The number of ASC purchase and sale transactions remained high in 2008. The most common structures for the typical transactions were as follows: (1) the acquisition of a majority interest in an ASC by a for-profit, strategic acquirer which focuses as a core business in buying majority interests; (2) the acquisition of a minority interest in an ASC by a for-profit, strategic acquirer which focuses as a core business in buying minority interests and/or investing in turn around centers; and (3) the hospital acquisition of a minority or majority interest in a local ASC. In a fourth, less common structure, a hospital purchases an ownership interest in an ASC side-by-side with a third-party ASC management company.

As the outlook for 2009 becomes clearer, the volume of transactions in which national companies buy majority interests in surgery centers is expected to decrease as compared to 2008. This is in part because as the latter half of 2008 emerged, and debt financing markets became very tight, multiples paid for such transactions decreased, and several of the traditional buyers in such transactions reduced the amount of buying they were doing. At the same time, the acquisitions by minority interest buyers and the investment by hospitals in existing ASCs tended to increase.

This article discusses several of the principal business and legal issues related to ASC acquisition transactions. It further discusses the traditional transaction continued on page 8

Currently, there are three primary ownership models in the ASC industry:

• independent (100 percent physician ownership);
• selling a minority stake to a corporate partner (e.g., 70 percent physician-owned; 30 percent corporate-owned);
• selling a majority stake (e.g., 49 percent physician-owned; 51 percent corporate-owned).

While there are some variations (e.g., joint ventures with hospitals and three-way partnerships), these models predominate for both new ASCs and existing centers that restructure.

In the past, full physician ownership was the rule, but surging growth in the ASC market, ongoing reimbursement issues and increasing regulatory complexity have led more surgeon-investor groups to seek corporate partners. That trend is likely to continued on page 12
IF DR. NELSON THE SURGERY CENTER OWNER AND MEDICAL DIRECTOR NEEDS TO REDUCE COSTS ON PHARMACY PURCHASES BY TEN PERCENT SO THAT HE CAN FIND THE CAPITAL TO PURCHASE NEW EMR TECHNOLOGY, HOW CAN HE INSTITUTE QUALITY MEASUREMENTS AND ASSURANCE PRACTICES AND INCORPORATE BETTER CREDIT COLLECTIONS SYSTEMS?

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- Establishing an ASC — A Primer from A to Z
- Best Practices for Profitable GI and Endoscopy in ASCs
- Hospital/Physician Joint-Ventures: Current Tips for Success
- 45 Management and Development Company CEOs to Know

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Note: Editorial content subject to change.
2008 is a year that most people, whether in the healthcare industry or in other industries, are glad to have behind them. 2009 promises to be a challenging year as well. However, there are several interesting items that can occur in 2009 that can make 2009 either better or worse than 2008. We expect that this will ultimately be a much better year than most people anticipate. This is a short highlight of some of the upcoming issues.

1. Healthcare reform. Healthcare remains one of the great positive drivers of the American economy. The services are difficult to outsource, they are people-intensive and they provide a great deal of jobs at all levels of income. Two of the great risks of healthcare reform are 1) that it reduces payments across the board for healthcare and thus reduces the ability of the healthcare industry to be a driver of employment in the country and 2) that miscalculations of the costs of reforming healthcare provide serious damage to the overall long term economy. In essence, will these changes, combined with other changes, cost so much that it will be extremely difficult to ultimately pay back the debt that the nation is taking on. Will this mean reduced national economic strength and flexibility?

Dr. Tom Price, a Congressman from Georgia, and the Chairman of the Republican Committee, discusses Tom Daschle’s thoughts on rationing in a recent Wall Street Journal op-ed piece on Jan. 7, 2009. There, he was quoted as follows:

“For a preview, look no further than ‘What We Can Do About the Health-Care Crises,’ a book published this year by former Sen. Tom Daschle, President-elect Barack Obama’s choice for Secretary of Health and Human Services. Atop the list of worrisome ideas proposed by Mr. Daschle is the creation of an innocently termed ‘Federal Health Advisory Board.’

This board would offer recommendations to private insurers and create a single standard of care for all public programs, including which procedures doctors may perform, which drugs patients may take, and how many diagnostic machines hospitals really need. As with Medicare, for any care provided outside the board’s guidelines, patients and physicians would not be reimbursed.

Mr. Daschle is quick to note the board’s standards would serve only as a suggestion to the private market. Yet to ensure that there are not rogue private insurers, he has proposed making the employer tax deduction for providing health insurance dependent on compliance with the board’s standards. In an overtly political ruse, Democrats will claim they are dictating nothing to private providers, while whipping noncompliant insurers in place through the tax code.

To be sure, this strategy seeks to eliminate private providers completely. Forced into accepting rigid Washington rules and unsustainable financing mechanisms under Mr. Daschle’s plan, most private insurers would be quickly eradicated. Or as Mr. Daschle soberly predicts in this book, ‘the health-care industry would have to reconsider its business plan.’”

Covering the uninsured
The most compelling reason for healthcare reform is the interest in covering the nation’s uninsured population. The uninsured population can broadly be broken down into three core categories. First, those that are eligible for Medicaid that have failed to sign up properly for Medicaid. This is generally estimated at approximately 33-35 percent of the uninsured.
Second, those that are very poor and make very small incomes and simply cannot afford to buy health insurance but are not covered by Medicaid. Third, those that can afford health insurance and simply make the economic and budgetary decision that they do not desire to buy health insurance.

The simplest way to solve this problem is similar to the Massachusetts approach. It is costly but not nearly as costly as some of the other alternatives being presented and not nearly as disruptive to the industry. This includes, in short, (1) providing additional assistance to assure that the 15 million or so or population that are eligible for Medicaid but not enrolled for Medicaid are enrolled, (2) offering some amount of stipend to those that are very poor and can't afford healthcare but aren't yet poor enough to be eligible for Medicaid, and (3) making compulsory the buying of health insurance by those people who choose not to buy it. On the third point, this can be a slippery slope if, e.g., the government is the party that provides the health insurance, essentially, allowing people to buy “Medicare or Medicaid coverage” when they otherwise wouldn't be eligible.

Presidential appointments

I am not impressed with the choices of the incoming President on the healthcare side, namely Tom Daschle and Peter Orszag. However, I do believe that the greatest promise of this administration lies in the ability of Pres. Obama to recruit the best and brightest of his generation. Not since the efforts made by FDR will we see a president reach so deeply into the private sector and be able to convince extremely capable people, like the leadership of McKinsey & Co., to join the administration and take time out from their private business interests. I believe that having the best and brightest in several levels of government is much more likely to help the country effectively uncover and handle problems in the banking or finance sectors and to at least assure there are serious debates on issues. The benefits of a listening-approach are even apparent thus far in the changing of the administration and take time out from their private business interests. I believe that having the best and brightest in several levels of government is much more likely to help the country effectively uncover and handle problems in the banking or finance sectors and to at least assure there are serious debates on issues. The benefits of a listening-approach are even apparent thus far in the changing of the government on the stimulus package. Rather than a straight stimulus package, it is now being partially recrafted into a tax reduction concept. Whether this may smart marketing, or truly an ability to listen and see different sides of an issue, this is a much more palatable approach towards government stimulus.

2. Surgery center transactions. There continues to be a certain amount of acquisitions of surgery centers at majority interest pricing. However, the pool of buyers and the amount of capital being directed towards acquisitions of majority interest transactions temporarily slowed towards the end of last year. Consequently, pricing for such majority interest transactions tended to move from a 7-8 times multiple down to a 6-7 times multiple. There seems to be more companies looking at investing in turnaround centers than ever before as well as a more active role by hospitals in seeking to buy majority interests in surgery centers.

We were privileged to be able to help several parties close transactions at the end of last year. These included the sale of part of a hospital to another hospital in Ohio, the acquisition by a hospital of part of an orthopedic-driven ASC in Washington, the sale of an ophthalmologic-driven ASC in Maryland to a national company, the sale of a substantial portion of an ASC to a large orthopedic group in Kentucky as well as several other ASC and hospital transactions.

3. Physician-owned hospitals. Physician-owned hospitals survived for another year in 2008. However, there remains tremendous pressure on physician ownership of hospitals at the federal level. This pressure has been increased by such appointments as Peter Orszag and Tom Daschle. Each tends to be quite negative towards physician ownership of hospitals. Both the physician-owned hospital industry and the surgery center industry should be leery of the increased power of these two persons. To see an article entitled “Will the Federal Government Shut Down Surgery Centers and Physician Owners Hospitals?” visit www.BeckersASC.com or www.HospitalReview Magazine.com. FTC Commissioner J. Thomas Rosch delivered a speech at the 6th Annual Washington Healthcare Summit entitled “Enforcement Strategies in the Health Care Industry”, and the following is a quote from his speech:

“On the one hand, specialty hospitals are a new type of competition for pre-existing full-service hospitals, and new competition is usually a good thing. On the other hand, specialty hospitals are often owned by referring physicians, and that raises a host of ethical and fiduciary duty concerns that complicates the competition issues. Furthermore, whether for good or naught, specialty hospitals take profit away from full service hospitals, and that creates complications too.

The pitfalls that arise are threefold. First, physician referrals of patients from a full service hospital where the physician has admitting privileges to a specialty hospital in which they have an ownership interest can raise ethical issues surrounding the physicians’ fiduciary duty to their patients. This is due to the financial incentives created by the physicians’ ownership interest in the hospital — they stand to profit from their investment in the hospital by the referral, separate and apart from the quality of care provided to the patient. For example, it is argued that these hospitals may offer only the most expensive procedures — e.g., heart surgery. Or, these hospitals may order more expensive procedures than most patients need. In short, it is argued that inevitably profit motives incentivizes cream skimming or cherry picking (referral of the most profitable patients to the physician-owned hospital).

Alternatively, a full-service hospital may also try to control the cream skimming problem by eliminating the privileges of the physicians who refer to specialty hospitals, or removing those physicians from staff. It may also create “quotas” for these physicians. These actions can also lead to litigation, this time by the referring physicians against the full service hospital.

Second, even in situations where physician owners of specialty hospitals do not engage in self dealing, full service hospitals sometimes claim that specialty hospitals leave the lion’s share of the most costly obligations, such as emergency care and uninsured care/charity care, to the full service hospitals, which taxpayers may ultimately have to finance.”

4. Orthopedic, Spine and Pain Management-Driven Ambulatory Surgical Center Conference. We have two upcoming ambulatory surgery center conferences this year. First, we have our Orthopedic, Spine and Pain Management-Driven ASC Conference June 11-13 at the Westin Hotel on North Michigan Ave. This conference includes a great deal of sessions on profiling from and adding musculoskeletal services, turning around surgery centers, benchmarking, recruiting physicians and a whole set of other subjects. The Ambulatory Surgery Foundation and ASC Association join us again in this conference. We think it will be a terrific event. If you have an interest in attending or exhibiting opportunities for this event, please e-mail me at sbecker@mcguirewoods.com or go to www.BeckersASC.com.

A sample of the topics and speakers is as follows:

A. Evolution of Healthcare and the Impact on ASC — Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics at Princeton University

B. Forecast for the Next Five Years — John Cherf, MD, Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago

C. Using Spine as the Backbone of a Multi-Specialty ASC — James Lynch, MD, Surgery Center of Reno

Corporate Development Professional

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D. 7 Steps to Maximizing an Orthopedic-Driven ASC's Returns in a Tough Economy — Brent Lambert, MD, CEO, Ambulatory Surgical Centers of America

E. Case Study — Two Years Later, a Physician-Owned Spine ASC: A Frank and Open Discussion of Financial Performance, Organizational Issues, Challenges and Problems — John Caruso, MD, Parkway Surgery Center

F. A Payor’s View of Orthopedics, Spine and Pain Management — Steven Stern, MD, VP Neuroscience, Orthopedics and Spine, United Healthcare

G. A Case Study Review of Current Outcomes and Issues — Marcus Williamson, MD; George Goodwin, SVP and Chief Development Officer, Symbion Healthcare

H. Making Big Cases Profitable in an ASC — Naya Kehayes, CEO, Eveia Healthcare; Greg Cunniff, CFO, National Surgical Care

I. Capturing Your Partners' Cases, The Carrot and Stick Approach — Chris Bishop, VP, Ambulatory Surgical Centers of America

J. Key Legal Issues: Safe Harbor Compliance, Out-of-Network, and Other Legal Issues — Scott Becker, JD, CPA, Partner, and Bart Walker, JD, McGuireWoods

K. How Economic Conditions Impact Health Care Strategies for Success — Tom Geiser, Senior Advisor, Texas Pacific Group; Joe Clark, Executive Vice President, Surgical Care Affiliates

L. Uni Knees and Shoulders in the Outpatient Setting: Cost, Staffing and Profitability Issues — Peter Kurzwell, MD, and Margarita de Jesus, Administrator, Surgery Center of Long Beach

M. Key Issues Faced by ASCs Today — Thomas Yerden, CEO, Founder, TRY HealthCare Solutions

N. Pro and Cons of Total Knees in a 23-Hour Setting: Financial and Safety Issues — Eric Monesmith, MD, and John Martin, CEO, OrthoIndy

O. Pain Management: 5 Keys to a Superior Pain Management Program Surgery Center — Lance Lehmann, MD, Medical Director and Liliana Rodriguez Lehmann, MBA, Hallandale Outpatient Surgical Center


We are also hosting our 15th Annual Ambulatory Surgical Center Conference on Improving Profits and Business and Legal Issues for ASCs from Oct. 8-10. Here we will have an exceptional lineup and we again host this conference in conjunction with the Ambulatory Surgery Foundation and ASC Association.

To join the ASC Association, please call (703) 836-8808.

