

BVR'S GUIDE TO HEALTHCARE VALUATION 2009 EDITION

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What It's Worth

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What It's Worth

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Introduction

Healthcare is the single largest segment of the economy, the financial aspects of which are perhaps the least well understood. BVR's Guide to Healthcare Valuation brings together the country's top healthcare industry experts in the first comprehensive undertaking aimed at providing both preparers and users of valuation reports with an in-depth understanding of individual industry subsectors. From physician practices to home health care agencies, valuation across the continuum of medical care venues is addressed.

First and foremost, each member of the panel of valuation experts provides guidance consistent with the mandatory regulatory constraints on valuation assumptions and methodologies in the healthcare industry. Specific risks under the Stark Law and Anti-kickback statute are addressed in a separate chapter along with *real* advice on how to deal with them in a valuation engagement. The import of the nonprofit hospital sector is addressed in another chapter on inurement and tax exemption issues.

As will be clear to experienced healthcare appraisers and other readers alike, no valuation task can be accomplished without a thorough understanding of the market area in which the entity being valued operates. Despite the significance of national trends and the federal Medicare program in the valuation of healthcare enterprises, local differences in provider reimbursement by health insurers and individual state Medicaid programs lead to significant differences in operating results and value.

Notably, each of the valuation chapters provides keen insights on the significance of understanding the revenue cycle. The manner in which healthcare providers—such as physicians, hospitals, imaging or ambulatory surgery centers—are paid or reimbursed for their services varies radically. As such, an assumption about inflation or growth in per unit reimbursement appropriate for one of these sectors may be wholly inappropriate for another.

The largest number of provider entities and the most frequent valuation engagement involves physician practices and the Guide reflects this. In addition to a detailed valuation chapter, the Guide includes chapters on how to analyze CPT® codes and the use of MGMA data. Where a medical practice valuation is the most common form of healthcare valuation, the most common reason for that valuation is a divorce. Two chapters on the unique issues of divorce valuation are also included.

Physician business relationships with hospitals and other provider entities are perhaps the major driving force in the healthcare industry today and the Guide devotes six separate chapters to valuation issues in this growing market segment. I am certain the heretofore unseen scale of these comprehensive works will stand as a major contribution to the healthcare community's Body of Knowledge.

Buy-ins and buyout agreements and formulas among the owners of an entity, which are another frequent consulting, valuation and litigation engagement area, are addressed as well. Another chapter addresses the tax aspects of transactions, which can have a significant affect on the manner in which a valuation method is approached.

As Technical Editor for this Guide, I was particularly appreciative of the willingness of my friends and colleagues in the healthcare valuation discipline to share their vast knowledge, without reservation, in their specialty areas. The separate chapters devoted to ambulatory surgery, imaging, dialysis, home health and hospitals offer the valuation analyst information and insight usually obtainable only through hours of study and years of experience.

The Guide is rounded out with contributions from thought leaders in the broader healthcare community addressing such diverse areas as private equity, globalization, quality of care and issues to be addressed by an organization's Board of Directors. In addition, readers and users will benefit from discussions of the Cost of Capital and Valuation Standards by industry leaders. Finally, a number of chapters include checklists to aid the valuation analyst in the performance of the engagement.

On behalf of Business Valuation Resources and my co-editor, Cindy Eddins Collier, our thanks to all of the contributors for their hard work on behalf of their colleagues, who we are certain, will find BVR's Guide to Healthcare Valuation an important and valuable addition to their professional library.

Mark Dietrich, Technical Editor, October, 2008

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CHAPTER 25
AMBULATORY SURGERY CENTERS

Ambulatory Surgery Centers

By Todd Sorensen, MBA

As patient care continues to migrate from an inpatient setting to an outpatient setting, surgery-center transactions have become one of the most popular joint-venture relationships involving both for-profit and not-for-profit health-care providers and surgeons who perform outpatient surgery. Outside of engagements associated with physician practice transactions, valuation engagements associated with ambulatory surgery center (ASC) transactions have represented the highest volume healthcare segment for our firm. As with most healthcare segments, ensuring that transactions between potential referral source physician owners and healthcare systems occur within the range of fair market value is critical to compliance with the Stark Regulations, Federal Fraud and Abuse statutes and in some cases, state law.

Types of private ASC equity transactions include (1) controlling interests in stand-alone licensed free-standing surgery centers; (2) minority or non-controlling equity transactions in free-standing ASCs; and (3) controlling and non-controlling equity transactions in hospital outpatient departments re-licensed as free-standing ambulatory surgery centers. Each of these transactions typically has a different value.

Minority equity interests in private ASCs tend to trade at lower levels than controlling interests in those same ASCs. Surgery centers with little or no physician ownership tend to be valued lower than those with significant ownership. In general, valuations of any equity interest are based not only on external market factors but the facts and circumstances of the particular ASC being valued.

The ASC industry is highly fragmented, composed of several large publicly or privately owned companies and many small, independent operators. Of the 4,707 ASCs operating in the United States, only 969 facilities, or approximately 22%, are owned or managed by multi-facility chains. HealthSouth, AmSurg, USPI and HCA, Inc. are a few of the largest owners and operators.

The tides of change have come with an increasing market share of hospital-physician joint-venture ASCs. Health-care systems have begun to recognize the role of such a business model within the industry, and what was once considered a competitive threat is now viewed as an intriguing avenue of partnership to increase profit margins and improve relations with physicians.

This chapter provides an overview of the ASC segment, typical ASC legal structures, ASC financial performance and primary value drivers, and the most common ASC valuation applications.

Segment Overview

Ambulatory surgery refers to lower-acuity surgical procedures performed on an outpatient basis that do not require an overnight stay. These surgeries can occur in either a hospital outpatient (surgical) department (HOPD) or in a free-standing ASC.

ASCs offer a more productive and comfortable environment for both physicians and patients. A surgeon using an ASC can typically better maintain a schedule with more consistent weekly time blocked to schedule surgeries (block time) and quicker, more reliable turnaround times. Patients who receive treatment at an ASC benefit from a convenient, less-institutionalized environment, streamlined care, specialized services and proven lower infection rates.

ASCs provide the surgical equipment and supplies, specialized personnel, and other support services that enable their surgeon-users to perform surgeries. Physicians typically do not pay for these services. Instead, the ASC bills a technical fee, or facility fee, to the patient or payor. The physician bills a professional fee separately. The ASC neither employs nor pays compensation to the surgeon-users. Consequently, an ASC's success or failure relates directly to its ability to provide the necessary technical services to enable its surgeon-users to perform their surgical cases.

History of ASCs

The idea of performing outpatient surgery first materialized in 1966, in an article in the Journal of the American Medical Association (JAMA). Shortly thereafter, the health insurance industry began exploring alternatives to the high costs associated with procedures in hospitals, and the U.S. National Advisory Commission on Health Facili-

Ambulatory Surgery Centers

ties began experimenting with ways to lower them. In 1970, the first ASC opened. In 1971, the American Medical Association (AMA) endorsed ASCs performing surgery under general and local anesthesia for selected procedures and patients. By 1976, 67 ASCs existed around the country.

Although the government, through Medicare, began collaborating with six ASCs in 1974, it wasn't until 1982 that the program approved payment for 200 selected procedures performed in ASCs. Today Medicare, Medicaid and private insurers allow and pay for more than 3,300 procedures performed in ASCs, and these numbers are expected to grow. Approved procedures generally are those offered in a hospital inpatient setting that also can be performed safely in outpatient facilities. ASC-approved procedures generally require less than 90 minutes of operating-room time, less than four hours of recovery-room time and no overnight stay.

Expanded acceptance by Medicare and other payors has led to large growth in the number of ASCs and total procedures performed. For example, the number of Medicare-certified ASCs grew at an average annual rate of 8% from 1999 to 2005. During that same period the Centers for Medicare & Medicaid Services (CMS) noted an annual average of 337 new Medicare-certified ASCs. There are currently close to 4,500 Medicare-certified facilities nationwide. There are an additional 500 ASCs that are not Medicare-certified.

Total Medicare payments for ASC services have continued to grow at a rapid pace. For example, data show that Medicare payments to ASCs more than quadrupled between 1992 and 2005. Payments increased by 15% per year, on average, from 1999 to 2005. Surgery case growth (as a percentage) peaked in 1996 and has slowed to a current rate of near 6%.

