other hand, the Big 4 and Super Regional Accounting Firms all have cost segregation departments. They simply cannot ignore this phenomenal tax application as it would compromise

their position of being on the cutting-edge when it comes to saving their clients money.

In the instance of healthcare facilities, a cost segregation study shall generally allow the reclassification of between 25-to-43% of the invested capital costs to be reallocated from 39-year life to their more appropriate 5, 7 and 15-lives. The results then create a significant increase in the deductions in a building's first 5-years, improving the cash flow within this facility which then allows other strategies to occur such as paying down debt or freeing up capital for other acquisitions. In fact, employing a cost segregation strategy in the planning stage of a healthcare facility may indeed be THE defining item which allows the conceptualized project to get full approval and "out-the-door" into its development and construction stages. (For every \$100,000 of a facility's improvement value which is reclassified from 39 to 5-year property, the depreciation increases from \$2,564 to \$20,000. If your facility has a \$5 million improvement cost, and 25% of its value is reclassified to 5-year property, your depreciation increases from



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3100 West End Avenue, Suite 940 Nashville, Tennessee 37203 615-777-7300 \$123,050 to \$342,288 in the first year. This does not account for the 7 and 15-year property which shall be stated as 1% for 7-year assets and 9% for 15-year assets in this facility. Thus, a cost seg study would create a depreciation expense of \$1,799,708 in this building's first 5-years compared to 39-year straight line depreciation of \$641,025. It's your money. Which would you rather have?)

Further, this application allows for a "look-back." Buildings that have not been cost seged can employ this application thus creating the improved and tax-accurate Depreciation Schedule. The depreciation which has not been claimed previously can now be retroactively realized through the automatic approval process which an IRS Form 3115 allows with the owner then realizing the benefits immediately. Thus, investment capital is now making itself available for other purposes.

Another aspect of cost segregation concerns Abandonment Studies. An Abandonment Study is an expanded Cost Segregation Analysis. Not only does an Abandonment Study provide the benefit of quicker depreciation deductions but also the advantage of writing off "structural" components that are removed when prior tenants move out and new tenants move in. The benefits of an Abandonment Study are even greater than those of a Cost Segregation Study. The value of disposed "structural" components are generally the highest costs spent in any given suite. Owners who are not writing off abandoned assets are simply leaving huge dollars on the table and paying excessive tax. An Abandonment Study allows owners to claim these losses and significantly increase their tax savings.

Given these facts, cost segregation is an application every "for profit" entity owning healthcare facilities should employ. But, one needs to exercise caution concerning the cost seg provider which is commissioned as cost seg study providers are not created equal. This tax application has birthed a cottage industry of study providers with the IRS paying close attention as it concerns fraud. It is crucial that you procure a cost seg study that shall withstand the scrutiny of the IRS if your study is ever audited. In an effort to insure that you obtain the optimum tax savings allowable by law, you should seek a provider adhering to the following standards: (1) possesses engineering, construction and tax expertise, (2) keeps current with the ever-changing tax laws, (3) has knowledge of prior court cases and rulings pertaining to specific assets, (4) operates within full compliance of the IRS Audit Techniques Guide (this is a detailed outline of that criteria which constitutes a proper cost seg study which the IRS issues to their field agents), and (5) is proactive in identifying other tax savings opportunities.

Further, if your accountant states that your facility's assets have been cost seged, understand that unless this is a full-time activity that this firm is engaged in , your accountant has only identified the low hanging fruit. A qualified cost segregation study provider shall be able to identify 4-to-5 times more value in shorter life assets than your accountant's best-intentioned efforts.

In closing, the Internal Revenue Service's position is as follows: "As a practical matter, cost segregation studies should be applied by Taxpayers."