5. Becker’s ASC Review; The Hospital Review; Becker’s Orthopedic & Spine Practice Review. We added last year, to the longstanding Becker’s ASC Review, two additional publications. First, we added a publication from ASC Communications entitled The Hospital Review. This magazine focuses on business and legal issues for hospitals and health systems. We also added a publication entitled Becker’s Orthopedic & Spine Practice Review. This magazine focuses on business and legal issues for orthopedic and neuro-surgical practices. For information regarding the magazines or a complimentary subscription to The Hospital Review or Becker’s Orthopedic & Spine Practice Review, please e-mail me at sbecker@mcguirewoods.com. To learn more about these publications, visit www.BeckersASC.com or www.HospitalReviewMagazine.com.

Overall, we expect 2009 to be a challenging but much better year than people are anticipating. Should you have any questions, please feel free to contact me at (312) 750-6016.

Very truly yours,

Scott Becker
documents and the key provisions which are often negotiated as well as key miscellaneous issues that parties should consider. This article does not focus on either de novo/start up ASCs or on physician-to-physician sale transactions. This article also does not focus on regulatory issues such as the Stark Act or anti-kickback issues.

I. Pricing of transactions

The pricing for majority interest deals is often dependent upon the strength and the risks of the ASC being acquired. For example, a center with all of the following characteristics will typically receive the highest price on an earnings before interest, taxes, depreciation and amortization (EBITDA) basis: (1) location within a certificate of need state; (2) low reliance on out of network payments; (3) reasonable, but not overly high, reimbursement rates per procedure; (4) not overly dependent upon a few doctors; and (5) low levels of physician non-competition risk. A typical price for such an ASC may be 6-8 times EBITDA minus debt. A year ago, such ASCs might have sold for closer to 7.5-8.5 times EBITDA minus debt. Today, such ASCs often sell closer to 6-7 times EBITDA. Further, the number of possible buyers may be smaller, driving competitive bidding down even further.

Finally, an ASC with two or more of the key risk challenges will have much more difficulty finding a majority-interest buyer and will typically be sold at a lower price. Such ASCs can be more probable targets for turn-around buyers and minority-interest buyers.

II. Key transaction issues

There are several interesting miscellaneous issues involved in the potential sale of an ASC. These include some of the following issues:

1) Resale of shares after transaction. Typically, a majority interest buyer will buy in at 6-8 times EBITDA minus debt. A year ago, such ASCs might have sold for closer to 7.5-8.5 times EBITDA minus debt. Today, such ASCs often sell closer to 6-7 times EBITDA minus debt. Further, the pool of majority buyers is smaller than it was a year ago. With fewer buyers, the demand and the prices paid for profitable ASCs has decreased.

A typical majority buyer will buy 51-66 percent of the equity of a center, will also obtain a management agreement paying between 5-6 percent of collections, and the acquisition will be structured such that, at closing, there will be a certain amount of accounts receivable and cash minus accounts payable in the company. In essence, the sellers of the ASC cannot generally take out all of the accounts receivable and cash immediately prior to closing.

An ASC that lacks a perfect score on the five criteria set forth above — (1) certificate of need; (2) out-of-network; (3) reimbursement risks; (4) non-competition issues; and (5) over-reliance on key doctors — will receive a lower multiple of EBITDA per share. For example, the price may be a multiple of 4-5 times EBITDA minus debt as opposed to 6-7 times EBITDA. Further, the number of possible buyers may be smaller, driving competitive bidding down even further.

Finally, an ASC with two or more of the key risk challenges will have much more difficulty finding a majority-interest buyer and will typically be sold at a lower price. Such ASCs can be more probable targets for turn-around buyers and minority-interest buyers.

Over the last few years, an increasing number of hospitals have become very competitive in such acquisitions and are paying prices close to what the national companies will pay. A hospital, in part, because it receives other referrals from the physician owners of the ASC, and often due to concerns as a tax-exempt buyer, will usually have to obtain a third-party valuation as to price and to defend such a transaction. Hospital competition in buying such shares has grown in part due to: (1) a reduction in national company pricing and (2) an increase in the number of hospitals interested in buying into such ASCs.

There is also a new and growing group of buyers that are interested in buying at-risk centers at a reduced price with the intent to turn around such ASCs. Such companies may often choose to be buyers of a minority interest in such transactions versus a majority interest. For example, if you have an unprofitable center, one of the benefits of partnering with a management company that specializes in turnaround projects is that while the existing owners sell a minority share to the turnaround company, there is still potential to participate in a second profitable sale to a majority interest buyer if and when the center becomes profitable.

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provides some concern from a regulatory perspective. In essence, at minimum, it is critical that when selling shares to physicians at a price that is different than the price of shares sold to a majority interest buyer, that a valuation be obtained (or at minimum rigorous analysis) to help support and clarify the rationale for the difference in price. The difference may be due to several factors, such as: (1) discount for a minority interest or lack of control; (2) the fact that minority interest buyers of shares do not receive a lucrative management agreement; or (3) for other factors that an appraiser may take into account when determining the fair market value of the shares. Parties should keep in mind that while expressing a valuation as a multiple of EBITDA may be a convenient and efficient method of estimating a purchase price, there are many factors that are accounted for in third-party fair market value appraisal. In any event, it is critical that a valuation be obtained to help defend any such efforts and pricing.

2) Limits on indemnification. A typical transaction will include limits on indemnification such that a physician owner, even if representations and warranties are ultimately breached, will not have liability for indemnification for more than the purchase price received by such seller. However, there may be “excluded liabilities” which are not subject to the limitation. Because the buyer after a transaction is reliant upon the physician owners, it is not often that we see claims for significant lawsuits in indemnification. That stated, there is an increased risk of lawsuits particularly where a center’s results and business significantly erode after a purchase.

3) Interest in other ASCs. The more interest that existing physicians in a project have in other ASCs, the more likely it is that the buyer will either decide not to pursue the transaction or significantly reduce the price of the transaction.

4) Capital gains versus ordinary income. Because the taxes that are paid on a capital gain in an ASC transaction equate to between 15-25 percent (this assumes a certain portion of the purchase price will be with taxed as ordinary income) as opposed to the 35-40 percent that parties pay on the ordinary income distributions each year, this provides an additional incentive to sell part of the ASC. In essence, if a party sold an ASC from which they typically receive profit distributions, for a multiple of 7 times EBITDA, it would take 10-11 years with distributions to receive the same amount as they receive on the sale transaction, taken on an after-tax basis. This is because the ordinary income distributions each year are taxed at 35-40 percent whereas the one time capital gain is taxed at a rate of 15 percent plus certain additional amounts.

5) Financing market. The freezing of the financing market in 2008 has had a significant impact on the number of buyers for ASC transactions and the pricing for such transactions. Although there are still a significant number of buyers, as of the beginning of 2009, it is more often that we see a smaller number of buyers and pricing at 6 or so times EBITDA for premier ASCs, as opposed to the 7-8 times EBITDA that we were seeing last year. The capital markets freeze has had several other important impacts on leveraged transactions. In a typical leveraged transaction, the buyer funds a portion of the purchase price with cash and then borrows the remainder of the purchase price from a bank or other lender. First, any transaction that requires debt has experienced significant delays over the past six months. Second, lenders of all kinds have generally tightened their credit standards; only the most credit-worthy borrowers have been able to secure financing. Finally, once a loan commitment is received, banks have generally been much stricter about their documentation and their loan terms and conditions. For example, in the last two quarters of 2008, we have seen greater guaranty requirements and more stringent financial covenants.

6) Provider numbers and licenses. As part of a transaction, it is critical in the early stages to review what contingencies there are to obtaining a new Medicare provider number and a new state license. Many states interpret their licensure and change of ownership regulations very differently, although the text of the statutes or regulations maybe very similar. In fact, we have even seen different CMS field offices and fiscal intermediaries interpret the same Medicare regulations differently in the same or similar circumstances. Some of the key questions that need to be considered are as follows:
   a. Is a certificate of need required?
   b. Will there be a slow down or delay in getting the new license or a new provider number?
   c. Are there any conditions to improve the ASC or bring it up to date with current life safety codes before obtaining a new provider number?
   d. Is a new provider number required or can the center continue using its existing number?
   e. For Medicare, will a new Form 855 be required or can a change of information on Form 855-B be filed?
   f. Are there currently pending any lawsuits or legislation that would materially harm the ability of the ASC to do business.

7) Billing and coding audit. Many surgery center companies require a billing and coding audit prior to the closing of a transaction. This is to help ensure that the center does not have a great deal of exposure for past claims, and to also ensure that the revenues have been recorded correctly. Improper billing and claims can lead to significant liability both as to financially change the potential after transaction net income of a center. For example, if revenues are overstated due to over billing, this would likely reduce net income on a prospective basis as well.

8) Fraud and Abuse Statute compliance. Buying companies will be very concerned with whether or not a surgery center has maintained or substantially maintained safe harbor compliance during its operations and whether the center, post-transaction, will operate in a manner consistent with the safe harbors.

A center that is significantly out of safe harbor compliance may find it very hard to find a buyer for a transaction or may need to make changes to come into compliance as a condition to closing the transaction.

III. Transaction documents, legal documents and process

This section first focuses on the letter of intent that is entered into at the start of a transaction. Then, it discusses the three main transaction documents negotiated in such a purchase transaction. These include the purchase agreement, the operating agreement and the management agreement. This section also provides a discussion of the key negotiated provisions.

A. Letter of intent. The letter of intent (or term sheet) includes the negotiation of core transaction terms of the deal. Here, a party often starts with informal discussions with multiple potential buyers. Typically, a party that is looking to sell an ASC may start with a list of 10-12 possible buyers. After seeking out offers and signing confidentiality agreements, the seller may receive offers from 4-5 potential buyers. Of those offers, 2-3 are often superior to the rest. The selling party will typically attempt to negotiate a letter of intent with each of these potential buyers with the intent of actually signing a letter of intent with only one party. Once a letter of intent is signed, a period of exclusive negotiations commences, with the intent to close the transaction with that one party.

Certain of the core terms negated as part of the letter of intent include: (1) the purchase price for the transaction; (2) the ownership structure (i.e., what percentage will be sold); and (3) whether it will be an asset or stock type transaction.

The letter of intent will also discuss such items as the accounts receivable minus accounts payable and cash amount required at closing; the terms of the management agreement including the compensation under the management agreement; the non-compete terms; and the expected closing date.

The letter of intent will also set forth a lock-up period of time — typically 60-90 days— and note that the transaction is subject to several closing conditions such as completion of the core documents (i.e., the purchase agreement, operating agreement and management agreement), regulatory and licensure review and filing, and due diligence review. For buyers, the lock-up (or exclusivity period) is a key provision to ensure that the seller is only negotiating with that particular buyer. It may also include a break-up fee or liquidated damages clause.

The letter of intent will contain the non-binding obligations of the parties, as well as certain provisions which will be binding. For example, the purchase price to be paid and the relative post-closing governing rights of the parties may not be fully negotiated at the time a letter of intent is executed and may be
subject to due diligence. Thus, the parties will make these terms non-binding and then negotiate in good faith to finalize those points in the core transaction agreements. Exceptions to the non-binding nature of a letter of intent often include the confidentiality provisions and the lock-up (or exclusivity provision). Each of the parties typically cover their own expenses for due diligence during the negotiation period. This is also generally a binding agreement.

The parties, after a letter of intent is agreed to and executed, negotiate the purchase agreement, operating agreement and management agreement.

B. Purchase agreement. The purchase agreement focuses on several key issues. These include: (1) the purchase price and the delivery of the purchase price; (2) the discussion of any targets that are part of the purchase price such as working capital targets or cash balance targets; (3) a description of the assets purchased and liabilities assumed and the liabilities which are excluded; (4) the representations and warranties made by each party and what limits and qualifications are in place with regard to such representations and warranties; (5) the indemnification provisions, including the limits on and process for indemnification; (6) the non-competition provisions (these often have a much longer tail than in the operating agreement); (7) the closing date; (8) the process and any special terms of closing such as closing conditions (these may include physician syndication or other requirements); (9) termination provisions (e.g., under what terms can either party decide not to move forward); and (10) other promises and covenants that are to be made between the parties.

C. Operating agreement. There are typically 8-10 key operating agreement issues. These include such items as:

(1) Seller physician reserve rights — In essence, what can the buyers in a majority interest transaction not do after the deal without physician approval? What issues will the physicians have veto or reserve rights over?

(2) Controlling owner dilution — How do the physicians control the ability of the buyer to dilute them significantly? For example, do they approve of new owners and will the buyer be diluted in part as well? Typically, the admission of a new member may require the approval of the members holding a majority of the units issued and outstanding in the company, in addition to the approval of the majority interest holder.

(3) Self-dealing controls — These are protections that the physician investors will have against the buyer entering into transactions with itself. These could reduce the earnings of the company and the distributions to its physician members.

(4) Non-competition provisions — These will typically describe what is restricted, as well as the time of the restriction and the radius of the restriction. A typical operating agreement will include a 2-3 year tail and a 10-30 mile radius depending upon a number of factors. The covenants may also be drafted to be narrower or broader with respect to the conduct prohibited.

(5) Redemption price of units — This will involve a description of the events that cause redemption of physician shares, whether the redemption events are mandatory or optional, and the price paid upon the occurrence of such events, and the timing of and limits on payments. Also partners often attempt to negotiate the ability to later buy out the buyer under certain circumstances.

(6) Amendments — What control will each party have over amendments to the operating agreement? Will amendments require a super majority vote?

(7) Board — The size of the Board, who elects the Board and what powers the Board has. Will the majority owner control the Board?
Evolution of ASC Ownership Models – Independent, Minority Partnership and Majority Partnership (continued from pg. 1)

continue. It’s also important to note that more ASCs are evolving their ownership models over time, in line with their needs and objectives, as well as market conditions and a shifting legal landscape.