Certificate of need requirements

Some states require a certificate of need (CON) to operate an ASC. A CON is a regulatory review process that evaluates whether a proposed service or facility is actually needed in a specific market. Those subject to CON regulations include hospitals, nursing homes, outpatient surgery centers and anyone purchasing medical equipment valued above certain state-determined thresholds.

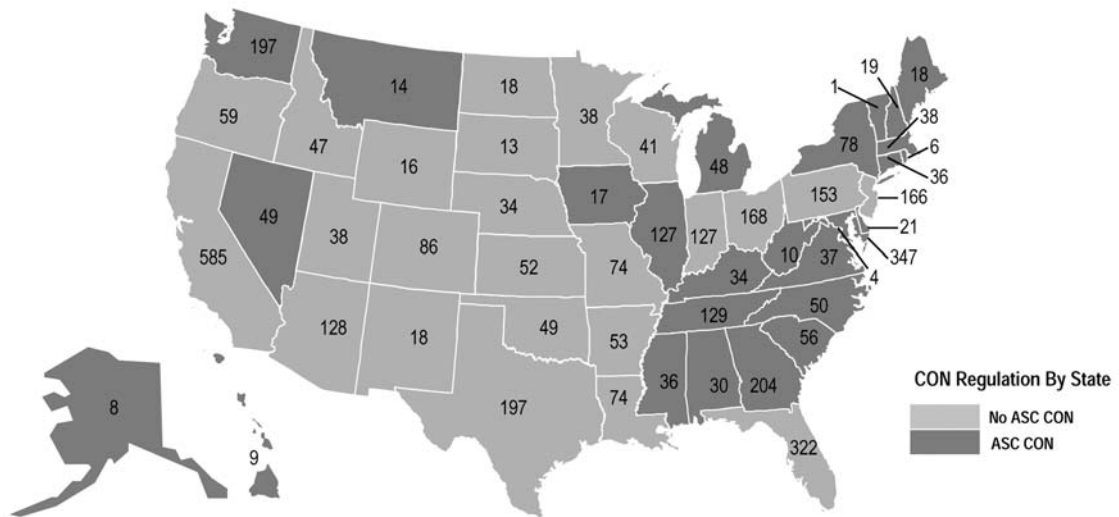
The CON mandate began in response to overwhelming requests for federal funding spurred by the 1946 Hill-Burton Program, which matched grants for the construction of hospitals in medically under-served areas. Congress needed to infuse effective measures to appropriately manage the billions of dollars in federal assistance being requested in response to the program.

In 1974, Congress passed the National Health Planning and Resources Development Act, offering states powerful incentives to enact laws implementing CON programs. By 1980, all states but Louisiana had one. Congress repealed the federal law in 1986 and many states have since relaxed or eliminated CON laws.

Exhibit 1 illustrates the states that require a CON, those that do not, and the number of Medicare-certified ASCs in the United States in 2005.

Ambulatory Surgery Centers

Exhibit 1



ASC growth

That healthcare costs have increased at rates in excess of inflation is considered the primary factor in the development and increased use of surgery centers. Procedures performed in an outpatient setting generally cost between 30 and 60% less than the same procedures performed in a hospital. As a result, Medicare, managed care and other payors have encouraged moving procedures to ASCs.

While cost containment was the initial driver in the growth of ASCs, current growth in the industry is also driven by advantages to both patients and physicians. In a survey completed by the Office of the Inspector General (OIG), part of the U.S. Department of Health and Human Services (HHS), Medicare beneficiaries who underwent procedures in ASCs strongly preferred the facilities to hospitals.¹ Reasons included less paperwork, lower costs, more convenient locations, better parking, less wait time, better organization and friendlier staff. The study also determined that ASCs provided safety and post-operative care comparable to a hospital.

For physicians, the benefits of performing surgeries in ASCs go beyond increased patient satisfaction. Not only are their patients happier, but they can also achieve larger volumes and greater economies of scale. Unlike doctors at a hospital that provides a variety of surgical procedures and uses an array of supplies and equipment, doctors at free-standing surgery centers typically focus on a few select procedures. This increases patient turnaround time and decreases time between surgeries because the operating room needs minimal preparation for the next patient.

Physicians who act as partial owners or investors in the venture (by partnering with an ASC management chain like AmSurg or United Surgical Partners International (USPI), for example), have an additional incentive to prefer the ASC environment: they earn income for the procedures they perform. In other words, physicians capture a portion of a technical fee not accessible to them at a hospital.

Technological developments also have contributed to substantial growth in the ASC segment. Advances in laser, endoscopic and arthroscopic minimally invasive procedures have allowed for more variance in the array of procedures conducted at ASCs.

Demand for outpatient surgery will continue to increase during the next decade, driven by growth in the 55-plus population, as baby boomers shift into the senior-citizen bracket. This is largely because utilization rates for many outpatient surgical procedures appear to correlate directly with age. Population growth alone could drive a 2% annual increase in ambulatory surgical procedures through 2010.

Ambulatory Surgery Centers

Changes in Medicare payment system for ASCs

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) set in motion some much-anticipated changes to the ASC payment system. Through the MMA, CMS eliminated the update for ambulatory surgical center services for fiscal year 2005, changed the update cycle to a calendar year, and eliminated updates for calendar years 2006 through 2009. The MMA also removed the requirement that CMS survey ASCs' costs and charges every 5 years. It also asked the General Accounting Office (GAO) to study the relative cost of services in ASCs and HOPDs and determine whether the outpatient prospective payment system's (OPPS) procedure groups reflected ASC procedures. The results of this study formed the basis for the 2007 Proposed ASC Rule.

On August 8, 2006, CMS unveiled its proposal for a new ASC payment system. On January 1, 2008, CMS implemented the new system for payments to ASCs for the provision of medical services to Medicare beneficiaries. Exhibit 2 gives a brief description of the major events leading up to the implementation of the new system.

Exhibit 2

NEW ASC PAYMENT SYSTEM TIMELINE	
1998	CMS proposes a new ASC payment system and a new hospital outpatient department ("HOPD") payment system.
2000	CMS Begins paying HOPD using prospectively determined rates for bundles of services, called APCs. Congress prohibits CMS from implementing a new system for ASCs without a new cost survey.
2003	Congress requires CMS to implement a new ASC payment system by January 1, 2008, and freezes ASC payment rates through 2009.
2005	Introduction of Ambulatory Surgical Center Medicare Payment Modernization Act of 2005 (legislation) by Congressman Herger (R-CA) and Senator Crapo (R-ID).
2006	CMS issues proposed rule detailing its recommendations for a new payment system.
2007	On August 2, 2007, CMS issues a final rule establishing a new payment system for ASCs, including the methodology to be used in determining rates, and proposes rates for 2008. On November 27, 2007, CMS issues final rates for 2008.

The new payment system is similar to the old Medicare payment system in that CMS pays ASCs a facility fee intended to cover the non-professional costs associated with providing a surgical procedure. But instead of categorizing payments into one of nine groupers, the new payment is based on one of 201 ambulatory payment classifications (APCs). Medicare uses the same APCs for ASCs and HOPDs. Each procedure performed is assigned a common procedural terminology (CPT) code which in turn cross-walks to an APC, and each APC has a specific payment rate. But because CMS will continue to report payment rates by CPT code, ASCs will continue to bill and collect from Medicare using CPT codes.

Though ASCs and HOPDs both use APCs, payment rates vary between the two. The rate paid to an HOPD for each APC is based on relative weight, a measurement that ranks the costs to perform the procedures in one APC compared to the costs of those in another. CMS determines the relative weight for each APC using hospital cost reports. The relative weight is then multiplied by a uniform dollar conversion factor to get the national HOPD payment rate. ASCs payment is a percentage of the national HOPD rate. For 2008, ASCs received, on average, 65% of HOPD payments.

Medicare reimbursed ASCs for providing 3,390 surgical procedures in 2008, 819 more than were reimbursable in 2007. Some of the new procedures will realize reimbursement significantly higher than 65% of HOPD rates. For example, procedures that requires use of a device estimated to cost more than 50% of the procedure's total APC

Ambulatory Surgery Centers

reimbursement, the ASC payment rate includes the same dollar value that an HOPD receives for the device, without any discount. Forty-five ASC device-intensive procedures will be reimbursed in this fashion.