Raymond N. Irving operates two M&A firms dealing in the sale of healthcare and financial service businesses. Understanding cost segregation and the tremendous benefits it has on healthcare businesses he has aligned himself with KBKG, an independently owned firm specializing in the delivery of cost segregation studies that greatly exceed the criteria set by the IRS. Ray can be reached at 866-412-6911 Ext 702 or raymondi@kbkg.com

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Physician Disclosure of Ownership

By Scott Becker and Melissa Szabad

his note provides an overview of legal considerations and makes recommendations relating to a physician's disclosure of ownership interest in an ambulatory surgery center ("ASC") to which the physician refers patients. This memorandum sets forth the general requirements as outlined in the Fraud and Abuse Statute.

The ASC safe harbor to the Fraud and Abuse Statute requires that: "Patients referred to the investment entity by an investor are fully informed of the investor's investment interest." 42 CFR § 1001.952(r). In conjunction with codifying this requirement, the Center for Medicare and Medicaid Services ("CMS") noted in commentary "that such disclosure in and of itself does not provide sufficient assurance against fraud and abuse of the Federal health care programs. This conclusion derives from our observation that a disclosure of financial interest is often part of a testimonial, i.e., a reason why the patient should patronize that facility. Thus, often patients are not put on guard against the potential conflict of interest, i.e., the possible effect of financial consideration on the physician's medical judgment." 64 Fed. Reg. 63,536. CMS has not, however, given further

significant guidance specifying what form of notice is sufficient to "fully inform" a patient.

Compliance with the ASC safe harbor, in short, requires physician owners to disclose their investment interest in the ASC in such a way that alerts patients to potential conflicts of interest. Additionally, physician investors may provide patients with the option to have a procedure performed somewhere other than the ASC in which they are an investor.

Investors in an ASC typically inform their patients of their ownership interest in the four types of disclosure methods outlined below. With each additional type of disclosure used by an investor, the risk of being viewed as not having made complete disclosure decreases:

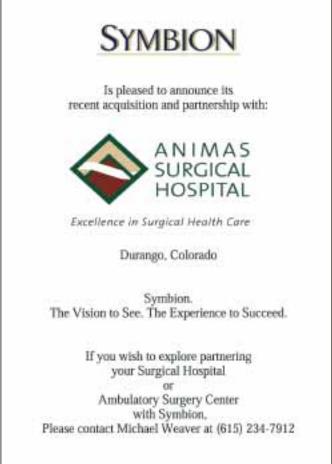
A. At the ASC

 A sign should be posted conspicuously at the ASC informing all patients of the fact that the ASC is owned in part or entirely by physician investors. The sign would, if practicable, also specifically disclose the names of physician investors. 2. A disclosure, in addition, would preferably be made in the patient informed consent package that is provided to each patient in order to enhance the ASC's compliance with the disclosure requirement. Sample language of such disclosure is as follows: "This surgery center is owned [in part/entirely] by physician investors who also perform procedures at the surgery center. If you have any questions regarding this arrangement, please ask your physician or the administrator for further details." Again, the disclosure may also specifically set forth the names of the physician investors.

B. At the Practice

- 1. We recommend that a sign disclosure per (and/or step 2 below) also be posted at each of the physician investors' offices informing all patients of the physician's ownership in the ASCs to which they may be referred for further procedures.
- 2. Each physician investor should make the effort to orally inform any patient of the fact that the physician owns an interest in the ASC. The





physician should also preferably make the disclosure part of his or her office practice's consent package. Additionally, such physician investor may inform the patient that choosing a facility other than the ASC will not impact the patient's treatment in any way. These steps will enhance the ASC's compliance with the disclosure requirement.

Company Profiles

Service Providers

Eveia Health Consulting & Management Company Profile

Millennium Health Consulting, LLC was founded by I. Naya Kehayes, MPH in 1998 and is located on the east side of Seattle in Issaquah, Washington. Due to the growth of the company and its presence on a national basis, the company adopted the business name Eveia Health Consulting & Management in July of 2006. Eveia is comprised of a team of seasoned professionals who are experts in reimbursement management, managed care contracting, and business management with a specialization in Ambulatory Surgery Centers (ASCs) and surgical practices. Senior Management serve as advisors to national corporations and provide leadership in health policy initiatives related to reimbursement on behalf of ASCs both at State and Federal levels.