This article presents six brief case studies exploring the three predominant models, with an emphasis on the criteria and thought processes of ASC investors in weighing their options for ownership.

1. Long-term independent

Lakewalk Surgery Center (Duluth, Minn.)

Ownership model: 100 percent physician-owned and operated since 1998

Facility: Six ORs, three procedure rooms; 90 physicians with privileges; 15 surgeon-investors, 20 regular users (in addition to the owners)

Primary specialties: Orthopedics, plastic surgery, pediatrics, gastroenterology, ENT, general surgery, ophthalmology

President/Medical director: Andrew Baertsch, MD (plastic surgeon)

Physician control is the primary reason why Lakewalk Surgery Center has chosen to remain independent since its founding.

“Our surgeons really like the feeling of being in control of everything that goes on,” says Andrew Baertsch, MD, a plastic surgeon and Lakewalk’s president and medical director.

Though Dr. Baertsch has no advanced business or management training, he has learned on the job. The formation of Lakewalk grew out of his successful experience in developing a single-OR facility for his own practice.

“I carried forward what I learned in syndicating a larger group of surgeons,” he says. Lakewalk, which is located on the banks of Lake Superior, has been profitable since inception and undergone several expansions. As of Sept. 30, it has handled a total of 65,000 procedures in its decade of operations.

Other unique factors in this ASC’s history of independence include:

• Staff efficiency. Dr. Baertsch credits his staff for Lakewalk’s success and ability to remain independent. “We have an excellent team and our center runs efficiently, so it’s hard for us to see the advantages in paying a management fee,” he says. Lakewalk’s administrator plays an especially important role in managing human resources issues, given that there are 55 staff members.

• Control — perception vs. reality. Dr. Baertsch acknowledges that control can be a matter of perceptions and that it’s possible for physicians to exert control of ASCs in partnership agreements. However, his group prefers complete freedom and authority. “If we want a new piece of equipment, we don’t have to consult with an administrative entity or negotiate for approval,” he says.

• Time factor. There is no doubt that hands-on management responsibilities can put pressure on surgeons’ schedules, but for Dr. Baertsch it’s a matter of striking a balance. Plus, he enjoys attending to both business and clinical matters. “Yes, there are time constraints, but managing the business is an extra dimension that I find gratifying,” he says.

• Weighing the options. Lakewalk’s owners have received formal offers in the past to sell the ASC to management companies, but so far no deal has been compelling enough. “From time to time, some partners have expressed concerns about staying independent and we’ve even had serious discussions about selling, but not enough to relinquish control,” says Dr. Baertsch. “Independence still works very well for us.”

2. Independent to minority partnership to joint venture

Knightsbridge Surgery Center (Columbus, Ohio)

Ownership model: 100 percent physician-owned from 2001-2004; Regent Surgical Health purchased 20 percent stake in 2004; Ohio Health purchased 49 percent stake in 2007

Facility: Four ORs; 65 physician-utilizers

Primary specialties: General surgery, urology, plastics, obstetrics/gynecology
The surgeon-investors of Knightsbridge Surgery Center have experience with a range of ASC ownership models, according to Philip Taylor, MD, a general surgeon and president of the facility. After starting as 100 percent physician-owned in 2001, Knightsbridge has evolved its ownership model in line with industry trends and its own needs.

The ASC was developed with the help of another corporate partner, who was more effective in launching the business than in managing it. As a result, the center produced only break-even results in the first few years, with periodic cash calls necessary. In 2004, Regent Surgical Health bought a minority stake in the business and took on responsibility for contracting, financial management and other matters. In early 2007, a joint-venture deal was struck with Ohio Health, a large hospital company in the region. Today, Regent and the surgeons own 51 percent, with Ohio Health holding 49 percent. Knightsbridge has consistently made monthly profit distributions since 2004.

The keys to success at this ASC include:

- **Embracing change.** After the initial struggles to realize a profit, the group weighed all its options. “We did some soul-searching and even considered closing,” Dr. Taylor says. In 2004, Regent provided a good match for the center’s needs. Knightsbridge embraced change again in 2007, when broader competitive and industry trends — specifically, the need to improve contracts and strengthen case volume and mix — led it to partnering with Ohio Health.

- **Complexity and details.** Dr. Taylor believes that the main value of a corporate partner is in handling the details. “The complexity and technical aspects of the business, like dealing with insurers and accreditation, can be overwhelming,” says Dr. Taylor. “The truth is, we did not have people on staff with the business acumen to run the center.” Regent handles all the details of accounting and financial management, freeing the surgeon-investors to focus on patients and the big picture.

- **Define the roles.** In the three-way ownership model, each partner brings unique expertise and qualities. Ohio Health’s most important contribution is increased leverage with payors. Beyond that, however, it has provided valuable legal support, brand recognition and a shared commitment to patient satisfaction and clinical excellence. Proximity is another benefit; Riverside Hospital, an Ohio Health facility, is just two miles away and very convenient when patients need to be transferred.

- **Mutual benefits.** The merger with Ohio Health was “natural,” says Dr. Taylor. “They’ve been an extraordinary partner, especially in helping with contract negotiations,” he says. “For our part, we’ve helped replace lost revenue and provide a high-quality option for outpatient treatments. We feel this is a very strong team.”

### 3. Minority partnership

**The Surgery Center of the Main Line**
(Bryn Mawr, Pa.)

**Ownership model:** 80 percent physician-owned; 20 percent owned by Blue Chip Surgical Center Partners

**Facility:** Three ORs, one procedure room; 15 surgeon-investors and 24 surgeon-utilizers

**Primary specialties:** Orthopedics, general surgery, gastroenterology, pain management, otolaryngology, vascular surgery, urology

**President/Medical director:** Anthony Coletta, MD (general surgeon)

When Anthony Coletta, MD, a general surgeon and president of The Surgery Center of the Main Line, and his surgeon colleagues began planning their own multi-specialty ASC, they fully expected to work with a local hospital. But, for a number of reasons, the project followed a different course.

Dr. Coletta and his partners engaged Blue Chip Surgical Center Partners, which owns a 20 percent stake. Blue Chip developed the business plan, provided support during architecture and construction, and today handles financial and business management. The multi-specialty center opened in 2007 and was profitable within a year.

Dr. Coletta and his partners considered the following in seeking the right partner:

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Local market landscape. According to Dr. Coletta, Stark laws, contracts and reimbursement issues in Pennsylvania make it logical for an ASC business to include the local hospital. Only when discussions with the hospital proved to be “amicable, but not fruitful” did he and his partners turn their attention to evaluating corporate partners.

ASC goals and culture. The group briefly “kicked the tires” on a proposal where it would be a minority owner, but, again, it didn’t make sense. “These were our patients, so we asked ourselves why we shouldn’t be majority owners,” says Dr. Coletta. Further, when looking closely at their own goals, the surgeon-investors recognized just how much they wanted to establish a new working environment with a healthy culture and different management style.

Clinical excellence. “Contracts, billing, claims, human resources — as important as these matters are, they are secondary to quality outcomes and patient satisfaction,” Dr. Coletta says. That reasoning led to potential partners being evaluated on their commitment to clinical excellence, as well as their business track record.

“Skin in the game.” The surgeon-owners liked Blue Chip’s willingness to share the economic risks, as well as the rewards. “They were ready to put skin in the game, and invest in our mutual success,” says Dr. Coletta. Delivering the business plan and legal documents on time and on budget also made a difference. “On-time, on-budget had not always been our experience in dealing with hospitals and management firms,” Dr. Coletta says.

Achieving synergy and balance. According to Dr. Coletta, it all boils down to finding the right partner — whether a minority or majority owner — who adds value, helps the surgeons meet business and personal goals and is easy to work with. “We feel there’s a great balance here because Blue Chip needs us as much as we need them,” he says.

4. Transition to a minority partnership
Adult and Children Surgery Center of Southwest Florida (Ft. Myers)
Ownership model: 70 percent physician-owned; 30 percent owned by ASCOA
Facility: Two ORs, 16 surgeon-investors
Primary specialties: Orthopedics, podiatry, ENT, pain management
President/Medical director: Fletcher Reynolds, MD

Founded by a group of podiatrists, the independently-owned Summerlin Bend Surgery Center (later renamed the Adult and Children Surgery Center) operated unprofitably for several years. After a split in the initial investor group in 2004, Fletcher Reynolds, MD, an orthopedic surgeon, and his practice partners were offered shares at very attractive prices. “It was a leap of faith for us to invest in a struggling center, but a fairly low-risk proposition because of the price,” says Dr. Reynolds.

After 18 months of trying to turn around the business on their own, the investors sought a corporate partner. In 2006, Ambulatory Surgical Centers of America (ASCOA) purchased a 30 percent stake. The facility temporarily limited services and re-opened full-time a few months later as the Adult and Children Surgery Center. It achieved profitability within a few months, and remains so today.

The following are the critical factors in the successful turnaround and selection of the management:

• Contracts. Because of low volume, the original owners “would do anything to get a contract,” some of which paid only 60 percent of Medicare rates, according to Dr. Reynolds. Thus, the ability to renegotiate contracts and “stop the bleeding” was the primary criteria for management partner. “ASCOA showed strong knowledge of our contracting situation in this market,” Dr. Reynolds says. “We also liked their plan to basically shut down, wipe the slate clean and start over.”

• Evaluating partners practically. The ownership group received a number of proposals, and evaluated them individually, at face value. It wasn’t philosophically opposed to selling a majority stake, “We received an offer to sell a 51 percent stake, but the surgeons were also being asked to invest even more to bail out the original owners,” says Dr. Reynolds. Similarly, a local hospital made a very opportunistic offer to buy a majority stake, but it wasn’t seriously considered. In the end, ASCOA simply had the most attractive offer.

• Teamwork and hustle. ASCOA’s willingness to “pound the pavement” in finding new surgeons to invest in and utilize the newly opened center was another critical factor. The newly energized owners also worked hard to drum up more volume, particularly with local orthopedic and ENT practices. “It really was a group effort,” says Dr. Reynolds.

• Flexibility, risk and reward. The new contracts, higher case volume (including more out-of-network cases) and revised ownership structure (with the original podiatrists remaining as owners of the building) helped restore a sense of partnership and generate profitability within a few months. “From a risk-reward perspective, this has been an outstanding partnership and a very successful salvage job,” says Dr. Reynolds.

5. Independent ASC sells majority stake
Laurel Surgical Center (Greensburg, Pa.)
Ownership model: 100 percent physician-owned 2004-2007; Meridian bought 56 percent stake in 2007
Facility: Three ORs, two procedure rooms, 11 surgeon-investors, used by additional 35-40 surgeons
Primary specialties: Orthopedic, general surgery, gastroenterology, ENT, general surgery, urology, pain management
President/Medical director: Gregory Lauro, MD (orthopedic surgeon)

The history of Laurel Surgical Center illustrates both the advantages of challenges of operating independently. It took several attempts for Gregory Lauro, MD, an orthopedic surgeon, to assemble the right group of surgeons-investors. The planning process involved plenty of “trial and error,” according to Dr. Lauro, partly because a development consultant offered incomplete information about initial costs. “Anyone considering a start-up should be aware of the considerable investment of time, energy and political capital involved,” he says.

Opening in 2004, the center initially handled only 25 cases per week. But, after more than a year of steady effort to attract more volume, the center achieved profitability. Today, volume can be 140 cases per week. “It’s a matter of creative disruption when you ask physicians to change their practice patterns and referral habits,” says Dr. Lauro. “But, the upside is, if you have an
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attractive and efficient ASC, non-partner surgeons will want to bring patients there, and that leads to more revenue.”

In 2007, Meridian Surgical Partners purchased a 56 percent stake in the facility. Here are just a few of the most significant factors considered by the Laurel ownership group when it was evaluating its options for a partner and some of the benefits the ASC has experienced by working with Meridian:

• ROI and succession planning. The owners had two goals in taking on a partner — an equity event for the original investors and long-term succession planning. Meridian’s purchase represented a significant payout, but the increased ability to attract new investors and sell shares was just as important. “Today, we are better prepared for retirements or if one of our surgeons moves away,” says Dr. Lauro.

• Hospital vs. corporate partner. Laurel’s owners also considered a proposal from a local hospital, but its valuation of the center was far too low. That, along with the hospital’s competitive attitude, made a corporate partner an easy choice.

• Productivity. Operationally, Meridian has been most helpful with financial matters, negotiating more favorable reimbursement and helping the center save money on supplies.

• Keeping the focus. “Building an independent ASC isn’t easy, but as long as you have patients coming in the door and having good experiences, you can make it,” he says. “The community acceptance has been wonderful because doctors and patients love coming here.”

6. Independent ASC sells majority stake
Cypress Surgery Center (Wichita, Kan.)

Ownership model: 100 percent physician-owned 2000-2006; Symbion purchased 51 percent in 2006
Facility: Six ORs; two pain rooms; two endoscopy rooms; 34 surgeon-investors
Primary specialties: ENT, orthopedics, general surgery, urology, obstetrics/gynecology
President/Medical director: David Grainger, MD (obstetrics/gynecology)

The Cypress Surgery Center was founded with a very specific need in mind. David Grainger, MD, and his partners in an in-vitro fertilization practice wanted more clinical control and a calmer environment for their patients. But after completing initial designs and sharing their plans with friends and colleagues in other specialties, they realized a full surgery center made more sense. Cypress Surgery Center opened in late 2000, with 20 surgeon-owners, two ORs and a “shell” to be completed if case volume warranted, which it soon did.