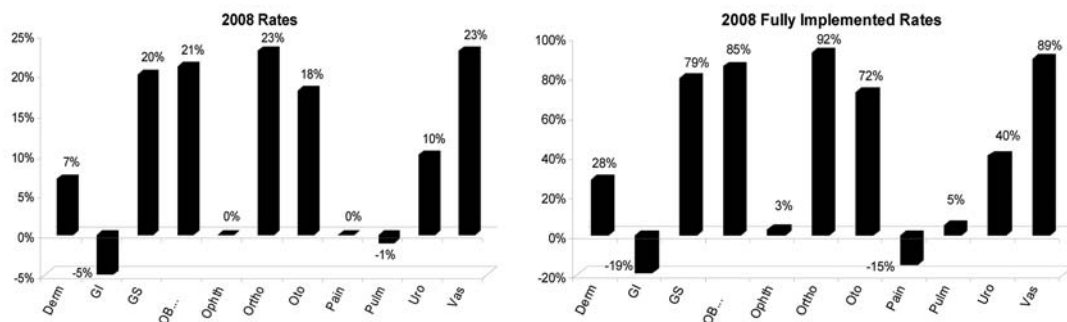
Approximately 44% of the new procedures have reimbursement rates lower than the 65% HOPD conversion factor. For procedures performed in physician offices more than 50% of the time, the ASC payment is the lesser of either the payment rate determined using the HOPD conversion factor or the amount Medicare typically pays the physician for performing the procedures in the office. This payment methodology only applies to new procedures introduced under the new payment system, not to procedures on the list in 2007.

When it comes to multiple procedures, the policy in effect prior to the implementation of the new payment system will remain. ASCs will earn 100% for the primary procedure (defined as the one with the highest reimbursement rate), and 50% for each additional procedure. Certain procedures are not subject to the multiple procedure discount; the classification of these procedures hasn't changed.

CMS established a four-year transition period for procedures already on the ASC list, to give individual ASCs more time to adjust to the new payment system. In 2008, Medicare ASC payment rates for these procedures will be based on a blended rate of 75% of the 2007 ASC payment rates and 25% of the amount Medicare would have paid in 2008 under the new system. In 2009, the ASC rate will be based 50% on the 2007 rate and 50% on the 2009 rate. In 2010, the payment will be made based on 25% and 75% of those respective payment rates, and in 2011, the transition will be complete.

The new payment methodology will affect surgical specialties differently. Using the 2008 rates, the Federated Ambulatory Surgery Association (FASA), which has since been merged with the American Association of Ambulatory Surgery Center (AAASC) to form the Ambulatory Surgery Center Association (ASCA) estimated a 5% decline for GI rates and a 23% increase for orthopedics. FASA estimates that once fully implemented, the new payment system will cause an overall decline of 19% for GI and an overall increase of 92% for orthopedics. FASA's analysis, detailed in the November/December *Update Magazine*, is summarized in Exhibit 3.

Exhibit 3



Under the new payment system, Medicare will reimburse nine of the 10 highest-volume procedures performed in ASCs at a lower rate. According to CMS, the overall lower payment rates, taking into consideration the 819 newly covered procedures, will result in the same total 2008 Medicare spending on ASCs than if a new payment system had not been adopted.

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Typical ASC Legal Structures

Typically, ASC entities are either structured as limited liability corporations (LLCs) or limited partnerships (LPs). In name and in legal form, these entities may differ, but they are similarly governed by the applicable agreement governing operations associated with ASCs, the operating agreement for LLCs and the partnership agreement for LPs.

The most critical elements that may affect the valuation of assets or an interest in an ASC include:

- Cash distributions
- Ownership restrictions
- Buy/sell provisions

In particular, these elements in turn have a direct or indirect impact on minority and marketability issues flowing from the valuation of an interest in an ASC.

Cash distributions

Most ASC operating or partnership agreements include detailed provisions that provide for the distribution of virtually all of the discretionary cash on at least a quarterly, and sometimes monthly, basis. Since the cash distributions are normally defined in this manner, this may reduce the impact of any applicable discounts for both lack of control and lack of marketability.

Ownership restrictions

As previously discussed, federal regulations allow physicians who perform surgery in and refer patients to ASCs, to maintain ownership in an ASC. In order to fit in a safe harbor from the federal fraud and abuse statutes, physicians who maintain an ownership interest in an ASC must:

1. Derive one-third of their professional income from outpatient surgery; and
2. Perform one-third of their eligible cases in the ASC in which they invest.

Through the relevant operating or partnership agreement, some ASCs require that all physician owners meet both of these one-third tests to maintain ownership in the ASC while other ASCs are more flexible and the terms for maintaining ownership are less defined. Not all, but most ASCs require that physician owners be approved for admission to ownership and that they be redeemed upon their disability, retirement or move from their service area.

Buy/Sell

In either case (purchase or redemption), most ASC operating or partnership agreements require that physicians are redeemed or purchase shares at either fair market value or an amount based on a formula – often 3 to 4 times EBITDA less interest-bearing debt. While on occasion ASC operating or partnership agreements may in effect penalize owners selling an interest, more often than not the buy/sell provisions ensure that the amount received for a redemption is either at or similar to fair market value.

To summarize, the provisions for cash distributions, ownership and buy/sell arrangements typically included in ASC operating or partnership agreements reduce the impact of lack of control and marketability for non-controlling equity interests.

Typical ASC Financial Structure and Performance

All facilities are different. However, VMG HEALTH annually completes benchmarking studies. The *Endoscopy Intellimarker Study* and *Multi-Specialty Intellimarker Study* are based on analyses of actual detailed financial and operating performance information from more than 300 endoscopy and multi-specialty surgery centers across the United States. Exhibits 4 through 6 summarize the aggregate statistical analysis of the income statements from the *Multi-Specialty ASC Intellimarker 2007*. Our observations on this data then follow.

Ambulatory Surgery Centers

Exhibit 4 Income Statement

<i>\$ in thousands</i>	Mean	Standard Dev.	25%	Median 50%	75%	90%
Patient Revenues						
Gross Charges	\$ 20,233	\$ 14,736	\$ 9,921	\$ 16,637	\$ 27,454	\$ 42,356
Adjustments	(13,914)	11,323	(17,998)	(10,781)	(6,211)	(3,086)
Net Revenue	6,768	5,461	3,638	5,647	8,945	11,940
Operating Expenses						
Employee Salary & Wages	1,491	936	884	1,305	1,869	2,677
Employee Taxes & Benefits	320	318	173	273	419	580
Occupancy Costs	429	319	221	393	540	769
Medical & Surgical Supplies	1,338	952	710	1,158	1,739	2,498
Other Medical Costs	335	930	30	99	262	721
Insurance	70	58	33	53	89	136
Depreciation & Amortization	305	219	152	252	401	575
General & Administrative						
Bad Debt	133	161	48	86	154	275
Management Fees	282	245	133	250	356	488
Other G & A	593	476	317	501	729	1,063
Total G & A	881	531	495	774	1,141	1,540
Total Operating Expenses	4,903	2,720	2,966	4,379	6,233	8,536
Operating Income	1,812	3,965	199	1,183	2,512	4,194
Other Expense (Income)	100	(550)	-	(3)	(13)	(75)
Net Interest Expense	73	128	3	43	107	195
Earnings Before Taxes	1,734	3,949	172	1,128	2,575	4,029
EBITDA	\$ 2,117	\$ 4,000	\$ 417	\$ 1,519	\$ 2,797	\$ 4,595