Typically, Eveia serves as the Contracting Administrator and Manager on behalf of its clients. A revenue management plan is customized based upon the client's financial needs. Eveia's approach includes a comprehensive contract evaluation, coupled with a financial analysis of the business. This enables Eveia to develop a strategy for enhancing and maximizing the financial position of its clients. Eveia also works with providers to develop and implement a revenue plan that is focused on income retention when they are faced with changing reimbursement methodologies or are moving from an out of network to an in network provider status. Eveia implements training and reimbursement calculators that enable ASCs and surgical practices to understand reimbursement expected by payor, and to maximize cash flow via contract compliance. Finally, Eveia provides financial services related to business development projects which include feasibility studies, payor due diligence, fee schedule development and coordination of business related activities.

Eveia understands the revenue requirements of its clients and knows how to achieve success. With a proven track record, Eveia has serviced over 100 clients in 25 states since its inception in 1998. For more information contact Naya Kehayes at 425-657-0494 or at nayak@eveia.com or visit www.eveia.com.

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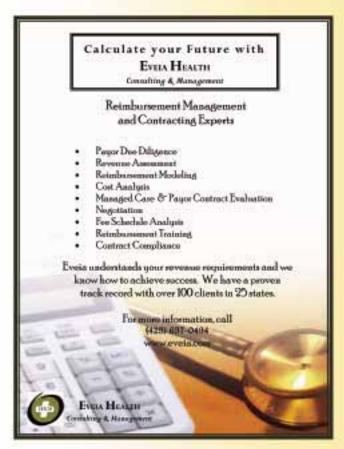
Based in suburban-Chicago, MedHQ provides accounting, billing and collecting, human resources and credentialing services to clients in ten states. Our services save medical facilities time and money and enable physicians to perform more cases. You're able to focus on patients because MedHQ is focused on the business. Contact Thomas Jacobs at (708) 492-0519 or tjacobs@medhq.net.

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Somerset has extensive experience in the development and/or renovation of single-specialty and multispecialty ambulatory surgery centers (ASCs), medical office buildings (MOBs) and single-specialty hospitals. Somerset prepares feasibility studies, valuation of ASC and specialty hospital ownership interests, operations reviews, licensure/certification/policies/procedures/accreditation, revenue cycle evaluation, benchmarking and succession/strategic planning.





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Electronic Medical Records

Amkai, Inc.

Amkai, Inc. specializes in electronic clinical and administrative solutions for outpatient surgery centers, physician-owned hospitals, clinics and physician practices. Amkai's clinical documentation system, AmkaiCharts™, and its administrative component, AmkaiOffice™, are each standalone systems. However, when installed together as AmkaiEnterprise™, a facility is able to move into the next generation of system functionality − Single Foundation Software. AmkaiEnterprise is the only product available that provides revolutionary functionality and benefits for the management of today's busy ASC and Surgical Hospital along with a true, discrete data clinical documentation system. AmkaiCharts provides such features as CPOE, Anesthesia Documentation, Patient Kiosk and much more, allowing the solution to grow as your business grows.

Amkai works with their clients to help them become more efficient, reduce costs and improve patient care and safety through the use of the first truly intelligent Electronic Medical Record designed specifically for the outpatient healthcare environment. Amkai can help your organization become more efficient with our private practice/clinical solution, AmkaiEnterprise-PM. Imagine getting all documentation from your surgeons in a digital format that flows smoothly into your AmkaiCharts-ASC system because they are using AmkaiCharts-PM in their offices along with AmkaiOffice-PM. This level of quality and integration is not available from any other vendor. Contact Steve Noxon at 866-265-2434 or steve.noxon@amkai.com.