Cypress was profitable within six months of opening and by 2004 had expanded to six ORs. One key to success at Cypress has been its ability to operate lean. According to Dr. Grainger, the center is one of the most productive and efficient in Wichita, treating a high number of patients with a relatively small staff of full-time employees – approximately 50. The facility uses many part-time staff for both clinical and business operations, and the whole team recognizes the value of efficiency. “Everybody at our center will tell you how important it is to stay on schedule,” says Dr. Grainger.

Endoscopy rooms were added in 2006 and, in that same year, Symbion Healthcare bought a majority stake of the business. The ownership group was motivated by the opportunity to enjoy an equity event and the favorable business conditions. “It was a very good time to sell,” Dr. Grainger says.

In deciding to sell a majority stake in their business, the surgeons at Cypress weighed the following factors:

• Timing is everything. “We had the business operating smoothly and it was a seller's market,” Dr. Grainger says. “And, frankly, taking equity out of the deal was attractive to many of the partners.”

• Partner relationships. Cypress received proposals from three different entities, and Symbion’s offered the most attractive terms. But it was the mutual comfort level that sealed the deal. “You have to live with the people you partner with, so being comfortable matters a great deal,” says Dr. Grainger. “We have a lot of autonomy and there’s no need for Symbion to micromanage since we’ve been profitable from the start. The relationship has gone very well.”

• Front-office management. The biggest challenge at Cypress, as at many ASCs, is keeping the front-office running smoothly. Though Dr. Grainger says the center has a “truly outstanding clinical director,” who has been with Cypress since the beginning, turnover has been an issue. “Symbion’s expertise in human resources, staffing and front-office administration was another reason their offer was attractive to us,” he says. “They’ve also brought a lot of value in financial management.”

Cole Ollinger (cole@ollingercreative.com) is a freelance writer based out of Cincinnati.
For the past six years, HealthCare Appraisers has surveyed the surgery center industry to determine trends in both the value of ownership interests in surgery centers and management fees charged to surgery centers. This year’s survey had 18 respondents representing more than 500 surgery centers across the United States.

Background on respondents
During 2008, the respondents were actively involved in searching for potential acquisitions; 33 percent performed diligence on more than 16 different centers and 61 percent performed diligence on more than six centers. While the companies were active in looking for deals, 2008 was consistent with 2007 in that eight companies only closed 1-5 deals and three companies closed 6-10 deals. However, in 2008, one company claims to have purchased between 11 and 15 surgery centers. In 2009, 67 percent of respondents plan to close 1-5 deals, while two respondents plan to close 6-10 deals and one respondent hopes to close 11-15 deals.

Start-up or purchase
When developing a new surgery center (i.e., de novo), 56 percent of respondents have experienced “buy in” prices $10,000-$15,000 per 1 percent. The respondents were fairly evenly spread on the percent interest that they are looking to purchase in a given center between 11-29 percent, 30-50 percent, and 51-75 percent.

With regard to the respondents’ strategies, 61 percent are looking for de novo opportunities, 44 percent are looking for turnaround opportunities and 44 percent are looking for established cash flowing centers. The percents do not equal 100 percent as some of the respondents are looking for multiple forms of opportunity.

Within the bidding process, the respondents are almost evenly split on the number of companies involved in the bidding process between 1-2 bidders and 3-4 bidders.
When purchasing an interest, 63 percent of the respondents fund their acquisitions through debt while 37 percent fund through cash. In deciding to make an investment, 56 percent of respondents would consider a purchase regardless of the buy-in price while 25 percent would not consider an investment more than $2 million.

Overall, 88 percent of the respondents would be interested in any deal if the terms were reasonable while the remaining 12 percent have certain markets they are concentrating in developing.

**Surgery center operations**

When developing or purchasing a single specialty surgery center, 61 percent of respondents prefer to have 6-10 active physicians. For multi-specialty surgery centers, 33 percent prefer 11-15 active physicians while 44 percent prefer 16-20 active physicians.

Within the 2008 survey, and given the impending changes in Medicare reimbursement, it appeared that gastroenterology may not have been as preferred as in previous years. However, the results of the 2009 survey indicate that GI is once again among the most preferred specialties. Other preferred specialties include general surgery, orthopedic surgery, ophthalmology, ENT, pain management and podiatry. For urology, the respondents were almost evenly split between desirable and not having any preference; a reduction from 2008 when 62 percent preferred having urology involved in the surgery center.

Almost 50 percent of the respondents wrote in the preference of having spine and/or neurospine involved in their surgery centers. One respondent was interested in involving bariatric surgery in surgery centers.

Plastic surgery remains undesirable. While in 2008, plastic surgery was 15 percent desirable; in 2009, not a single respondent desired plastic surgery involvement in their ASCs.

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**Operating agreement**

When buying out a retiring or under-performing physician, 82 percent of respondents use a formula. When allowing new physicians to purchase an interest in the ASC, only 56 percent of respondents use a formula, 22 percent allow the board to decide the purchase price and 17 percent get an independent fair market value opinion.

**Multiples**

Reflecting back on the results of 2008, 56 percent of respondents feel that acquisition activity in the ASC market is declining while only 17 percent believe that activity has increased. Along the same line, 33 percent of respondents feel that competition for the purchase of an interest in an ASC has declined, 22 percent feel that competition has increased and the remaining 45 percent believe competition is fairly consistent.

When determining multiples and valuing a potential acquisition, 88 percent of respondents measure earnings based on earnings before interest, taxes, depreciation, and amortization (EBITDA). In valuing a potential acquisition candidate, 81 percent look at trailing 12 months of financial data.

As displayed in the following graph, when buying out retiring or under-performing physicians, 35 percent of respondents are paying between a 3.0-3.5 multiple of EBITDA while another 35 percent is paying a multiple of 4.0 times or higher.

**Other considerations**

For a surgery center with hospital ownership, 53 percent of respondents would not adjust the multiple paid because of the hospital ownership, 24 percent would pay a premium and 18 percent would pay a discount.

For surgery centers in certificate of need states, 88 percent of respondents would pay a premium. The premium would be equal to 0.26-0.50 times EBITDA according to 31 percent of respondents or between 0.51-0.75 times EBITDA according to 38 percent of respondents.
For surgery centers with out-of-network strategies, 75 percent of respondents felt that this strategy creates additional risk, which would be accounted for through a downward adjustment to value, while the remaining 25 percent would have to know the extent of out-of-network contracts before forming an opinion on its effect on value.

**Management**

Of the respondents, 67 percent maintain an equity interest in all surgery centers they manage. However, 47 percent of the respondents would consider managing a surgery center in which they do not have an equity interest.

In the context of pricing management services, 39 percent would charge no less than 5 percent of net revenues while 22 percent would charge no less than 6 percent of net revenues. In the context of setting a ceiling on management fees, 56 percent of respondents would charge no more than 6 percent of net revenues and 22 percent would charge no more than 7 percent of net revenues.

![Graph showing distribution of management fees](image)

In the context of pricing management fees relative to center revenues, 67 percent of respondents stated that a center's revenues have no impact on the magnitude of management fee charged while the other 33 percent would vary their fee or using a sliding scale for centers with high net revenues.

With regard to the level of services provided in connection with the management agreement, 61 percent would customize their management fee based on the level of services provided while 39 percent would not.

With regard to the correlation of management fees and equity investment, 87 percent of respondents would not change the management fee based on the level of equity owned in the center.

If the respondents do not have an equity interest in the surgery center they are managing, 46 percent would not adjust their management fee, 15 percent would decrease their fee by 2 percentage points and 31 percent would increase their fee by 2 percentage points.

Since hospital outpatient departments typically generate higher net revenue per case than their freestanding, independent counterparts, HealthCare Appraisers inquired as to the impact management of a hospital might have on the magnitude of management fees charged. Fifty percent of the respondents might change their management fee when managing a hospital department as opposed to a freestanding surgery center depending upon the level of services required, 43 percent would not change their fee and for 7 percent it would depend upon the net revenue level of the department.

Of those willing to adjust their management fee for a hospital-based department, 50 percent would adjust management fees by 1.0-1.5 percentage

continued on page 23

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12:00 – 1:30 pm – Registration
12:00 – 4:30 pm – Exhibitor Setup
Pre-Conference Workshop – Concurrent Sessions A, B, C, D, E
1:30 – 2:30 pm
A. Developing a Highly Successful Orthopedic-Driven ASC
Brent Lambert, M.D., CEO, Ambulatory Surgical Centers of America; and Tom Mead, M.D., Surgery Center of Allentown

B. Using Orthopedics and Spine to Turn Around an ASC
Tom Mallon, CEO, and Jeff Simmon, President Western Division, Regent Surgical Health

C. Sequencing an Orthopedic Start-Up ASC – Tactics for New and Ramp-Up ASCs to Optimize Their Operations
Larry Taylor, President and CEO, Practice Partners in Healthcare

D1. (1:30 – 2:00 pm) Valuing ASCs for Syndication - A Presentation of Current Market Multiples and Question and Answer
Greg Koonsman, Principal, and Jon O’Sullivan, Principal, VMG Health

D2. (2:00 – 2:30 pm) The Impact of the Financing Market on Valuations
Jon O’Sullivan, Principal, VMG Health; Doug Lewis, Managing Director and Shannon LeBoy, CEO and Managing Director, Physicians Capital

E. A Year Later – The Successful Turnaround of a Failing Hospital-Physician Joint Venture ASC
George Trajtenberg, M.D., Mark Beaugar, M.D., and Lisa Shriver, Administrator, Turks Head Surgery Center

2:30 – 3:20 pm
A. Managed Care Negotiation Strategies for Orthopedic and Spine-Driven Centers
Naya Kehayes, CEO, Eveia Health Consulting and Management

B. Uni Knees in the Outpatient Setting – Is This the Right Fit for Your ASC? Clinical and Financial Issues
Blaine Fairless, M.D., and James McGeeber, RN, Administrator, Cleburne Surgical Center; and Sarah Martin, RVP of Operations, Meridian Surgical Partners

C. Physician-Owned Hospitals - Key Factors for Success and Core Challenges
Molly Sandvig, Executive Director, Physician Hospitals of America; John Thomas, EVP, HC REIT; and John Rea-Waller, CEO, National Surgical Hospitals

D. Are Stark and Self Referral Laws Going to Close Down ASCs and Physician Owned Hospitals?
Scott Becker, JD, CPA, Partner, and Amber Walsh, JD, McGuireWoods LLP

E. Spine ASC – An Important Element in a Health System’s Spine Center of Excellence
Jeff Leland, Managing Director, Blue Chip Surgical Center Partners

3:20 – 4:10 pm
A. How to Recruit and Retain Great Administrators and Directors of Nursing
Greg Zoch, Partner, Kaye Baumun

B. A Case Study and Strategies to Achieve Excellent Results for an ASC
Kenneth Austin, M.D., Ramapo Valley Surgery Center; and Bob Zasa, Founder, Woodrun ASD

C. Handling Complex Spine Cases in an ASC, High Level Fusion and 23 Hour Cases
John Seitz, CEO, Ambulatory Surgical Group

D. Key Strategies for Controlling Implant Costs in ASCs and Surgical Hospitals
Randi Pisko, CEO, North Carolina Specialty Hospital; and Richard F. Bruch, M.D., Triangle Orthopaedic Associates

Bill Woodson, SVP, SG2; Tom Stallings, Partner, Kristian Werling, JD, and Elisa Moore, JD, McGuireWoods LLP

4:15 – 5:00 pm
A. Physician Recruitment in 2009 – Some Key Thoughts and Challenges on Recruiting Orthopedics Neurosurgeons and Pain Management Physicians
Kenny Spiter, SVP Development, HealthMark Partners

THURSDAY, JUNE 11, 2009

B. New Trends in Ambulatory Spine Surgery
David Abraham, M.D., Reading Neck and Spine Center

C. Ten Keys to Improving Billing and Collections in a Challenging Economy
Caryl Serbin, CEO, Serbin Surgical Center Billing

D. Healthcare Valuations – Current Trends and Perspectives in Majority Interest Valuations
Todd Mello, Principal and Co-Founder, Healthcare Appraisers

E. Physician Owned Hospitals – Key Concepts to Increase Profits
Tom Michaud, CEO, Foundation Surgery Affiliates

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

FRIDAY, JUNE 12, 2009

7:00 – 8:00 am – Registration and Continental Breakfast
Main Conference – General Session
8:00 am
Introductions
Scott Becker, JD, CPA, Partner, McGuireWoods LLP

8:00 – 8:55 am
The Evolution of Healthcare and the Impact on ASCs
Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics at Princeton University

9:00 – 9:40 am
Orthopedics – The Forecast for the Next Five Years
John Cherf, M.D., Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago

9:45 – 10:20 am
Using Spine as the Backbone of a Multi-Specialty ASC
James Lynch, M.D., Surgery Center of Reno

10:20 – 11:20 am – Hall Break
11:20 – 11:55 am
7 Steps to Maximizing an Orthopedic-Driven ASC’s Returns in a Tough Economy
Brent Lambert, M.D., CEO, Ambulatory Surgical Centers of America

12:00 – 12:30 pm
Case Study – Two Years Later, A Physician-Owned Spine ASC – A Frank and Open Discussion of Financial Performance, Organizational Issues, Challenges and Problems
John Caruso, M.D., Parkway Surgery Center, Hagerstown, Maryland

12:30 – 1:30 pm – Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E

1:30 – 2:05 pm
A. A Payor’s View of Orthopedics, Spine and Pain Management
Steven Stern, M.D., VP Neuroscience, Orthopedics and Spine, United Healthcare

B. Spine Centers – A Case Study Review of Current Outcomes and Issues
Marcus Williamson, M.D., and George Goodwin, SVP and Chief Development Officer, Symbion Healthcare

C. Making Big Cases Profitable in an ASC
Naya Kehayes, CEO, Eveia Health Consulting and Management; and Greg Cunniff, CFO, National Surgical Care