VMG HEALTH Multi-Specialty ASC Intellimarker 2007

Exhibit 5 Common Size Income Statement

	Mean	Standard Dev.	25%	Median 50%	75%	90%
Patient Revenues						
Gross Charges	298.9%	269.8%	272.7%	294.6%	306.9%	354.7%
Adjustments	-205.6%	207.3%	-494.7%	-190.9%	-69.4%	-25.8%
Net Revenue	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Operating Expenses						
Employee Salary & Wages	24.9%	10.9%	19.0%	23.5%	29.0%	35.2%
Employee Taxes & Benefits	5.5%	6.7%	3.7%	4.8%	6.2%	7.5%
Occupancy Costs	8.5%	7.4%	3.9%	6.7%	10.3%	17.0%
Medical & Surgical Supplies	21.5%	10.1%	17.3%	20.9%	25.5%	30.7%
Other Medical Costs	4.6%	10.4%	0.6%	1.6%	3.7%	8.9%
Insurance	1.2%	1.1%	0.6%	1.0%	1.6%	2.4%
Depreciation & Amortization	5.9%	5.1%	2.9%	4.4%	7.1%	11.2%
General & Administrative						
Bad Debt	2.1%	1.9%	1.0%	1.9%	2.3%	4.0%
Management Fees	4.6%	2.8%	3.0%	4.8%	5.6%	6.6%
Other G & A	10.0%	6.7%	6.3%	8.5%	12.2%	18.1%
Total G & A	14.8%	7.9%	10.5%	13.1%	18.2%	23.9%
Total Operating Expenses	82.4%	36.0%	65.7%	77.8%	93.7%	113.8%
Operating Income	16.8%	35.4%	5.5%	22.1%	34.1%	44.5%
Other Expense (Income)	0.9%	-4.9%	0.0%	-0.1%	-0.3%	-1.2%
Net Interest Expense	3.0%	2.9%	0.1%	0.8%	2.1%	4.3%
Earnings Before Taxes	15.6%	36.5%	4.9%	20.3%	33.6%	43.4%
EBITDA	22.6%	32.5%	11.2%	26.4%	38.5%	48.8%

VMG HEALTH Multi-Specialty ASC Intellimarker 2007

Ambulatory Surgery Centers

Exhibit 6 Operating Expense Analysis

<i>as a % of Net Revenue</i>	Standard		Median			
	Mean	Dev.	25%	50%	75%	90%
Employee Salary & Wages	24.9%	10.9%	19.0%	23.5%	29.0%	35.2%
Employee Taxes & Benefits	5.5%	6.7%	3.7%	4.8%	6.2%	7.5%
Occupancy Costs	8.5%	7.4%	3.9%	6.7%	10.3%	17.0%
Medical & Surgical Supplies	21.5%	10.1%	17.3%	20.9%	25.5%	30.7%
Other Medical Costs	4.6%	10.4%	0.6%	1.6%	3.7%	8.9%
Insurance	1.2%	1.1%	0.6%	1.0%	1.6%	2.4%
General & Administrative	14.8%	7.9%	10.5%	13.1%	18.2%	23.9%
Total Operating Expenses	76.9%	32.9%	61.5%	73.3%	88.7%	104.4%
<i>per Square Foot</i>						
Employee Salary & Wages	\$ 117.70	\$ 133.74	\$ 74.41	\$ 102.36	\$ 127.58	\$ 167.78
Employee Taxes & Benefits	24.41	28.38	15.29	20.98	26.87	35.22
Occupancy Costs	31.71	17.91	22.27	31.89	40.34	48.01
Medical & Surgical Supplies	110.74	180.46	63.08	88.42	119.09	149.91
Other Medical Costs	37.34	130.29	2.41	9.31	17.82	34.74
Insurance	5.55	6.06	2.52	4.17	6.36	10.45
General & Administrative	69.68	68.82	40.09	56.00	82.35	107.29
Total Operating Expenses	\$ 368.20	\$ 435.96	\$ 244.20	\$ 316.85	\$ 389.64	\$ 483.72
<i>per OR (\$'s in thousands)</i>						
Employee Salary & Wages	\$ 358.9	\$ 159.8	\$ 257.7	\$ 328.3	\$ 448.2	\$ 567.6
Employee Taxes & Benefits	79.4	73.7	48.7	69.4	98.3	126.4
Occupancy Costs	107.8	65.3	64.4	101.9	136.7	200.0
Medical & Surgical Supplies	324.4	164.2	204.3	310.3	425.3	531.5
Other Medical Costs	74.3	188.9	8.9	29.8	58.5	129.9
Insurance	17.8	13.7	8.9	13.8	22.6	32.5
General & Administrative	216.2	109.6	135.9	200.7	272.5	360.2
Total Operating Expenses	\$ 1,121.4	\$ 447.5	\$ 800.0	\$ 1,056.9	\$ 1,426.2	\$ 1,749.1
<i>per Case</i>						
Employee Salary & Wages	\$ 343.00	\$ 132.97	\$ 254.90	\$ 318.58	\$ 407.36	\$ 525.57
Employee Taxes & Benefits	70.49	32.58	48.60	67.05	88.68	119.40
Occupancy Costs	117.55	107.72	47.55	91.01	148.03	226.98
Medical & Surgical Supplies	304.23	148.45	210.47	277.22	362.79	494.66
Other Medical Costs	52.06	112.45	6.59	20.08	47.09	81.87
Insurance	17.00	14.49	8.59	13.94	20.24	29.33
General & Administrative	205.95	115.39	128.62	182.49	254.15	348.50
Total Operating Expenses	\$ 1,069.40	\$ 437.13	\$ 768.83	\$ 995.39	\$ 1,250.06	\$ 1,641.77

VMG HEALTH Multi-Specialty ASC Intellimarker 2007

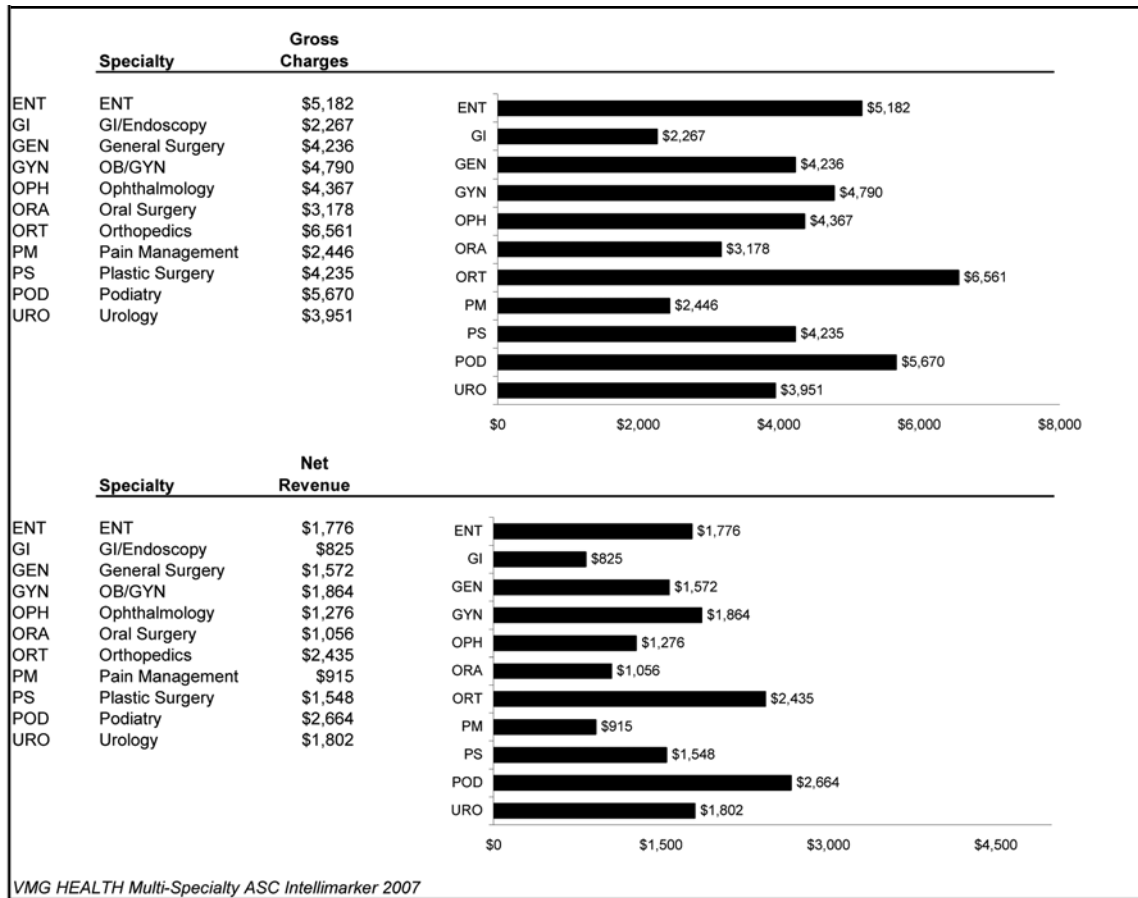
Income statement observations

Median net revenue, or reimbursement for ASCs participating in the *Multi-Specialty ASC Intellimarker 2007* is \$5.6 million and median earnings before interest taxes depreciation and amortization (EBITDA) is \$1.5 million. The single largest expense component is employee cost, including salaries, wages, taxes and benefits, representing 28% of net revenue. Median medical and surgical supplies costs represent 21% of net revenue. Median EBITDA is 26% of net revenue.