ASC Management and Ownership

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HealthMark Partners is committed to making a difference. We take a comprehensive approach to providing ASC services, continually keeping all of our customers' goals in focus. HealthMark recognizes that a successful ASC requires satisfied patients, ASC partners including hospitals and surgeons as well as staff associates. HealthMark tailors its services to meet the needs of each project and has vast experience in all phases of ASC development and operations.

ASC Excellence Through Partnership – HealthMark does not mandate majority ownership nor a specific governance structure. HMP develops facility-specific partnerships that provide flexibility to adequately address the individual dynamics of a given ASC. HealthMark selectively partners in the following areas:

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- Physician/Hospital Joint Venture ASCs
- Single and Multi-Specialty ASCs
- New ASC Development
- Existing ASC Acquisition/Turnaround

Contact Bill Southwick at 615-329-9000 or at bsouthwick@healthmarkpartners.com.

Instantia Health

Instantia Health performs turnkey ASC development services from feasibility, through first patient, and Medicare certification. Instantia develops with the goal of handing over a well conceived, efficiently designed facility that is managed by a center's own in-house professionals. Instantia does not require an equity stake in its projects, or a long term management agreement. For more information contact Lisa Freeman at 303-554-0046.

Meridian Surgical Partners

WHO IS MERIDIAN SURGICAL PARTNERS?

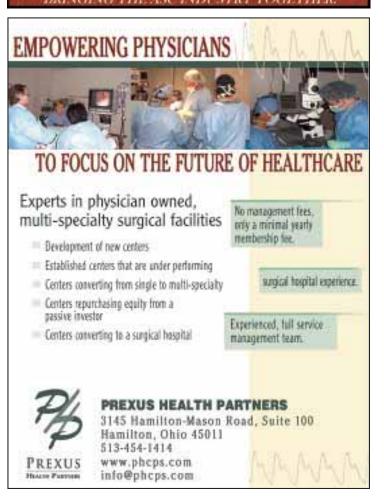
Meridian Surgical Partners is an ambulatory surgery center company focused on partnering with physicians to reach the highest level – the meridian – of a joint venture opportunity. We accomplish this through taking the time and working with our partners to define what success means for every unique partnership, and then tailoring each joint venture to meet these defined parameters of success.

WHO DOES MERIDIAN TARGET FOR PARTNERSHIPS?

Typical Meridian Target - Ambulatory Surgery Centers

Meridian is actively seeking Ambulatory Surgery Centers ("ASCs") that fit into one of three distinct categories:







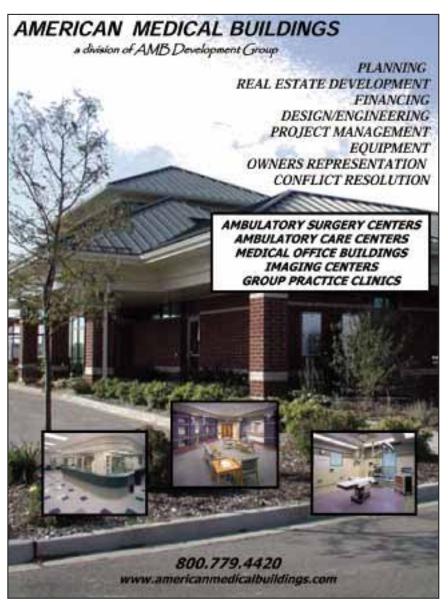
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- Established Facilities: Meridian targets successful ASC partnerships with positive cash flow, the opportunity for partnership development, and the capacity to increase surgical volume.
- 2. Turnaround Opportunities: Some ASC partnerships may require assistance to maximize a facility's financial performance. Many partnerships lack capital resources and a strong management focus. Opportunities of this type allow Meridian to deploy capital to eliminate debt, focus on physician recruiting, and implement a strong operations team to propel the partnership into a profitable business.
- 3. De Novo Opportunities: Meridian seeks new development opportunities (De Novo) in which we partner with physicians to plan and develop a new ASC. Depending on the partnership needs, Meridian assumes either a minority or majority ownership stake and manages the partnership long term.