D. Capturing Your Partners’ Cases, The Carrot and Stick Approach
Chris Bishop, VP, Ambulatory Surgical Centers of America

E. Key Legal Issues – Safe Harbor Compliance, Out of Network, and Other Legal Issues
Scott Becker, JD, CPA, Partner, and Bart Walker, JD, McGuireWoods LLP

2:10 – 2:45 pm
A. Hand Surgery in ASCs – Key Concepts for Success
Ed Rudisill, M.D., The Hand Center, Greenville, SC

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B. Pain Management in ASCs - Current Methods to Increase Profits
Amy Mowles, President & CEO, Mowles Medical Practice Management

C. 5 Tips for Managing Anesthesia in Your ASC
Thomas Verden, CEO and Founder, TRY HealthCare Solutions

D. How to Recruit Great Surgeons to Work at Your ASC
Robert Carrera, President, Pinnacle III

E. Turnarounds – 2 Case Studies – 5 Key Ideas for Success
Joe Zaza, President, Woodrum ASD

2:45 – 3:45 pm – Exhibits Open

3:45 – 4:20 pm
A. How Much is Your ASC Worth? What Terms Can You Expect? What Does a National Company Want After a Deal? 10 Facts That Will Drive a Buyer Away
Bill Kennedy, SVP Business Development, NovaMed; Kenneth Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion

B. Is Your Center too Dependent on a Single Specialty? How to Diversify and Make Change Happen
John Seitz, CEO, Ambulatory Surgical Group; Joe Zaza, CEO, Woodrum ASD; and Larry Taylor, President and CEO, Practice Partners in Healthcare

C. 5 Core Concepts for Great ASC Joint Ventures with Hospital Partners
Mike Pauley, Administrator, Ambulatory Surgery Center of Spartanburg; and Caryl Serbin, CEO, Serbin Surgery Center Billing

D. Assessing the Profitability of Orthopedics, Spine and Pain in ASCs
Luke Lambert, CEO, Ambulatory Surgery Centers of America

E. 5 Core Strategies to Immediately Improve ASC and Hospital Operations
Doug Johnson, COO, RMC MedStone Capital

4:20 – 4:55 pm
A. How Much is Your ASC Worth? What Terms Can You Expect? What Does a National Company Want After a Deal? 10 Facts That Will Drive a Buyer Away (continued)
Bill Kennedy, SVP Business Development, NovaMed; Kenneth Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion

B. Ulnar Collateral Ligament Reconstruction: “The Tommy John Surgery”
Timothy Kremchek, M.D., Medical Director, Cincinnati Reds; Larry Taylor, President and CEO, Practice Partners in Healthcare

C. The Development & Integration of Orthopedics into a Multi-Specialty ASC
William Jacobson, M.D., President, West Lakes Surgery Center; Rob McCarville, Principal, Medical Consulting Group; and John Marasco, Principal and Owner, Marasco and Associates

D. 2 Key Issues: Working with Implant Brokers and Out-of-Network Issues
Dan Connolly, Vice President, Pinnacle III

E. Turnarounds – Lessons of the Last Five Years – Expectations of the Next Five Years
Bill Southwick, President and CEO, HealthMark Partners

4:55 – 5:30 pm
A. Orthopedics in ASCs – What Works and What Doesn’t From a Business and Clinical Perspective
John Cherf, M.D., Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago

B. Physician Owned Hospitals – What Should You Do Now?
Ajay Mangal, M.D., CEO, Precis Health; and Brett Goeney, CEO, Animass Surgical Hospital

C. How to Work Successfully with Generation Y
Lt. Colonel Bruce Bright, Director of Business Development, The Sanders Trust

D. The 5 Best Ways to Improve Billings and Collections and to Improve Revenue Cycle Management
Lisa Rock, President, National Medical Billing Services; and David Hamilton, President & CEO, MNET Collections

E. Common Litigation Issues in ASCs – Antitrust, Non Competes and More
Jeff Clark, Partner, and Richard Greenberg, Partner, McGuireWoods LLP

5:30 – 7:00 pm – Networking Reception & Exhibits

SATURDAY, JUNE 13, 2009

7:30 – 8:15 am – Continental Breakfast

8:15 – 9:00 am
How Economic Conditions Impact Health Care Strategies for Success
Tom Geier, Senior Advisor, Texas Pacific Group; and Joe Clark, Executive Vice President, Surgical Care Affiliates

9:05 – 9:50 am
A. Uni Knees and Shoulders in the Outpatient Setting – Cost, Staffing and Profitability Issues
Peter Kurzweil, M.D. and Margarita de Jesus, Administrator, Surgery Center of Long Beach

B. Key Issues Faced by ASCs Today
Thomas Verden, CEO, Founder, TRY HealthCare Solutions

C. The Pros and Cons of Total Knees in a 23-Hour Setting – Financial and Safety Issues
Eric Moneymith, M.D., OrthoIndy; and John Martin, CEO, OrthoIndy

D. Pain Management – 5 Keys to a Superior Pain Management Program Surgery Center
Lance Lehmman, M.D., Medical Director and Liliana Rodriguez Lehmman, MBA, Hallandale Outpatient Surgical Center

E. Implant Costs: Why Facility-Physician Collaboration Makes Sense
Karen Barrow, SVP Business Development, Amerinet

9:55 – 10:35 am
A. Key Concepts to Managing an Effective Interventional Pain Management Practice and Center
Las Manchikanti, M.D.

B. An Analysis of Clinical Outcomes for Spine – Procedures Performed in ASCs
Ken Pettine, M.D., Rocky Mountain Surgery Center

C. Making the Best Use of An ASCs IT System
Jeff Blankinship, President, Surgical Notes

D. Tracking and Improving Patient Satisfaction and How to Apply the Measures to Improve Results
Paul Faraslas, President and CEO, CTQ Solutions

10:40 – 11:20 am
A. The 10 Statistics Your ASC Should Examine Each Week
Shannon Blakely, VP, Operations, National Surgical Care

B. 7 Keys to Successful Physician Hospital Joint Ventures
Edward Herrick, President and CEO, Facility Development and Management; and Christian Ellison, VP, HealthVentures

C. Practical Case Costing and Benchmarking for Orthopedic, Spine and Pain-Driven ASCs – Strategies You Can Use Monday Morning
Susan Kizirian, COO, and Anne Geier, VP, Ambulatory Surgical Centers of America

D. 2009 Pain Management Coding Update and Pain Industry Business Trends
Linda Van Horn, MBA

11:25 am – 12:05 pm
A. Buying and Selling ASCs – 5 Key Concepts
Scott Becker, JD, CPA, Partner and Scott Downing, Partner, McGuireWoods LLP

B. Cost Justifying an EHR, What Is The ROI?
Todd Logan, Regional VP, Source Medical; Daren Smith, Administrator, Fremont Surgical Center

C. Practical Case Costing and Benchmarking for Orthopedic, Spine and Pain Driven ASCs – Strategies You Can Use Monday Morning (continued)
Susan Kizirian, COO, and Anne Geier, VP, Ambulatory Surgical Centers of America

D. 10 Keys to Improve Coding for Orthopedic, Spine and Pain in ASCs
Christina Bentin, Founder, Coding Compliance Management

12:10 – 1:00 pm
Legal Q & A; Safe Harbors; War and Peace with Hospitals
Scott Becker, JD, CPA, Partner, McGuireWoods LLP

1:00 pm – Meeting Adjourns

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Note: HealthCare Appraisers would like to thank the following companies for their participation in this year's survey:

- Ambulatory Surgical Centers of America
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- Nueterra Healthcare
- Practice Partners in Healthcare
- Regent Surgical Health
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To obtain a copy of this year's survey, call or e-mail Curtis Bernstein with HealthCare Appraisers at (303) 688-0700 or cbernstein@hcfmv.com.

Buyers More Prudent in ASC Acquisitions, But Pricing Remains High for the Right Opportunity

By Dana Kulvin, JD, MPH

Pricing trends in ASC sales differ depending upon the ASC’s individual characteristics; and yet overall, ASCs are experiencing the same favorable pricing they have seen for years. In particular, the lower-risk, more desirable ASCs have seen an uptick in their prices.

“The most desirable, and therefore highest priced, ASCs are those containing the greatest potential for future earnings and growth with low risk factors,” says Kenneth Hancock, president and chief development officer of Meridian Surgical Partners “These ASCs are approaching sales prices with multiples as high the upper seven times earnings before interest, taxes, depreciation and amortization (EBITDA).”

Jon Vick, president of ASCs Inc., agrees.

“Majority interests in centers with solid, definable growth potential and projections, that were selling at six to seven times EBITDA a couple of years ago, are now selling as high as seven or almost eight times EBITDA, less long-term debt, plus cash,” he says.

Michael Weaver, vice president of development at Symbion, has witnessed a few values rise as high as the upper seven-times EBITDA, but says it is an exception and not a rule. He generally sees valuations remaining at a steady rate over the last two to three years. “In cases where ASCs sell north of seven times EBITDA, it is difficult to support an accretive valuation for the buyer,” he says.

Prices for desirable ASCs have increased, in large part, due to competition. Recently, momentum in the marketplace has shifted from corporate buyers to ASC sellers.

“With over 30 companies competing for a limited number of good quality ASCs with decent growth potential, sellers are in a position to negotiate higher prices,” says Mr. Vick. “There are now several buyers for each ASC and sellers can be choosier about their deal terms.” For example, he says ASCs that would have received a corporate bid of four to five times EBITDA for selling a minority interest two years ago can now negotiate that price up to five to six times EBITDA.

While Mr. Weaver has not seen a complete shift in the marketplace, he has seen changes in larger acquisitions.
“Due to the high prices of acquiring larger ASCs combined with the recent credit crunch and some consolidation in the market, there has been a reduction of companies with the ability to acquire bigger ASCs,” Mr. Weaver says. In addition, because of the difficulty in securing capital on credit, corporate buyers are making much more conservative, disciplined, and careful ASC purchases than in the past, he says.

**Buyers weigh numerous considerations**

In making more prudent purchases, buyers will evaluate several factors. For example, instead of simply basing valuation on an ASC’s historical 12 month EBITDA, buyers are also assessing future earning potential.

“Buyers may consider a blended formula where they look historically for earnings and forward in regards to potential new contracting opportunities and physician syndication,” says Mr. Weaver. He adds that these new potential opportunities may result in supporting an improved valuation.

David Hall, chairman of Titan Health Corp., agrees that profitability must take into account the number of prospective physicians who can be recruited to invest in the ASC.

“Without first-rate physicians to bring into the ASC, there will be no case load and perhaps no case mix increases,” Mr. Hall says.

A lack of available physicians can have negative implications, agrees Brett Brodnax, executive vice president and chief development officer of United Surgical Partners International.

“Without new physicians to bring into the ASC, there will be reduced case growth expectations and consequently a discount on the future earnings projections” says Mr. Brodnax.

There are other evaluative factors besides earnings that are also considered. Traditionally, buyers have focused primarily on an ASC’s payor mix. These days, buyers are looking not only at the ASC’s payor mix, but also its case mix, Mr. Hall says. Recent CMS changes to Medicare reimbursements resulted in decreases in reimbursements for GI and pain procedures.

There may be additional revenue losses in other procedures, as reimbursements decrease and costs increase, says Mr. Vick. An ASC with a diversified case mix (or with the potential for one) that includes more highly reimbursed specialties such as orthopedics, bariatric, hernia and spine, will be more likely to offset reimbursement losses.

“Only by evaluating an ASC’s present and future case mix will a buyer be able to assess its growth and earnings potential,” he says. Mr. Vick generally likes to see a future case (and EBITDA) growth potential of at least 10-20 percent a year.

**Buyers watch for challenges**

In looking for ASCs with solid growth and earning potential, buyers examine competitive and reimbursement hurdles that may exist. One such hurdle is out-of-network reimbursement.

“As payors continue to crack down on out-of-network reimbursement, ASCs with a large percentage of these cases will face decreases in revenue which can harm their growth and earning potential,” says Mr. Hancock. “For this reason we are only interested in ASCs with less than 15-20 percent of these cases,” he adds.

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**10 Popular Articles on www.BeckersASC.com**

Here are just 10 of the most popular articles that recently appeared on www.BeckersASC.com and in the *Becker's ASC Review* E-weekly.

1. Statistics on Surgery Center Staff Hourly Wages and Administrator Salary by Region of the Country
2. 10 Top Surgery Center Stories of 2008
3. Physician Self-Referral Ban Suggested in AHA Proposed Health Reform Package
4. 96 Questions to Ask When Reviewing Managed Care Contracts
5. New York Surgery Centers Face Possible 10% Surgical Procedures Tax
6. 5 Top Surgery Centers Performing More Than 10,000 Cases Per Year
7. Poor Economy, Reimbursement Rates Force Closing of Minnesota Surgery Center
8. BCBS Changes Out-of-Network Elective Services Plan; Members See 5% Responsibility Increase
9. MedPAC Recommends Surgery Center Payment Rate Increase of 0.6%
10. OIG Issues Advisory Opinion Regarding a Proposed Arrangement Under Which a Corporation Would Pay Two Part-Time Physicians to Perform Endoscopies

Mr. Weaver agrees with this percentage benchmark but, in these cases, he also evaluates the ASC’s means for making up the potential lost revenue.

A second hurdle is the competitive landscape, says Mr. Brodnax.

“An ASC in a Certificate-of-Need state has fewer competitive obstacles because the state actively controls the number of ASCs and other healthcare facilities that can be developed,” he says.

Lastly, buyers are not interested in well-established, fully-utilized ASCs. Instead, they are interested in an ASC that has the potential to expand its business and to physically expand its facility.