Net revenue for ASCs is driven by volume and specialty mix and varies widely across the spectrum of specialties. Exhibit 7 summarizes the median net revenue per case by specialty from the *Multi-Specialty ASC Intellimarker 2007*.

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Exhibit 7 Revenue per Case



From the *Multi-Specialty ASC Intellimarker 2007*, net revenue per case ranges from \$825 for GI/Endoscopy and \$915 for Pain Management on the low end, to \$2,435 for Orthopedics and \$2,664 for Podiatry on the high end.

While there is some variability in operating expenses from center to center, the largest components—employee costs and medical and surgical supplies—are both driven primarily by the case specialty mix in an ASC. Generally speaking, less complex cases such as those procedures for GI/Endoscopy and Pain require fewer staffing hours and supplies than more complex cases such as those in Orthopedics. Exhibit 8 contrasts costs per case for ASCs doing only GI/Endoscopy and ASCs with greater than 50% Orthopedics.

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Exhibit 8 Operating Expense Analysis Comparison

	Median		
	GI	All MS	MS > 50% Ortho
as a % of Net Revenue			
Employee Salary & Wages	22.3%	23.5%	23.3%
Employee Taxes & Benefits	5.2%	4.8%	4.4%
Occupancy Costs	4.3%	6.7%	6.9%
Medical & Surgical Supplies	7.6%	20.9%	22.5%
Other Medical Costs	1.8%	1.6%	1.1%
Insurance	1.2%	1.0%	0.9%
General & Administrative	13.8%	13.1%	11.9%
Total Operating Expenses	60.0%	73.3%	70.2%
per Case			
Employee Salary & Wages	\$ 135.92	\$ 318.58	\$ 369.58
Employee Taxes & Benefits	36.86	67.05	64.98
Occupancy Costs	27.14	91.01	114.44
Medical & Surgical Supplies	44.63	277.22	372.91
Other Medical Costs	10.44	20.08	14.92
Insurance	5.94	13.94	15.69
General & Administrative	99.37	182.49	192.76
Total Operating Expenses	\$ 368.60	\$ 995.39	\$ 1,147.94

VMG HEALTH Endoscopy Intellimarker 2007 and Multi-Specialty ASC Intellimarker 2007

Unlike employee costs and medical and surgical supplies per case, median employee costs and medical and surgical supplies as a percentage of net revenue are fairly consistent across the spectrum of case complexity from GI/Endoscopy to greater than 50% Orthopedics.

Since the most significant operating expense categories tend to vary somewhat consistently with revenue, the primary driver of surgery-center profitability is relative reimbursement levels. Relative reimbursement levels are, in turn, determined by both the payor mix and an individual center's commercial reimbursement. Government payors such as Medicare and Medicaid tend to reimburse ASCs less than commercial or managed care payors. Local market conditions and/or the strength of the ASC's commercial and managed care contracts may affect that ASC's relative commercial reimbursement.

Balance sheet observations

Median total assets for ASCs participating in the *Multi-Specialty ASC Intellimarker 2007* is \$3.0 million and median long-term debt is \$1.0 million. Median total current assets and net property, plant and equipment represent 44% and 48% of total assets, respectively. Median long-term debt is 32% of total assets. In comparison to the income-statement categories, the standard deviation for balance-sheet categories, and in particular, long-term debt, is much higher.

Exhibits 9 and 10 demonstrate the aggregate statistical analysis of the balance sheets from the *Multi-Specialty ASC Intellimarker 2007*.

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Exhibit 9 Balance Sheet

<i>\$'s in thousands</i>	Mean	Standard Dev.	25%	Median 50%	75%	90%
ASSETS						
Cash & Equivalents	\$ 463	\$ 763	\$ 50	\$ 263	\$ 735	\$ 1,386
Net Accounts Receivable	674	1,007	379	645	1,062	1,555
Other Current Assets	471	1,187	146	261	452	1,096
Total Current Assets	1,608	1,383	735	1,428	2,179	3,099
Gross PP&E	2,817	2,363	1,063	2,122	4,050	5,716
Accumulated Depreciation	(1,684)	1,281	(2,465)	(1,698)	(574)	(198)
Net PP&E	1,464	1,599	732	1,163	2,210	3,467
Other Assets	930	2,041	22	209	881	2,518
Total Assets	\$ 3,673	\$ 3,545	\$ 1,616	\$ 3,023	\$ 4,705	\$ 7,647
LIABILITIES						
Current Liabilities	\$ 504	\$ 507	\$ 218	\$ 378	\$ 651	\$ 968
Current Portion of LTD	358	390	91	215	454	857
Total Current Liabilities	589	567	242	448	783	1,210
Total Long-Term Debt	1,504	1,731	328	977	2,057	3,674
Other LT Liabilities	186	588	3	15	86	333
Total Liabilities	1,836	1,963	604	1,336	2,426	3,974
EQUITY						
Total Shareholders' Equity	2,177	2,731	695	1,586	2,790	4,743
Total Liabilities & Equity	\$ 3,673	\$ 3,545	\$ 1,616	\$ 3,023	\$ 4,705	\$ 7,647

VMG HEALTH Multi-Specialty ASC Intellimarker 2007

Exhibit 10 Common Size Balance Sheet

	Mean	Standard Dev.	25%	Median 50%	75%	90%
ASSETS						
Cash & Equivalents	17.3%	37.3%	1.4%	9.0%	20.3%	36.6%
Net Accounts Receivable	20.5%	24.0%	13.0%	19.1%	33.3%	42.2%
Other Current Assets	12.0%	22.4%	4.5%	8.0%	15.0%	30.1%
Total Current Assets	46.3%	33.3%	27.7%	44.1%	62.1%	75.3%
Gross PP&E	58.3%	35.6%	32.6%	58.8%	80.2%	94.4%
Accumulated Depreciation	-43.1%	41.4%	-65.4%	-38.9%	-14.9%	-7.1%
Net PP&E	47.1%	23.7%	30.6%	47.9%	64.6%	77.0%
Other Assets	15.3%	22.7%	0.8%	5.8%	26.7%	46.6%
Total Assets	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%
LIABILITIES						
Current Liabilities	15.1%	55.0%	6.8%	11.6%	20.9%	35.3%
Current Portion of LTD	17.3%	33.8%	3.3%	7.1%	13.5%	46.3%
Total Current Liabilities	19.6%	60.3%	7.2%	13.4%	27.1%	52.4%
Total Long-Term Debt	40.4%	57.2%	12.7%	32.4%	56.2%	82.5%
Other LT Liabilities	4.2%	11.8%	0.1%	0.3%	2.8%	8.4%
Total Liabilities	53.4%	93.5%	22.4%	43.3%	73.0%	118.3%
EQUITY						
Shareholders' Equity	49.5%	37.5%	31.6%	57.4%	77.9%	91.4%
Total Liabilities & Equity	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%

VMG HEALTH Multi-Specialty ASC Intellimarker 2007

Does the past tell us anything about the future?

Yes. No. Maybe. Maybe not. It depends. These all could be appropriate answers in a given situation. Whether an appraiser attempts to attach an appropriate market multiple to historical earnings or to develop "most likely case" projections, the future is much more important than the past. For ASCs with a substantial portion of Medicare revenue (and all other things equal), changes in the Medicare payment methodology over the next four years may

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affect revenue significantly. ASCs with a substantial portion of out-of-network revenue, (and all other things equal) the sustainability of maintaining relatively high out-of-network reimbursements, is in question. In other words, there is a substantial “risk” in relying on the past to project future performance.

ASC risk-assessment matrix

It's important to look at the inherent risks of investing in an ASC. To do so, we'll look at a tool developed by Jon O'Sullivan of VMG HEALTH that measures risk along the following lines:

- contracting
- service-area growth
- competition
- physician ownership
- non-owner utilization
- concentration by specialty
- out-of-network concentration
- staff and supplies efficiency
- location
- condition of the facility and equipment

See Exhibit 11 for the complete ASC Risk-Assessment Matrix.