WHAT IS MERIDIAN'S OPERATIONS PLATFORM?

Meridian facilities are strengthened by a proven clinical operations platform that was developed by our team over two decades. The PEAK Program enables every Meridian facility to achieve the right combination of Performance, Efficiency, Achievement and Knowledge to be successful. The PEAK Program is the clinical operations platform of our company.

Meridian applies the clinical program to each facility in order to focus on and enhance the patient experience. That experience doesn't start in the operating suite of a surgical facility, but rather in the physician office and then continues as the patient moves through the center. So, at Meridian, we believe it is imperative to reach beyond the surgical facility and fully integrate with the physician practice. We want to improve the patient experience by creating a seamless patient pathway.

As part of that, we must focus on throughput, or how efficiently you can manage a case with the best use of resources. We concentrate on collecting data at every operating point in the center and then analyze and complete comparative studies on that data. Then, with our physician partners and facility clinical staff, we utilize that analysis to develop a plan to address and improve areas of weakness. An important and ongoing part of the PEAK program is the ability to use the data to enhance the operations.

Contact Jennifer Fuqua at 615-301-8156 or jfuqua@meridiansurg.com.

National Surgical Care

National Surgical Care ("NSC"), a nationwide owner and operator of ambulatory surgical centers, focuses on addressing the needs and problems confronting surgery centers across the country. These challenges, which include increasing competition, complex legislative issues, and a difficult managed care contracting environment, threaten both the growth and profitability of surgery centers. NSC's experienced management team offers a high degree of knowledge, skill, understanding and strategic resources for its centers.

NSC specializes in the acquisition and operational enhancement of existing surgery centers and the development of new surgery centers in partnership with hospitals and physicians. Aligning with NSC allows physicians to realize some of the value they have created and gain the resources of a skilled management team. Physicians can then spend more time focusing on patient care as NSC focuses on the business. Currently, National Surgical Care operates 21 surgery centers across the country. Contact Rick Pence at 972 447-8285 or at rpence@natsurgcare.com.

Financing

MarCap Corporation

For more than 30 years, MarCap Corporation has provided financing for healthcare organizations, including ambulatory surgery centers, diagnostic imaging centers, oncology centers, dialysis centers and hospitals. We specialize in developing creative, flexible financing solutions to meet a variety of needs, and our experience in the healthcare arena has enabled MarCap to grow into a leading provider of financing for developers and doctors around the country.

Flexibility and creativity are hallmarks of our approach. We offer limited and non-recourse financing and flexible payment structures designed to balance risk. We provide a high level of personal service, including access to decision makers. And, MarCap can create a program to suit your needs. We also provide private label financing for vendors and equipment manufacturers. Contact Peter Myhre at (800) 621-1677 or at myhre@marcapcorp.com

Equipment Planning

HELP International

HELP International is the leading provider in healthcare technology planning. Working with surgery centers, hospitals and their architects across

the country and abroad for over 24 years, HELP expertly identifies the appropriate technology for a client's facility, acquires that equipment and oversees its proper installation.

HELP offers unparalleled technological sophistication and experience in medical equipment planning, and delivers value through long-term client/vendor relationships and responsive service to clients' needs. HELPro, HELP International's exclusive software, maintains the most comprehensive and accurate database of medical equipment specs and prices in the industry. HELP ensures that the appropriate equipment is procured for clients at the best possible price. Contact Jim Freund at 203-733-8818 or j.freund@snet.net.

Real Estate - Construction

AMB specializes exclusively in the development of medical office buildings, clinics, ASC's, imaging centers and ambulatory care centers. Hospitals and physicians nationwide have benefited from their multi-disciplined approach including real estate advisory, development, leasing, financing, architecture, engineering, and project management. AMB will work with its clients on a fee for service basis or under a develop-leaseback program. Its reputation for delivering complex projects with difficult site, program, budget and time hurdles is unchallenged. For more information contact Jack Amormino at 414-291-4430 or at jamormino@ambdevelopment.com.