“An ASC that is 100 percent utilized and is very profitable but not expandable, will not be valued very highly if there is no growth potential,” says Mr. Vick. “This is a change from just a couple of years ago when some companies were simply seeking high cash flow.” To that end, buyers are evaluating whether an ASC is physically capable of adding more procedures and one or more operating rooms and addition recovery beds.

Ms. Kulvin (mrbones@the-beach.net) is a freelance writer based out of Surfside, Fla.

### Factors Contributing to a Highly-Valued and Desirable ASC

Buyers are looking to purchase ASCs that have future growth and earning potential. Growth and earning potential, and thus valuation, is measured by various benchmarks. Here are some of the key benchmarks experts use when assessing the value and desirability of an ASC.

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<td>Out-of-network reimbursement</td>
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<td>Recruitment prospects</td>
<td>Available pool of qualified physicians to invest</td>
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<td>Capacity for growth in case volume</td>
<td>20–30 percent annually (based upon historic growth patterns)</td>
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<td>Capacity for physical growth</td>
<td>ASC is not at full capacity; there is room to physically expand</td>
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Ms. Kulvin (mrbones@the-beach.net) is a freelance writer based out of Surfside, Fla.
Determining the Value of a Medical Practice

By Jonathan O'Sullivan and Thomas Washington

The value or worth of a medical practice to a third-party buyer in an acquisition is often the subject of much debate, theoretical analysis and often confusion. As the healthcare environment undergoes its cyclical market rituals that often includes the acquisition of physician practices, the employment of physicians and then ultimately the divestiture of money-losing strategies, the issue of what a practice is worth invariably plays a leading role.

Historical look at market drivers
A brief, recent historical framework is useful for understanding the market drivers that result in the physician practice acquisition cycles. As recently as the mid 1990s, the imperative for hospital systems all across the United States was the development of the integrated delivery network (IDN). The conceptual idea of the IDN included a multi-faceted organization that included the primary care physician as the “gatekeeper” physician that served not only as the first point of contact for the patient experience but also as the entry point into the rest of the IDN. In most cases, a patient had to see their primary care physician in order to get authorization or referral to a specialist.

The central money making part of the IDN was the facility-based services that included the hospital at the core but might also include other ancillary services such as imaging, surgery centers and other outpatient services. Finally, in many cases, the IDN might have included its own managed care health plan that served little purpose except that the IDN could manage all aspects of the health insurance risk and reap the related financial rewards.

Given that the primary care physician was the central gatekeeper into the rest of the IDN, the imperative for health systems was to aggregate as many primary care physicians under its IDN umbrella, especially if those physicians had historically been referral sources to competitor hospitals. Thus, the primary care physician acquisition frenzy of the late 1990s was born.

The central money making part of the IDN was the facility-based services that included the hospital at the core but might also include other ancillary services such as imaging, surgery centers and other outpatient services. Finally, in many cases, the IDN might have included its own managed care health plan that served little purpose except that the IDN could manage all aspects of the health insurance risk and reap the related financial rewards.

Value of a practice
Determining the value of a medical practice should, in theory, be fairly simple. Like most small privately held businesses, the value is either a function of the future earnings that can be generated from the business or the value of the identifiable tangible and intangible assets that can be deployed to generate a future earnings stream. This may sound simple in theory but in practice, a number of variables can be introduced to confuse the analysis.

For a physician practice, the single greatest variable is the compensation level of the physician who is working in the practice. In theory, if the level of compensation paid to the physician is low enough to produce positive earnings after all expenses, the practice has a measurable level of value. In practice however, most medical practices pay all earnings out to their physician shareholders. As such, if this is the model post-acquisition, then the practice has no going-concern or operating value. After all, who...
would buy a business that will never make money for its shareholders? Therefore, the single greatest determinant of value for these practices was the level of agreed upon physician compensation and the expected future earnings.

This is where things got really ugly. The disjoint between the assumed level of compensation included in most valuation analysis and the actual level of compensation paid to primary care physicians post-acquisition resulted in financial catastrophe for a large number of IDNs in the late 1990s. Physicians who were making $500,000 per year from working very hard in their medical practice were paid $1 million for their practice and were guaranteed to make $500,000 per year. In most cases, the only thing that improved post-acquisition was the physician’s golf handicap. Hospital systems lost tens of millions of dollars each year as a result of these arrangements.

By the early 2000s, most hospitals were working to unwind their failed IDNs and divest themselves of money losing physician practices. In most cases, the hospital sold the practices back to the physicians based on the value of the fixed assets (furniture and equipment).

Lessons learned
The following lessons learned by hospital systems relating to physician practice acquisitions during this period were both painful and obvious.

• A physician practice rarely has going-concern or operating value based on the expectation of a future earnings stream. If the practice generates earnings in the future, the physician will expect to receive all or most of it as part of his or her compensation.
• The values of the identifiable tangible and intangible assets of a physician practice are the best measure of the value of the practice — with the majority of the practice value based on the tangible assets of furniture and equipment.
• Physicians are accustomed to being compensated on a basis that is in direct proportion to their productivity. A guaranteed salary will almost always result in a lower level of productivity.
• Physicians generally have an acute understanding of the operating costs incurred by their practice and limit those costs in a direct effort to maximize their earnings. Once the relationship between operating expenses and compensation is removed, operating expenses increase dramatically.
• A physician in private practice is accustomed to significant autonomy in almost every respect. In general, these physicians will make terrible and expensive employees.

Examining today’s market
Fast forward to 2008 and we find that many aspects of our healthcare environment have changed dramatically.

• IDNs are no longer a prevalent strategy for hospital systems.
• It is rare that a hospital that has a managed care plan as part of its healthcare system.
• Primary care physicians are no longer gatekeepers for managed care plans.
• Patients have unfettered direct access to specialists.
• Specialists (surgeons, cardiologists, oncologists, etc.) have expanded ownership in services historically owned by hospitals.
• Professional reimbursement — especially for specialists — has continued its rapid decline.
• Physician operating costs — especially medical malpractice costs for specialists — has continued to increase.

These changes have altered the business and economic landscape and have thrust the specialist into the forefront as the primary referral source for patients into a hospital or outpatient services setting. This new (or old) role enjoyed by the specialist has often been offset by the financial and administrative realities that include lower reimbursement; higher administrative burdens necessary to adjudicate managed care claims; onerous, or sometimes impossible, costs of medical malpractice coverage; additional time required to serve patients armed with internet downloads; and, in many cases, the loss of the intrinsic rewards of being in private practice.

Simultaneously, hospitals are striving and, in some cases, struggling to retain the referral relationships of the physician specialist and stem the tide of specialist investment in competing facilities that serve to erode the revenues and earnings of the hospital. These include surgery centers, heart hospitals,
The combination of the foregoing market conditions has set the stage for the next iteration of the hospital acquisition cycle of physician practice investment. This has rekindled the debate over the value of the physician practice — or specifically, in this case, the specialist.

**Current valuation characteristics**
The core of the valuation issue continues to revolve around the prohibition for any consideration to be paid to a physician in relation to the volume or value of referrals. Most for-profit and not-for-profit hospitals are far more attuned today to the ramifications of running afoul of federal and state anti-kickback statutes, and in many cases, have internal and external legal counsel oversight of physician-hospital transactions. Additionally, the painful lessons learned from the financial catastrophes of the 1990s have been etched (well, almost) into the minds of the administrators who are responsible for financial and operating results. The following are generally the resultant characteristics of an acquisition in today’s environment.

- An acquisition valuation based on the fair market value of identifiable tangible and intangible assets.
- A physician compensation structure based on a measure of productivity, generally relative value units (RVU).
- A FMV analysis and opinion on the physician compensation structure.

While, in most cases, the structures are far from perfect, the lessons of the 1990s appear to have had some meaningful effect on how hospitals are structuring their relationships with physicians. However, measuring the value of the medical practice is still fraught with some danger.

**New challenges and risks**
We once again find hospital systems engaging in cross-town competition in an effort to outbid their rivals for the acquisition of medical practices — more specifically, the specialist. Naturally, a determining factor in who wins the bidding process is based upon who can come up with the highest price. As a result, the pressure on independent valuation professionals to rationalize a higher value is becoming more intense.

While hospital systems have learned that the value of a medical practice (one that does not have significant non-professional revenue sources) is best measured by the value of its assets, the new question seems to be concerned with what are “assets.” While there is no formal definition for an asset pursuant to an acquisition, our company (VMG Health) defines assets as those resources that can be deployed by the acquirer in order to generate a return on investment whether in its current form or in an alternative environment. Most tangible assets are relatively obvious.

- Furniture and equipment are easy to identify and relatively easy to determine value.
- Tenant improvements have an original cost and can be depreciated over the life of the lease.
- Inventory can be valued at its cost.
- Other tangible assets are generally nominal.

Intangible assets can be more complicated. There is clearly a value to a trained workforce, which is the primary intangible value of most medical practices. However, that value can vary depending upon location and market conditions. There might be a value to a trade name depending upon the market’s perception of the name, and there may be value in certain other intangible assets, although generally nominal.

**Value of medical records**
Notice that we have not included “medical records” as a tangible or intangible asset. Medical records are ultimately an item that rests under control of the patient. A medical record cannot be deployed as an asset and cannot be transferred to an alternative environment without the patient’s permission. As such, a medical record does not in itself generate a return to an investing shareholder. The only value that can be ascribed to a medical record is the cost avoided to copy the record in the event of a legal transfer of that record.

In many cases, value of intangible assets may be allocated to a medical record. However, this is merely an issue of arbitrary allocation and not a financial calculation or generally accepted accounting treatment.

**Value of trained workforce**
Recently, the issue of the value of trained workforce has become an area where the risk of manipulation of the FMV of the practice has become apparent. Trained workforce is defined as the staff (fully-trained) that can contribute to the operations of a medical practice. In order to estimate the FMV of trained workforce, several components must be considered. These include:

- Recruitment costs
- Hiring expenses
- Training expenses
• Benefits
• Level of productivity one could expect from an employee while they are being trained for the position.

While certain expenses associated with “replacing” trained workforce are relatively easy to identify, others are based upon professional judgment and experience. This can lead to manipulation by using unusual, lengthy training times, expecting a high level of productivity during the training period and inflated recruiting costs. Each factor considered should be analyzed to ensure an accurate indication as to the FMV of trained workforce.

**Role of compensation in valuation**

While the FMV of the identifiable tangible and intangible assets can represent a “floor” value of a medical practice, the final answer as to whether there is any value over and above this floor amount rests in the compensation structure that will be put into place following the transaction. Physicians in private practice are accustomed to getting paid all earnings that are left after all expenses have been paid. This expectation will not change in a post-transaction environment. However, the new owners of the medical practice will require some return on their investment which should, in theory, reduce the level of compensation of the physician — no ownership equals no required return.

If a physician is expecting a big payday from the sale of the medical practice, the only way for this to happen, while remaining in the bounds of FMV, is for the physician to take less in salary than could be paid after the owner’s return is considered. However, the risk here is that, not too far in the future, the physician will forget about the amount received when the medical practice was sold and demand he or she be paid a similar salary that was earned historically. This can quickly sour the employed-physician relationship.

Realizing that compensation has a direct impact on the purchase price of a medical practice and understanding that the physician generally will require a similar level of compensation than has been historically enjoyed, most transactions involving medical practices include a compensation structure that pays out all earnings (less an appropriate return) to the physician, often times in the form of a pre-compensation earnings (PCE) split. A 90/10 split, for example, pays the physician 90 percent of PCE with the owner retaining 10 percent as a return on investment.

As previously discussed, a fixed, guaranteed salary over a definite period will oftentimes result in reduced productivity on the physician’s part if no mechanism is included in the employment agreement to penalize the physician for lower production and reward the physician for increased levels of production.

**Understand FMV, law before proceeding with acquisition**

While there was a time in the past where medical practices were purchased by hospitals and IDNs at a price that included, in some instances, high levels of intangible value, the lessons learned through those relationships have impacted the way transactions involving medical practices now occur. At the end of the day, we arrive back to the conclusion that the value of a medical practice is mainly comprised of the FMV of its tangible and intangible assets and typically contains little or no goodwill.

Further, in cases where medical practices are purchased by an entity where the physician could be or is a referral source, federal and state anti-kickback statutes and the Stark laws must be considered to ensure compliance. This has led, in many cases, to the purchase of medical practices for the tangible assets and only easily identifiable and measurable intangible assets.

While every situation is unique, you should clearly understand the facts and circumstances of any specific medical practice and the post-transaction compensation structure in order to provide an accurate estimate of the FMV of that medical practice. Failing to understand, identify and measure the appropriate factors that drive the valuation of a medical practice can not only result in poor financial performance but might also lead to violations of federal and state anti-kickback statutes.

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As Medicare incentivizes ophthalmologists to perform more procedures outside of hospitals, ASCs are luring more of them to do not only the traditional cataract surgeries, but also corneal transplants and retina surgeries.

Some ASCs are scrambling to recruit retinal surgeons to capitalize on the expected growth of retinal outpatient surgeries.

Ophthalmologists and ASC administrators say that with the right process, equipment and experienced eye team, surgeons using two operating rooms are capable of doing five to six cataract procedures an hour.

“We have surgeons who can perform cataract procedures without complications within 10-15 minutes,” says Ellen Johnson, vice president and chief operating officer for Facility Development & Management, which provides consultative, developmental and managerial services for ASCs. “Patients are leaving after surgery and nurses, anesthesiologists and technicians are bringing in trays for the next procedure. From cut to cut it can take between 8-10 minutes.”

Ms. Johnson says, “The name of game is to move things efficiently. One reason ophthalmologists perform procedures in ASCs is they don’t want to go to hospitals and wait around for ORs to open up. Pain management and ophthalmology are practically instantaneous turnarounds, with limited cleanup and prep compared to orthopedic or other procedures. Physicians like them because they can do a tremendous amount of cases and still be out the door at a reasonable time of day. Patients love it because the recovery is pretty quick. They’re not hanging around forever in recovery rooms and it’s usually not done under general anesthetic.”