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Exhibit 11 Risk Matrix

Risk Metric		Risk Metric: Sub-categories				
Description	Weight	1 (Highest Risk) to 5 (Lowest Risk)				
		Description	Weight	Rating	Grade	Total
Partnership Operating Agreement	3.0%	Buy/Sell Provisions: Voluntary/Involuntary (A1)	30.0%	5.0		0.05
		Covenants Not to Compete (A2)	30.0%	5.0		0.05
		Eligibility Rqmts: Safe Harbors, Active Staff (A3)	20.0%	5.0		0.03
		Governance Structure: GP/LP, LLC, LLP (A4)	10.0%	1.0		0.00
		Partnership Structure Sustainability/Legal Life (A5)	10.0%	5.0	84%	0.02
Partnership Distribution History	3.0%	Minority Distribution: Terms and History (A6)	40.0%	5.0		0.06
		5 year history of distributions (A7)	30.0%	5.0		0.05
		Percentage of Available Cash (A8)	30.0%	5.0	100%	0.05
Partnership Ownership	10.0%	Percent of Revenue Produced by Owners (B1)	30.0%	5.0		0.15
		Specialty Mix (B2)	25.0%	5.0		0.13
		Age Dispersion (B3)	25.0%	4.0		0.10
		Number of Physician Owners (B4)	20.0%	3.0	85%	0.06
Concentration of Surgical Specialty	5.0%	Volume Concentration by Specialty (D2)	50.0%	4.0		0.10
		Revenue Concentration by Specialty (D3)	50.0%	4.0	80%	0.10
Physician Utilization Profile	27.0%	Revenue Dispersion Among Owners (B5)	30.0%	2.0		0.16
		Revenue Dispersion Among Non Owners (C1)	15.0%	5.0		0.20
		Volume Growth History (D1)	12.5%	2.0		0.07
		Ownership by Utilizers in Competing Centers (B6)	12.5%	3.0		0.10
		Individual Physician Volume Retention (B7)	15.0%	3.0		0.12
		Physician Retention Risk (B8)	15.0%	2.0	57%	0.08
Market Reimbursement Risk Analysis	25.0%	Revenue Concentration by Payor (E1)	15.0%	4.0		0.15
		Percentage of out of network business (E2)	60.0%	2.0		0.30
		Commercial Reimbursement Relative to Medicare (E3)	10.0%	5.0		0.13
		Pending Legislation Impacting Reimbursement (E4)	15.0%	3.0	70%	0.11
Market Competition Profile	15.0%	Health system competition (A13)	20.0%	2.0		0.06
		Freestanding surgery center competition (A14)	25.0%	1.0		0.04
		Potential For New Centers (A15)	20.0%	2.0		0.06
		Market Demographic Growth (A16)	15.0%	2.0		0.05
		Percentage of Physicians with no ASC Investment (A17)	20.0%	1.0	32%	0.03
Barrier to Entry Analysis	5.0%	Existence of Certificate of Need (A11)	50.0%	5.0		0.13
		Managed Care Barriers (A12)	50.0%	5.0	100%	0.13
ASC Management/Expense Efficiency	2.0%	Relative Staff Efficiency (F1)	30.0%	5.0		0.03
		Relative Supply Cost Efficiency (F2)	30.0%	3.0		0.02
		Existence of Labor Unions (A9)	20.0%	5.0		0.02
		Geographic Cost Index (F3)	20.0%	3.0	80%	0.01
ASC Physical Attributes	5.0%	Location in Relation to Affiliated Acute Care Hospital (A10)	40.0%	1.0		0.02
		Age and Condition of Facility (G1)	20.0%	4.0		0.04
		Facility Location Sustainability (G2)	30.0%	4.0		0.06
		Capital Equipment Obsolescence (G3)	10.0%	4.0	65%	0.02
Total Risk Score	100.0%					3.05

Note: If any Risk Metric Category has a Grade of less than 60%, a FMV analysis should be conducted

The ASC Risk-Assessment Matrix produces a single score but gives different weights to different categories and sub-categories based on their relative importance to measuring risk. The weighting may be adjusted based on specific facts and circumstances, but typically, the highest weights are assigned to categories that directly affect volume and reimbursement expectations (e.g., the physician utilization profile, market reimbursement risk analysis and market competition).

Primary ASC Value Drivers

An ASC is an accumulation of the practices of the individual surgeons using the facility. Physician practices may be generally characterized as growing, mature or declining. To assess where an ASC falls on this continuum and the potential for its volume growth, it is critical to analyze the historical case volume by physician, by specialty. If, for example, the largest physician utilizers of an ASC are, for the most part, approaching the end of the mature stage of their respective practices, the current volumes and earnings may be relatively strong. However, this may not translate into expectations for growth or a strong future.

Remember, also, that 2008 is the first year of the transition from a payment system based on ASC groupers to one based on a percentage of HOPD APCs. While this move was designed to be neutral overall to Medicare payments,

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it will result in significant financial losses for GI/Endoscopy and Pain cases and significant gains for Orthopedics and General Surgery. For multi-specialty ASCs with a balanced case mix, this change may not affect overall revenues and earnings. However, ASCs with a concentration in one or more of the specialties significantly affected may win or lose big.

In addition, projected reimbursement should take into account out-of-network payments. In many states, large commercial/managed care payors such as Blue Cross have developed state-wide fee schedules that apply to all contracted (in-network) ASCs. Rather than simply accepting the relatively low rates, which may range between 110 and 130% of Medicare, ASCs using an out-of-network strategy may collect significantly more based on the usual and customary rates. Because reimbursement may be higher out-of-network, a large number of ASCs contract with few or no commercial or managed care payors.

However, many commercial and managed care payors have taken steps to eliminate or reduce the level of out-of-network payments. In many markets, commercial and managed care payors have instituted measures in response to the increased costs of out-of-network payments. Examples of these include the following:

- Increased patient responsibility for payment for procedures performed in out-of-network facilities;
- Payment to patients rather than to facilities, requiring ASCs to seek payment for out-of-network services from the patient; and
- Requirement that physicians conduct procedures in contracted facilities in order to receive professional fees.

Though the efforts of the commercial and managed care payors to curb out-of-network payments have either not been attempted or have not been entirely successful, the industry appears to agree that high out-of-network payments are not likely sustainable over the long term. In some cases, the conversion from out-of-network to in-network rates could be immediate; in others, it could take several years.

Regardless of how long the transition takes, it's crucial to look at the potential outcome it will have on volumes. Requiring physicians to do procedures in contracted facilities in order to receive professional fees may result in movement of those surgeries to hospitals or in-network surgery centers. The increase in volume that often comes with converting an ASC from out-of-network to in-network may partially or entirely off-set the reduction in rates.

ASC Valuation Purpose

As is the case with most valuations in the healthcare industry, the predominant overriding purpose for most ASC valuations is compliance with the fair market value requirements established by the Stark Regulations and the Federal Fraud and Abuse and Anti-Kickback statutes.

While the Federal Anti-Kickback statutes include a safe harbor for surgeons who wish to own an equity interest in an ASC to which they refer patients, pricing for any transaction involving a potential referral source physician must be consistent with fair market value. Whether they are buyers or sellers, hospital systems that have some level of ownership in an ASC are most concerned with ensuring that the purchase of an ownership interest from a physician does not exceed fair market value or the sale of an interest is not less than fair market value. Hence, most ASC valuation engagements happen at the request of a hospital or non-physician ASC owner/operator for either the hospital system or the ASC owner/operator. The most common specific applications involve:

1. Purchase or sale of controlling equity interest;
2. Purchase or sale of non-controlling equity interests; and
3. Conversion of a center operated as an HOPD to a free-standing joint venture and simultaneous offering of non-controlling equity interests in the free-standing joint venture.

Purchase or sale of controlling equity interest

The most common buyers of a controlling equity interest in an ASC are the national developers and operators of ASCs/hospital systems. Surveys have consistently found that the ASC owner/operators nearly unanimously analyze

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and price controlling equity interest transactions using a multiple of EBITDA less interest-bearing debt². In light of their talent for recruiting additional physician owners and improving or maintaining efficient operations, ASC owner/operators are typically less concerned than non-controlling equity interest holders or hospital systems about the risks associated with potential volume loss.