HBE is the largest designer and builder of healthcare facilities in the United States, having performed over 900 healthcare projects in 49 states since 1960. HBE's portfolio of projects include: ambulatory surgery centers, group practice facilities, hospitals, medical office buildings and a variety of other healthcare related facilities.

The HBE team is made up of some of the top architectural, engineering, interior design, and construction professionals in the United States. By employing all disciplines in-house, HBE offers its clients an efficient coordination and integration of planning, architecture, engineering, and construction services.

HBE's core competencies include: planning (including CON assistance), space programming, operational efficiency, high value design and engineering, and expertly sequenced construction management. All HBE projects include a Guaranteed Lump Sum Price so HBE clients can fix their budget early in the process and the GLSP protects clients from being surprised with costly change orders.

To find out more about HBE and why they should be part of your new construction or expansion strategy call VP of Project Development, Sandy Jacobs or VP of Sales, Lincoln Boschert at 314-567-9000. www.hbecorp.com



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There are specialists in healthcare for a reason. There are specialists in healthcare architecture for the same reason. Marasco & Associates is a 30-year old national healthcare architecture and design-consulting firm that specializes in outpatient medical facilities, ambulatory surgery centers, medical office buildings, private physicians groups, hospital and institutional clients. have completed thousands of projects, representing every specialty, in all 50 states as well as abroad, including over 300 ambulatory surgery centers and 16 specialty hospitals.

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Irmscher Construction

Irmscher, Inc. provides construction, planning, and delivery services for regional healthcare providers. Through innovative design and construction, healthcare providers cannot only participate, but thrive in today's competitive environment. Irmscher, Inc.'s project management services include feasibility studies, site search assistance, pro forma analysis, design, cost control, master scheduling, and general construction services with a specialty in ambulatory surgery centers.

Examples of successful projects are:

Fort Wayne Orthopaedics – 60,000-sq. ft. Ambulatory Surgery Center

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Orthopedic Institute of Lafayette and Innervision Imaging – 48,000-sq. ft. Ambulatory Surgery Center and Imaging Center

Unity Healthcare – 75,000-sq. ft. Multi-Specialty Medical Office Building

Faith, Hope, and Love Cancer Care – 8,960-sq. ft. Radiation Therapy Center

Beacon Orthopaedics & Sports Medicine – 66,000-sq. ft. Ambulatory Surgery Center and Baseball Training Facility

For more information contact Steve Goodman at 260-422-5572 or sgoodman@irmscherinc.com or visit www.irmscherinc.com.

Marasco & Associates, Inc.

Our firm has dedicated its entire efforts to the design/development of healthcare facilities for over thirty years. We only design healthcare facilities! Our experience includes, but is not limited to: medical practices, ambulatory surgery centers, therapy/wellness centers, recovery care centers, diagnostic centers, radiation therapy facilities, and specialty/surgical hospitals. Over the years we have helped design/develop over ten million square feet of healthcare facilities.

Marasco & Associates has designed over 1,100 healthcare facilities including 300+ ASC's and 15+ Specialty Hospitals across the country. Healthcare facilities are the only projects we accept, so 100% of our efforts are dedicated to the healthcare architecture industry. No project is too big or too small for Marasco & Associates to handle. We have helped design/develop everything from a 1,250 square foot remodel to a 225,000 square foot brand new medical office building. Throughout our history our workload has remained fairly constant at ~500,000 square feet of design work annually which is all a manageable, client focused, firm can handle. Our history speaks for itself and drives us into the future.