Here are 11 best practices to improve ophthalmology services in ASCs.

1. **Standardize surgical products.**

George Violin, MD, board-certified ophthalmologist and a co-founder and owner of Ambulatory Surgery Centers of America, an ASC management and development firm that owns interests in 34 ASCs, says ASCs can save money by sharing information between surgeons and minimizing idiosyncratic equipment.

“The bulk of ASC ophthalmology services are cataract removal and lens implantation,” says Dr. Violin. “If you can convince every surgeon to use the same knife, the same pre-packs of surgical instruments and cataract kits, then you don’t have to stock 10 different kinds of lid speculums and other tools. You achieve uniformity of disposable items and kits and avoid multiple iterations and variations of the same thing. And you save a lot of money.”

Dr. Violin also advises minimizing inventory of all supplies to reduce overhead costs. One way is to hold an annual “Dutch auction” to select the lens used by that ASC for the year.

“The lowest priced lens wins the auction and all surgeons must commit to use a common lens,” he says.
Also try to minimize the total number of vendors as uniformity results in greater volume purchasing power and lower costs.

“Standardization is the best thing,” agrees Ms. Johnson. “The more preferences, the higher the costs. If you can get the docs to agree on custom packs, you can negotiate better pricing deals with vendors.”

She also recommends keeping irregularly used kits out of the OR unless they’re requested.

“Don’t bring it out unless they need it and don’t open it until it’s requested,” Ms. Johnson explains, saying that helps protect the integrity of the custom pack, which includes eye drops, surgical drapes and sometimes gloves.

“Another trick is you don’t want to buy implants up front, but on consignment,” she adds, explaining that lenses, screws and other implants are costly to purchase up front and could sit on shelves for a long time. “If you have a consignment arrangement with a vendor, then the required items are on your shelf and you notify the company when you use them and only pay then.”

She also suggests trying a new product first to be sure it’s needed and pays to have it, rather than purchasing it upfront and waiting.

Ms. Johnson says she cultivates relationships with various vendors when her firm develops centers to price OR tables and lights and has inked national contracts with some firms. The ASCs her company manages contract with group purchasing organizations. “But sometimes I get an even better preferred rate because we have more than one center. This helps also when we bring on a new center because we can access better prices for them.”

2. **Give only the most efficient surgeons two operating rooms.**

“You probably should not have surgeons who can do less than three cases per hour,” says Dr. Violin. “We use two operating rooms in tandem and the surgeon goes room to room between procedures using two identically equipped and staffed rooms. You give those rooms to doctors who can do five to six cases an hour. Give the most efficient surgeons the chance to use two ORs and those who can’t perform that many should only use one room.”

Even efficient operations improve through advanced planning, says Rajiv Chopra, principal and chief financial officer with The C/N Group, an ASC and imaging center development and management company. “Pulling supply trays in advance, documenting lens requests, communicating with the surgeon’s office all have positive impacts on readiness, efficiency, inventory needs, turnover time and quality and risk management.”

3. **Make sure all paperwork is done before the day of surgery, including the selection of the lenses.** “That way the surgeon is not looking for lenses between cases,” Dr. Violin says. “The surgeon should validate the lens before the procedure, examine the patient chart and the lens picked and confirm that it’s the correct lens,” he says, explaining the practice not only improves quality, but reduces potential legal risks. “One of the most common causes of intraocular lens litigation is implanting the wrong power lens.”

4. **Schedule wisely.** The ASC should use per diem employees whenever possible. When the center is not busy, it should be closed. “If there is not enough business to make a day profitable, the center should be closed to keep a handle on costs,” Dr. Violin says.

5. **Require justification for expensive extra supplies.** If a surgeon needs such costly extras, he must justify their specific use, says Dr. Violin. “It’s a constant war between vendors and surgery centers to keep profit margins reasonable. And the ASC should be a profit center, not simply a facility for the surgeon’s convenience.”
Ms. Johnson says every U.S. region differs in Medicare reimbursement. “[ASCs] need to that and know what their costs are,” Ms. Johnson says. “This is global. They can’t go to the table with insurers and negotiate intelligently otherwise. With ophthalmology, ASCs have to remember to be sure their contracts cover lenses separately. Some companies will not reimburse 100 percent for the new super lenses. They should never negotiate a contract with a commercial insurer for less than what Medicare pays. I wouldn’t give a flat rate without including the price of lenses. Why should they eat that $150? If you forget to include lenses it can cost you a lot. If you don’t get it from the insurer, then you have to tell patients they’ll be charged extra.”

She says the contracts for her firm’s ASCs are all downloadable, so when someone asks about a product or procedure and aren’t clear about it, they can verify almost immediately.

“We can track each insurer’s payment times and if they aren’t within the 30-day frame, we can get on the phone with them,” Ms. Johnson says. “Insurers are always challenging us with out-of-network arrangements. Sometimes they send checks to the patients without telling us. We try to let the patients know that. Insurers can be quite capricious.”

Mr. Chopra says one key to collecting every cent is to know what each payor requires under contracts.

“Some payor contracts allow reimbursement for implants, but you have to make sure there is a nurse in the room when the surgery is performed to document everything,” he says. “Then that goes to billing and collections. You want to ensure that if medical supplies and implants are reimbursed under contract, that you have documented and not billed for them. If you don’t bill for them, you won’t be paid.”

7. Drive growth in volume by expanding scope of ophthalmology procedures. “Cataracts comprise the bulk of most ASC ophthalmology procedures, but centers should consider moving beyond cataracts to include corneal transplants and retina work,” says Mr. Chopra. “Corneal transplants are more complex, but yield higher reimbursements and volumes.”

Michael Sayegh, MD, ophthalmologist and co-owner of the Eastern Orange Ambulatory Surgery Center in Cornwall, N.Y., points out that Medicare is now allowing more retinal procedures to be performed in ASCs.

“This is one area that will grow a lot and we’ll soon see ASCs recruiting retinal surgeons,” Dr. Sayegh says. “Reimbursement looks promising.”

8. Hire, train and retain a team dedicated to ophthalmology. Having a trained and dedicated staff that works exclusively in ophthalmology improves efficiency, quality and profitability, says Mr. Chopra. “It also makes it easier to recruit and keep physicians.”

Ms. Johnson concurs. “Dedicated teams always work the best. When a surgeon works with the same team, it improves efficiency. That’s not to say if the ASC only has ophthalmology one day a week that the staff can’t work with other specialties. But if the eye surgeon works with the same team of experienced staff, it helps their confidence level and efficiency. Even if those are per diem nurses and techs, from the doctor’s point of view, he has his team, rather than a different person each week that he has to break in to adapt to his work style. And the team learns how a doctor works and what to anticipate and that doctor’s preferences and helps to move cases along. Many doctors have idiosyncrasies,” she says. “You may have to have backup during vacations and rotate people”

Dr. Violin also supports ASCs creating dedicated ophthalmology teams. “If you can, have a design set of nurses that do ophthalmology only. It builds excellence in the nursing staff.”

9. Surgeons must become active partners in improving efficiency. It behooves surgeons to become part of the same team working to improve quality and efficiency, says Dr. Sayegh.

“The team shouldn’t just be working around the surgeon,” he says. “I’ve met surgeons who think the ASC will make him efficient, that he doesn’t have to do anything and it will be a turnkey operation. But the surgeon needs to be involved in any attempts to improve efficiency will fail and the entire ASC will adopt his approach and efficiency will drop. If the captain of the ship isn’t efficient, no one else will be either.”

10. Schedule patients quickly. “People don’t like to wait for surgery to begin with, but with ophthalmology services, when patients finally decide, they want it quickly,” says Ms. Johnson. “By the time you need cataract surgery, your vision is already clouded and you don’t want to wait another 6-8 weeks. We like to schedule our patients as quickly as possible and they appreciate it.”

11. Pre-screen patients. “We’re seeing more and older patients with the aging of America,” Mr. Chopra says. “Our patients are much older on average than we saw three to five years ago. That creates a greater challenge in caring for that patient. We’re pre-screen before we schedule them for surgery. Someone who is 80 could have an irregular heart beat and might not be able to tolerate anesthesia. Because of this demographic shift some of our patients are at higher risk and we need to plan and adapt to that.”

Contact Mark Taylor at mark@beckersasc.com.

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3 Eye Surgical Machines
ASC Ophthalmologists Recommend

By Mark Taylor

Here are three pieces of surgical equipment that ophthalmologist Michael Sayegh, MD, of the Eastern Orange Ambulatory Surgery Center in Cornwall, N.Y., says are possible good investments for ASCs offering ophthalmology.

1. Yag laser — Traditionally, ophthalmologists say these $60,000-$100,000 lasers are found in doctor offices, not ASCs. Increasingly though, ASCs are purchasing these small lasers that hold multiple applications for the eye.

“They have two main uses,” Dr. Sayegh says. “One is for posterior capsulotomy, to break up the membrane that forms behind intraocular lenses after cataract surgery. The second use for the laser is an iridotomy procedure that takes care of a condition risk factor for glaucoma.”

2. Alcon Infinity — This cataract machine is the latest incarnation of a phacoemulsification unit, which is a high frequency ultrasound, Dr. Sayegh says.

“An ultrasonic needle liquefies the cataract. The emulsifier breaks up the cataract and the machine has an irrigation port to irrigate the eye with saline solution and an aspiration port that vacuums everything up. It’s a state of the art piece of equipment with multiple features to enhance safety and increase efficiency.”

3. Zeiss and Leica microscopes — Dr. Sayegh says both offer excellent three-dimensional vision, depth perception and visibility, allowing you to identify problems early and perform your work more efficiently. You can manipulate the light to give a better red reflex,” which he says occurs when the light enters the pupil bounces out.

“Both Zeiss and Leica make great lenses and make the surgical steps easier and more efficient.” He says the microscopes cost $30,000-$50,000.

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10 Interesting Stats About Ophthalmology and Cataract Surgery in ASCs

Here are 10 interesting statistics about ophthalmology and cataract surgery in ASCs.

1. The average 2007 Medicare sub charge (submitted charges divided by allowed services), average allow charge (Medicare-allowed charges divided by allowed services, including co-pays and deductibles paid by patient), and average payment (Medicare payments divided by allowed services, not including co-pays and deductibles paid by patient) for post-cataract laser surgery (CPT 66821) is:
   - Average sub charge: $1,006
   - Average allow charge: $307
   - Average payment: $241

2. The average 2007 Medicare sub charge (submitted charges divided by allowed services), average allow charge (Medicare-allowed charges divided by allowed services, including co-pays and deductibles paid by patient), and average payment (Medicare payments divided by allowed services, not including co-pays and deductibles paid by patient) for cataract removal, insertion of lens (CPT 66984) is:
   - Average sub charge: $2,827
   - Average allow charge: $966
   - Average payment: $766

3. Ophthalmology represented 15 percent of the case volume for the total number of cases performed in 230 licensed freestanding ASCs performing one million cases.

4. Of those centers performing less than 3,000 cases, ophthalmology represented 20 percent of the case volume for the total number of cases performed in 230 licensed freestanding ASCs performing one million cases. For centers performing 3,000-5,999 cases, it represented 13 percent of the case volume. For centers performing at least 6,000 cases, it represented 16 percent of all cases.

5. The average revenue per case for ophthalmology was $4,350 in gross charges and $1,153 in net revenue 230 licensed freestanding ASCs performing one million cases.

6. Of the 230 licensed freestanding ASCs performing one million cases, 177, 359 of these cases were ophthalmology. The 28 centers that had 1-2 operating rooms (OR) performed averaged about 301 cases. The 122 centers that had 3-4 ORs averaged about 692 cases. The 78 centers that had more than four ORs averaged about 1148 cases.

7. Approximately 23 percent of all single-specialty ASCs are ophthalmology centers, second only to gastroenterology (28 percent).

8. Approximately 38 percent of all single- and multi-specialty centers reported providing ophthalmology, second only to plastic surgery (39 percent). The average procedure volume was 1,696 ophthalmology cases per facility, second only to gastroenterology with 3,710 cases on average per facility.

9. Ophthalmology has seen significant growth in market share in ASCs. From 2000 to 2008, ophthalmology had the most growth at 27 percentage points, followed by gastroenterology at 26 points.

10. Lens and cataract procedures is the most commonly performed ambulatory surgery in hospitals, performed 431,000 times (rounded to the nearest thousands) in 2003. This comprised 8.7 percent of overall ambulatory hospital surgeries.

Note: CPT codes are copyrighted by the AMA.

Sources: Items 1-2: CMS.
Item 10: Agency for Healthcare Research and Quality’s Healthcare Cost and Utilization Project.

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5 Major Trends Impacting the ASC Marketplace in 2009

By Dana Kulvin, JD, MPH

There will be many opportunities but also hurdles in the ASC market in 2009, according to industry experts. Here are five of the most significant trends facing surgery centers in 2009.

1. Credit crunch, likely legislation changes will slow down the recent flurry of ASC acquisitions. While the last 6–12 months have seen a flurry of ASC acquisition activity, this will slow down in the coming months as the credit and financial markets continue to break down, predicts Kenneth Hancock, president and chief development officer of Meridian Surgical Partners.

“As the credit crisis continues, banks will be more conservative with the amount of debt financing provided to companies purchasing ASCs, thereby restricting the amount of cash available to complete these transactions,” Mr. Hancock says.

Recent activity in the ASC market has also, in large part, been in response to ASC owners fearing changes in public policy that could adversely affect their interests.