ASC owner/operators often prefer to own a controlling equity interest in order to gain control over decisions typically associated with ASC entities such as:

- Deciding which physicians retain or receive equity in the ASC
- Maintaining the contractual relationship for management of the ASC

Unlike ASC owner/operators who typically price controlling equity interest transactions using a multiple of EBITDA, most hospital systems rely on the fair market value opinion provided by an independent appraiser to ensure that they meet Stark and Fraud and Abuse statute requirements, and private inurement concerns. Various professional standards require that business appraisers consider all relevant approaches and methods in developing an opinion of value. These other approaches and in particular, the income approach or discounted cash flow method, may provide a superior framework for measuring the impact of the individual facts and circumstances surrounding a subject ASC.

Cost approach. Some ASCs are either not profitable or are not expected to provide a return greater than the required return on the working capital and fixed assets employed in the operation of the ASC. The key is not historical earnings or cash flows, but instead projected earnings and cash flows under the control of a typical owner/operator.

In a transaction for a controlling interest, an ASC owner/operator is not likely to pay for all, or maybe even any, of the intangible value created through the ownership and management of an ASC. However, in the context of a “make or buy” decision typical of this type of transaction, the buyer may pay for the assembly of all tangible and some intangible assets (e.g., CON, an ASC license and payor contracts) under the premise of value in continued use, as part of a mass assemblage of assets.

This asset approach provides a “floor” or lowest minimum value related to a controlling interest in an ASC and may be appropriate when the market and income approaches (which are discussed later) produce lower values.

Surgery centers are an asset-intensive business. The median gross property and equipment plus working capital per operating room from VMG HEALTH’s *Multi-Specialty ASC Intellimarker* is approximately \$835,000. Depending on the age and condition of the furniture and equipment, the costs associated with these assets for an ASC may be substantial. Often, the application of the cost approach is important in situations in which an ASC has been over-built in terms of the space (e.g., number of operating and procedure rooms) and equipment required to accommodate the book of business.

Intangible assets. Even an ASC that has historically generated operating losses must consider the effect of intangible assets. The intangible assets in this case would be those that almost always have some legal title and are often separately marketable, including:

1. Certificate of Need (CON)
2. ASC license
3. Payor contracts

Certificate of need. Some states require a CON for an ASC to be licensed by the state and receive reimbursement from public payors such as Medicare and Medicaid. Again, in the context of the “make or buy” decision, a potential buyer will evaluate the probability of obtaining a CON. In states such as Georgia, Iowa, Kentucky and Tennessee, for example, many markets are saturated, making it extremely unlikely that a CON for a new surgery center could be obtained.

The valuation methodology for a CON may take the form of a cash-flow comparison under two scenarios: 1) the first assumes the CON is in place; and 2) the second assumes it is not. Using this “with and without” methodology, the value of the CON is quantified as the differential in the present value of the cash flows. In cases where it is likely

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that a CON might be obtained after legal and consulting costs are incurred and the passage of time, the incremental cash flows simply represent the present value of these incremental costs and cash flows foregone during the time required to obtain a CON. In extreme cases where the perceived probability of getting a CON seems remote, the present value of the incremental cash flows resulting from this analysis approaches the entire unidentified intangible value of the ASC. Since in this case the cash flows without a CON simply reflect the liquidation of the ASC's assets, the present value in the first scenario should be reduced by the value of the working capital, tangible assets and identified intangible assets. While the probability of getting a CON today may currently be near zero in many markets, the probability likely increases over time. As a result, some discount to the incremental cash flows may also be considered.

Another consideration in the application of the "with and without" methodology is the use of actual/expected versus typical financial performance in the cash-flow projections for the two scenarios. The volumes, reimbursement and operating expenses put into the model should consider whether the buyers' or sellers' expectations reflect their specific circumstances or those of a typical buyer. This assumption is of particular import when either historical operations or future reimbursement expectations reflect the operation of the ASC as a department of a hospital. In particular, if either the historical or projected financial statements provided reflect reimbursement at hospital rates rather than normalized free-standing rates, the rates utilized in the projections for this analysis should reflect normalized free-standing rates.

ASC license. An ASC is normally licensed by both the particular state in which it operates and by Medicare. It may take two or three months before an ASC receives licensure from both entities. This delay causes a delay in commencing the ramp-up period for operations, and in turn, a delay in reimbursement.

An ASC with a license in place can avoid this period of reduced cash flows. Like with a CON, the valuation methodology normally takes the form of a "with and without" analysis. The value of a CON exceeds that of a license because licenses are much easier to obtain. However, there is still uncertainty surrounding the licensing process. In California, for example, it's unclear how long it could take to obtain an ASC license. Some developers believe that it could take more than a year. In states requiring a CON, the value of an ASC license is generally not separated from the value of the CON.

Payor contracts. Recent experiences in California also point to the need to consider payor contracts as a potential source of significant value, particularly in cases in which the ASC has contracts with reimbursement in excess of market levels or in which large payors are threatening not to extend contracts to new ASCs. ASC payor contracts that cannot be terminated without cause and multi-year terms are uncommon, but there may be circumstances in which ASCs expect current reimbursement levels to extend beyond the legal term of the contract. Once again, the valuation methodology for payor contracts normally takes the form of a "with and without" analysis.

Market approach. ASC developers and operators generally rely on the market approach in pricing transactions. More specifically, they rely on the individual transactions method and use a multiple of EBITDA less interest-bearing debt in pricing a controlling equity interest in an ASC. Surveys have found that most respondents typically observed valuation multiples for controlling equity interests of 6 to 7 or more times EBITDA less interest-bearing debt.³

While ASC developers and operators often reference and use these general market guideline multiples, many factors may lead to an adjustment of the historical EBITDA or an ultimate transaction price that resides outside of this range.

In the discussion of the primary ASC value drivers, we detailed the need to consider changes in Medicare and out-of-network reimbursement when analyzing historical information and developing future projections. Based on our experience, the 6 to 7 or more times multiple used to price the purchase of a controlling interest is often applied to prospective or adjusted, rather than raw historical EBITDA. Accordingly, ASC developers and operators often adjust for changes in reimbursement to estimate the EBITDA to which that the multiple is applied. Due to expected changes in the practices of physician utilizers or competitive factors that historical performance might not reflect, prospective or adjusted EBITDA may also reflect case volume changes.

In addition to adjusting for potential reimbursement and volume changes, historical EBITDA may not reflect the payment of a management fee.

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Valuation impact of management fees. Virtually all multi-center owner/operators of ASCs charge the centers a fee of between 4 and 7% of net revenues to provide management services. For this fee, the manager typically does the following:

- Manages the ASCs finances and annual operating budgets
- Administers all accounting, accounts payable and purchasing functions
- Manages human resources
- Oversees information technology
- Handles public relations
- Develops plans for facilities and services
- Maintain all necessary licenses and regulatory compliance
- Designs, institutes, and supervises the physical and administrative operations of the ASC
- Prepares and submits all tax returns and cost reports
- Negotiates and consummates agreements and third-party contracts

Incremental costs associated with providing these services are generally fairly minimal. As a result, the contribution margin is very high. In addition, because the owner/operator receives the management fee off the revenue line before operating expenses, the risk associated with the fee are significantly less than the earnings generated by the owner/operator's equity investment in the ASC. Accordingly, when evaluating multiples from guideline transactions, it is particularly critical to understand whether the buyer received a management fee contract pursuant to the transaction.

To illustrate, suppose that an ASC owner/operator pays an amount equal to 7.0 times EBITDA less debt for a 60% interest in the ASC, and enters into a long-term management contract at 5% of net revenues. Assuming the subject ASC's revenues are \$4 million, its EBITDA is \$1 million and the contribution margin on the management fee is 50%, this 7.0 multiple becomes a 6.0 multiple after consideration of the additional \$100,000 margin associated with the management contract. If the management fee is greater than 5% or if the assumed contribution margin is greater than 50%, the management contract could play an even greater role. There is a direct relationship between the level of the management fee and the assumed contribution (i.e. the higher the management fee, the higher the assumed contribution margin). We have not discovered any definitive data on the exact level of the contribution margins associated with management fees. While this question should certainly be posed to management for the subject ASC owner/operator, a definitive answer supported with any type of analysis would be the exception rather than the norm. Perhaps this is a function of the fact that many ASC owner/operators do not appear to make an attempt to isolate the costs or perhaps the ASC owner/operators do not simply wish to share this information. In any event, our experience with ASC owner/operators and review of transaction pricing would indicate that the contribution margin is likely in excess of 50% for management fees equal to 5% or higher of net revenues. Exhibit 12 demonstrates this analysis.