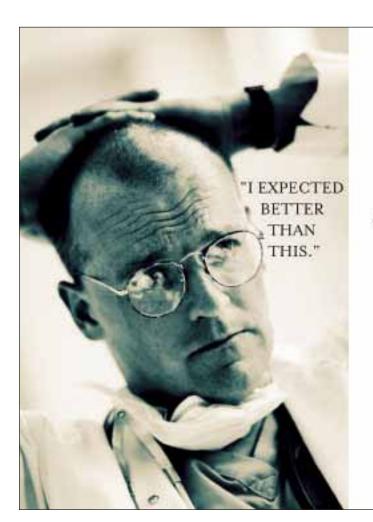
John A. Marasco, AIA, NCARB, Todd E. Larson, AIA and Brian R. Shearer are the principals and owners of Marasco & Associates, Inc. The three of them are registered architects that specialize in healthcare architecture. Much like a physician group the principals at Marasco & Associates specialize their skills to provide our clients with the very best service. You wouldn't let an internist perform your rotator cuff surgery, so why would you let a general architect design your facility. When looking for a surgeon to perform that rotator cuff surgery you look for the most experienced one you can find, so why wouldn't you apply that same strategy to the design of your facility. Combining the tried and true with new and innovative design techniques can allow you to see more patients in less time, with less stress, all while

maximizing your patients satisfaction. Like a rotator cuff surgery, good design can greatly enhance your providers, staff and patients life.

Marasco & Associates is capable of handling any or all of your design/development needs. With our unparalleled experience and dedication to our clients we can help move your project(s) down the path to success. Please feel free to check us out on our web site at www.marasco-associates.com. We encourage you to talk to your friends in your specialty or your geographic location and ask them pointed questions about our services. With healthcare costs growing faster than its revenue, your facility must be as efficient as possible. We feel there is no one else with the unique services and experience to help you get there. We would very much like to add you to our list of satisfied clients and we hope we can work together on a project. For more information contact John Marasco at 303-832-2887 or at john@marasco-associates.com.

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McShane Construction Corporation is an integrated design/build construction and real estate development firm offering comprehensive services for the healthcare industry. Established in 1984 and headquartered in Rosemont, Illinois, the firm also operates regional offices in the southeast, southwest and western regions. McShane Construction's healthcare specialties include both construction and real estate services for medical office buildings, ambulatory surgery centers, specialty hospitals, critical access hospitals, diagnostic imaging centers and centers of excellence. Contact Mr. John Daly, Vice President, Healthcare, at 847-692-8616 or visit the firm's web site at www.mcshane.com for more information.



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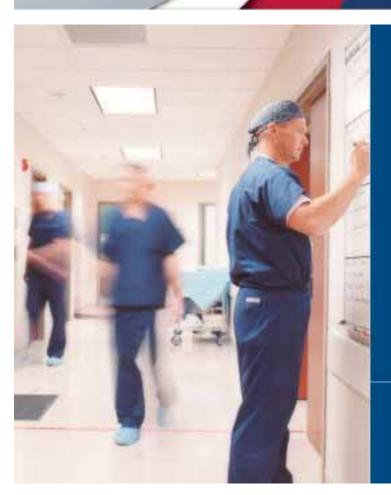
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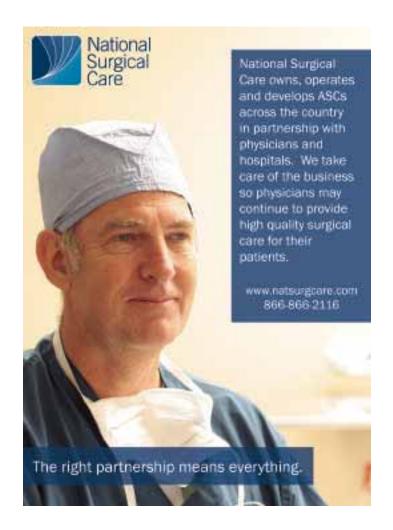
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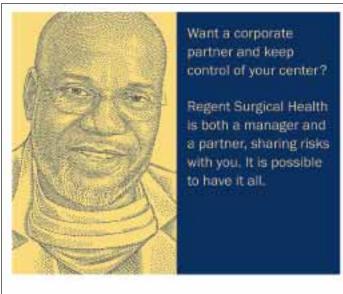
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