“In anticipation of a likely capital gains tax increase enacted after the presidential election, ASC physician owners are selling off ASC interests now to avoid a large tax liability later,” says Brett Brodnax, executive vice president and chief development officer of United Surgical Partners International.

Currently, long-term capital gains are generally 15 percent of the capital gains net total.

“An increase in the capital gains tax could potentially devalue an ASC physician-investor’s investment income,” says Michael Weaver, vice president of development at Symbion. “Without knowing the increase, many physician investors would rather sell now than pay capital gains taxes later on, which may be far greater than the taxes being paid currently on investment income.”

However, “a tax event should not supersede an ASC’s goals of finding the right partner whose culture and experience will allow an ASC to fulfill its growth strategy and legacy of providing high quality care,” Mr. Weaver says.

2. Turnaround opportunities abound.

While low-risk, large ASCs will be harder to find or priced too high for most buyers in the coming year, there will be ample opportunity for companies to buy into a struggling center.

“If adverse legislation prohibiting or restricting physician referrals to physician-owned ASCs is passed in any state, the value of all ASCs would be significantly reduced,” he says. “Some physician-owners are selling now to protect their investment.”

Anticipatory fear of potential adverse legislation is also at play, says Jon Vick, president of ASCs Inc.

“Some ASCs are in difficult financial and operational situations and are looking for partners to stabilize and improve their business,” says Mr. Brodnax. “These centers have experienced...
declining reimbursements, seen considerable decreases in out-of-network payments, suffer from inefficient operations, have had difficulty contracting with payors or have challenging partnership issues to overcome.”

In some cases, ASCs have been undercapitalized or overbuilt. Mr. Hancock has seen reports that indicate over one-third of all ASC partnerships are marginally profitable or are losing money.

“Because new projects are harder to find due to the maturity of the industry, companies will attempt to find investment opportunities in struggling partnerships where they can deploy capital to satisfy debt, deliver focused management to enhance and/or reengineer operations plus recruiting expertise to fuel growth,” he says.

With the current credit and the economic turmoil, a turnaround investment may be a better buy-in than a new (de novo) ASC for many corporate investors.

“The timeline to market with a takeover is substantially shorter for the management company than with a de novo project,” says Mr. Hancock. “Provided a successful operations plan is executed and cash flow is created, the partners will soon begin to receive checks versus having to write checks to the partnership.”

3. De novo deals becoming harder to close. Experts contend that de novo ASCs will be much more difficult to develop in the coming year. The first challenge is there are fewer independent physicians available to create a de novo center, says Mr. Weaver.

“In the past decade, there has been an astounding growth of new ASCs and currently there are approximately 6,000 operating in the United States; therefore, many physicians are already affiliated,” he says. “In addition, as in the 1990s, today many more new physicians are taking hospital positions and thereby restricting themselves from investing in an ASC by non-compete clauses. Given these conditions, it is more difficult today to get a group of 12 physicians together and build a new ASC.”

Note: See “Growth of ASCs Outpace Number of Available ASC physician Owners” on p. 37 for Deutsche Bank statistics on the limited supply of physicians.

There are other obstacles as well, Mr. Hancock says.

“Credit is tight and marginal deals are unlikely to receive financing,” he says. “For this reason, de novo projects will have to raise more equity and expect individual investor guarantees in addition to their cash invested.” There will also be additional challenges with regards to case mix and volume, insurance contracting and reimbursement, growth prospects and competition, he adds.

4. Seller scrutiny at a high. ASC sellers are looking more carefully at a potential buyer’s corporate track record for “same-center growth” in order to partner with the right company and maximize their profits.

“Sellers will more seriously scrutinize all potential buyers to ensure that the corporate partner will be able to grow the ASC at or above a 10–15 percent annual EBITDA (earnings before interest, taxes, depreciation and amortization) margin growth,” says Mr. Vick. He explains that if the physician-investors sell 51 percent of their ASC to a company, they will want to make sure that their distributions will return to their previous levels within three to five years.

“Many ASCs have seen their profit growth slowing and are seeking a sale to take some money off the table; at the same time, they want to attract a professional management company that will keep their pro rata distributions growing,” he says.

In evaluating a company, astute ASC physician-owners will look at the ASCs owned by the company as well as the track record of the company itself. In looking at the owned ASCs, they will assess, amongst other factors:

- annual financial growth;
- partner satisfaction;
- case referral numbers;
- average revenue per case;
- EBITDA margins;
- quality; and
- growth potential.

In looking at the company itself, physician-owners will review:

- the number of ASC deals completed annually;
- the number of partnerships dissolved;
- the strategic plan for going public or putting itself up for sale;
- record for renegotiated ASC contracts; and
- overall EBITDA margin.

Mr. Weaver says that sellers will also evaluate the continuity of a buyer’s corporate culture, as well as its ability to close a transaction. An evaluation of these factors will help ensure physician-owners that a new corporate investor will keep their distributions growing.

5. Healthcare real estate remains a profitable asset. Despite the economic challenges, the healthcare real estate market is still a viable means by which physicians can diversify their holdings.

“Healthcare real estate values have held up very well and we are obtaining very good offers for our clients,” says Mr. Vick. “As a result, physicians owning medical office buildings/ASC real estate can sell it at an attractive price and free up capital to further diversify their investments.

“There are some very desirable sale/leaseback deals offered by medical real estate investment trusts and private equity firms for physicians who own their ASC real estate and are interested in further diversification by selling their underlying real estate,” he says. “These sales are sometimes done at the same time as the sale of the ASC or separately, albeit to completely different buyers.”
Investment diversity is also part of physician owners’ desire to sell interests in their ASCs.

“Senior physicians, overweight in their ASC business and real estate investments, realize that selling a portion of their interest will help them diversify their assets so that upon retirement their retirement savings will be adequately diversified,” says Mr. Vick. “It is far better to sell an interest well before retiring to avoid significant discounting of a retiring partner’s value to the center.”

Ms. Kulvin (mrbones@the-beach.net) is a freelance writer based out of Surfside Fla.

**Growth of ASCs Outpace Number of Available ASC Physician-Owners**

A 2008 survey conducted by Deutsche Bank finds that currently there are an average 24 eligible surgeons per ASC. This number is down from more than 32 in 2000 and is likely to drop to a little more than 20 by 2010. Here is a summary of the Deutsche Bank data trending the number of eligible surgeons to ASCs:

- **In 1990**, there were 80,117 physicians and 1,326 ASCs. The number of eligible surgeons per ASC was 60.4.
- **In 1995**, there were 88,630 physicians and 2,057 ASCs. The number of eligible surgeons per ASC was 43.1.
- **In 2000**, there were 98,424 physicians and 3,028 ASCs. The number of eligible surgeons per ASC was 32.5.
- **In 2005**, there were 104,591 physicians and 4,506 ASCs. The number of eligible surgeons per ASC was 23.2.
- **Data from 2008** showed that there is an average of 24 eligible surgeons per ASC.
- **In 2010**, there will be an estimated 111,018 physicians and 5,482 ASCs. The number of eligible surgeons per ASC is estimated to be 20.3.

*Source: Deutsche Bank.*

**6 Factors Contributing to Increase in ASC Mergers and Acquisitions**

By Jonathan Vick

At ASCs Inc., we have seen a significant increase in surgery and endoscopy center acquisition and merger activity over the past 12 months with more deals and bigger deals than in previous years. We are also seeing higher multiples being offered due to more competition for good quality (less than 20 percent out-of-network) ASCs with growth potential. Here are six reasons for this increase in ASC transaction activity.

1. **Improved ASC financial performance.** We are seeing more centers that are doing very well, with high revenues, profits and earnings before interest, taxes, depreciation and amortization (EBITDA) margins. It is not unusual now to see physician-managed centers that have EBITDA margins of 40 percent or more. Many centers have added ancillary services to improve their financial performance and have attended seminars, such as those sponsored by the Ambulatory Surgery Center Association and ASC Communications, and have implemented the recommendations discussed. However, many have also seen their profit growth slowing and are seeking a sale to take some money off the table; at the same time, they attract a professional management company that will keep their distributions growing.

2. **Diversification opportunity.** The nation’s economic difficulties and the impact this has had on investment assets such as stocks and real estate have increased an awareness of the importance of asset allocation. Many surgeons are overweight in the investments they have in their ASC business and real estate and realize that selling a portion of their interest will help them diversify their assets. This becomes accentuated for senior physicians who are planning their retirement and want to make sure their nest egg is adequately diversified. It is far better to sell an interest well before retiring to avoid significant discounting of a retiring partner’s value to the center.

3. **Increased deal flow.** With more successful centers and more than 30 companies competing to acquire ASC interests, many centers are being bombarded with opportunities to sell a minority or majority share to a corporate partner. There are many good companies willing to buy minority interests and this makes a sale more attractive to many physicians as it allows them to retain a majority interest. For groups that want to take more money off the table, there is strong competition to buy majority interests as well. While it may be increasingly difficult for physicians to make a short list of the best 3-4 companies for them to solicit because of the growing number of companies, firms that specialize in ASC mergers and acquisition consulting can assist them to partner with the best companies and get the highest price.

4. **Higher prices.** Competition for good quality centers with growth potential has driven multiples higher. It is now common to see multiples for multi-specialty ASCs in the 7-8 times EBITDA (less debt, plus cash) range. We are now seeing offers only slightly below this range offered for single-specialty ASCs with significant cash flow and good growth opportunities. Minority interests are being valued in the 5-6 times EBITDA range. Buyers have money (some with credit lines of $200 million) and the credit crunch has not slowed their deal making.

5. **Incentives to sell: Capital gains taxes, adverse legislation.** We have seen a spike in ASC physician-owners wanting to make a sale now because of an expectation that capital gains taxes will increase in 2009 to pay for wars, Wall Street bailout, etc. This anticipation of an increase in the capital gains tax rate is providing a strong incentive to seek the sale of interests in ASCs prior to the enacting of new tax laws. Additionally, the fear of adverse legislation that could prohibit or restrict physician referrals to physician-owned ASCs, which could significantly reduce the value of all ASCs, is also a factor.

6. **Real estate sales.** Many physicians who own their medical office building (MOB)/ASC real estate are interested in further diversification by selling their real estate as well as their ASC. We have advised and assisted clients to obtain some very attractive sale/leaseback deals offered by medical real estate investment trusts and private equity firms. These sales are sometimes done at the same time as the sale of the ASC or separately, albeit to completely different buyers.

Mr. Vick (jonvick2@aol.com) is the founder and president of ASCs Inc. Mr. Vick has assisted in development, merger, and acquisition transactions for more than 200 physician-owned ASCs, endoscopy centers and surgical hospitals since 1984. Learn more about ASCs Inc. at www.asc-inc.com.
Historically, physician-owned centers that opened without corporate support have had an easier time doing well financially; then, if the physician-owners so chose, they could have their choice of corporate partners to whom to sell 51 percent of the ownership for a big payday. Unsuccessful centers could easily find corporate partners specializing in turnarounds willing to take them on.

The market downturn has caused a near-180 in the physician-owned-ASC-friendly atmosphere the industry has become accustomed to. Here, Joyce Deno, RN, the COO, Eastern Region, for Regent Surgical Health, discusses three trends in mergers and acquisitions that the ASC sector is seeing as a result.

1. Financing is tougher to obtain. “With less equity available and banks tenuous, it’s going to be harder to obtain de novo startup financing,” says Ms. Deno. And whether an established center is successful or unsuccessful, corporate partners are going to be more selective and are going to scrutinize more closely during due diligence because, “if they’re going to come in and buy 51 percent, it’s going to be harder for them to justify spending the capital on a facility that has only a minimal chance of survival or turnaround.”

2. There are still opportunities for joint-ventures and mergers with hospitals. With funding for purchasing shares in successful surgery centers difficult to come by and higher valuations tough to obtain, “I think we’re going to see more ASC joint-ventures with hospitals,” says Ms. Deno. “The payor market is shrinking to a few major payors, meaning there’s less ability to negotiate even marginally profitable contracts — in a lot of cases, payors are coming back with take-it-or-leave-it offers that would result in ASCs losing money on cases they perform.”

In other words, ASCs face serious financial challenges on more fronts than ever before, and this may prompt them to join with hospitals to present a stronger unit to payors and financial institutions alike.

“ASCs, a JV brings negotiating power, stability, less vulnerability,” says Mr. Deno. “ASCs can bring a large volume of cases under the hospital’s wing. If physicians and hospitals are open and receptive to what they can bring to each other, they will be able to provide better healthcare. Really, they need to band together to get through this time — and a lot of strong symbiotic relationships can come out of it.”

3. Another rough year — or even two — is on the horizon. There are two key reasons that the industry will likely remain in this trough before improvement is seen.

First, “Payors are probably losing money on the funds they’ve invested, so we’re going to see a lot of slow pays, and that hits down at the facility level,” says Ms. Deno. “More facilities counting on those day-to-day dollars may begin to fail. Those making marginal profits or hanging in there and doing well may want to look to a corporate partner or JV in order to spread their risk around.”

Second, it may take that long for things to settle at the consumer end.

“The banking and stock market situations are trickling down to patients; if they are losing jobs and insurance coverage and homes, unless it’s a very emergent situation, they won’t be spending co-pay and deductible dollars on elective surgery in the ambulatory setting,” she says. “Those with no insurance may look at ASCs as a lower-cost method for getting necessary procedures done, but they still may have a hard time paying. Until the whole job situation is turned around for the end users of healthcare, it’s going to be tough time.”

Ms. Deno (jdeno@regentsurgicalhealth.com) is the COO, Eastern Region, for Regent Surgical Health, which buys, develops and manages outpatient surgery centers and physician-owned hospitals, and specializes in turnaround situations. Learn more about Regent Surgical Health at www.regentsurgicalhealth.com.
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