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Exhibit 12 Management Fee Valuation Impact

Subject ASC			
Revenues			\$ 4,000,000
Operating Expenses (Excluding Depreciation)			3,000,000
EBITDA			\$ 1,000,000
	Management Fee	5.0%	\$ 200,000
	Contribution Margin	50.0%	\$ 100,000
Valuation of 60% Interest (assumes no Long-Term Debt)			
EBITDA (60% Interest)	\$ 600,000	\$ 100,000	\$ 700,000
X	X		X
Invested Capital / EBITDA Multiple	7.0 -----> 6.0		
Value Indication - 60% Interest			\$ 4,200,000

Though the existence of the management contract effectively lowers the multiple of EBITDA paid in the previous example, many hospitals and health systems purchasing a controlling interest in an ASC do not receive a management fee. This factor should be considered in utilizing guideline transactions.

Guideline public company method. The pricing of these companies, in terms multiples of revenues or earnings, provides little in the way of guidance regarding the pricing of either a controlling or non-controlling interest in an individual ASC.

Three of the largest ASC owner/operators moved out of the public sector in the past two years when HealthSouth, USPI and Symbion sold to private equity groups. In addition, though HealthSouth and HCA, both had or have significant ASC operations, their primary operations fall outside of the ASC segment, in inpatient and outpatient rehabilitation and acute care hospitals, respectively.

The only pure-play, publicly traded ASC owner/operators are AmSurg and NovaMed. The larger of the two, AmSurg, operates 170 centers, with a majority of these being single-specialty GI/Endoscopy and Ophthalmology centers. NovaMed operates 34 single-specialty and multi-specialty centers, with some focus on Ophthalmology. Exhibit 13 summarizes the key valuation multiples for publicly traded ASC companies. Trailing twelve month EBITDA multiples are approximately 10.2x and 10.7x for AmSurg and NovaMed, respectively.

Exhibit 13 Public Company Multiples

\$ in Millions	As of April 23, 2008						
	Share Price	Shares Out	Market Cap	LTD	MVIC	MVIC / LTM Rev	MVIC / LTM EBITDA
AmSurg Corp (AMSG)	\$ 25.45	31.38	\$ 798.5	\$ 222.6	\$ 1,021.1	1.9x	10.2x
NovaMed Inc (NOVA)	\$ 4.48	24.59	\$ 110.2	\$ 102.2	\$ 212.4	1.7x	10.7x

Note: LTM EBITDA is less Minority Interest

Company Financial Statements

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Companies such as AmSurg and NovaMed, and until they went private, Symbion and USPI, likely trade at much higher multiples than individual ASCs due to growth achieved through acquisition, access to and lower cost of capital, geographic diversification and size. There is a fairly substantial spread between acquisition prices and the public company multiples, thereby making it fairly easy for public companies to add substantial value from acquisitions.

Accordingly, while it's necessary to consider the guideline company method, it rarely has a direct application to the valuation of either a controlling or non-controlling equity interest in an individual ASC.

Income approach/discounted cash flow method. In this method, the total equity value is calculated using equity cash flows. Whether the appraiser projects a number of scenarios with a range of applicable discount rates or develops a single most-likely case scenario with a single appropriate discount rate, the mechanics of the projections should be similar.

Volume is the first primary determinant of financial performance. Volume is typically analyzed and projected in terms of number of surgical cases. However, each case may consist of a number of individual procedures. As such, it is important to understand whether the information that has been provided is measured in cases or procedures. As previously discussed, reimbursement varies widely by specialty. In addition, volumes are driven by the sum of individual physician practice expectations. The combination of these factors makes it absolutely essential to analyze and develop volume projections by specialty, by physician.

Reimbursement levels are the second primary determinant of financial performance. Like most healthcare services, ASCs maintain a fee schedule consisting of gross charges, by procedure, for services performed and supplies utilized during surgery. Gross charges, though somewhat arbitrary, are often set as a percentage of the Medicare reimbursement for a procedure, say 300 to 400%.

Most governmental (including Medicare and Medicaid), commercial and managed care payors reimburse according to a set fee schedule (either their own or one negotiated during the contracting process). A large share of commercial and managed care payors either directly or indirectly base their fee schedules on Medicare rates, making Medicare reimbursement and reimbursement trends particularly important to future projections.

Except in the fairly rare event that an ASC has a substantial number of payors that reimburse based on a percentage of gross charges, gross charges are somewhat irrelevant.

In addition, employee costs and medical and surgical supplies vary significantly by specialty. To properly accommodate the largely variable component of employee costs, base projections on staffing hours per case and/or costs per case. Other expenses that typically vary based on volume, specialty mix or revenues may include contract services, insurance, office supplies and postage and management fees.

Capital Expenditures (CAPEX) are also significant to the discounted cash flow method for ASCs. A surgery center is typically an asset-intensive business. While the dangers of following rules of thumb have been subject to lively debate throughout the history of the valuation profession, we typically look at annual amounts ranging from \$50,000 to \$100,000 per operating room and slightly less per procedure room as a starting point for maintenance CAPEX. In addition to considering the age and condition of the existing furniture and equipment and the potential maintenance required, CAPEX assumptions should also consider possible growth in volume.

Consistent with the tendencies of ASC owner/operators, we typically execute the indirect convention of the discounted cash flow method whereby the market value of invested capital (MVIC) is calculated using debt-free cash flows and book value of debt is deducted from MVIC to arrive at a Total Equity Value. Use of debt in the capital structure of ASCs varies widely based on the range of long-term debt to total assets from the *Multi-Specialty ASC Intellimarker 2007*. Based on our experience, use of substantial amounts of long-term debt is more prevalent for newer surgery centers and is almost entirely asset-based. While most ASCs typically use long-term debt to fund initial operations, many ASCs fund subsequent furniture and equipment purchases out of cash flows.

ASCs are generally located in either a medical office building or a separate freestanding facility. While it is certainly not uncommon for an ASC to own the land and building, particularly if the ASC is a separate facility, most lease their facilities. This comes into play in the ASC's valuation. If the ASC owns the real estate as well, the business appraiser should consider the potential difference in required returns on the real estate and ASC operations. The preferred solution is to engage a real estate appraiser to value the land and/or building and to then combine the

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values of the real estate and the ASC operations. This convention requires an adjustment for the rental rate from the real estate appraisal.

If a separate real estate appraisal cannot be obtained, adjust the discount rate utilized in the discount cash flows to reflect the generally lower expected returns associated with the real estate. An adjustment to account for real estate may be considered when using the market approach (discussed earlier) and is applicable in the valuation of either a controlling interest or non-controlling interest.

The valuation of a controlling equity interest approaching 100% requires an additional consideration. Under the income and market approaches, the pricing of most controlling interest transactions is for 51 to 60% interest. The same market multiples and rates of return may not apply to the incremental 40 to 49% interest of a 100% equity purchase. Generally the market multiples and implied rates of return reflect the buyer's assumption that the physician utilizers will maintain meaningful ownership. Buyers may not be willing to pay the same premium for ownership in excess of 60%.

Purchase or sale of non-controlling equity interests

Generally speaking, ASC owner/operators and healthcare systems are the typical buyers of controlling equity interests. Whether an ASC is a joint venture between a healthcare system and physicians; a three-way joint venture between ASC owner/operators, a healthcare system and physician utilizers; or wholly owned by physicians, individual physician utilizers are generally the non-controlling equity interest buyers.

Non-controlling equity interests in ASCs typically transact at relatively lower values compared to controlling equity interests. The same survey in which a large majority of respondents typically observed valuation multiples for controlling equity interests of 6.0 to 7.0 or more times EBITDA less interest-bearing debt found that a large majority of respondents typically observed valuation of non-controlling equity interest of 2.5 to 4.0 times EBITDA less interest-bearing debt.⁴

While the lower values associated with a non-controlling interest are consistent with the levels of value framework from general valuation theory, in which there may be discounts from the value associated with a controlling interest for both lack of marketability and lack of control, we generally prefer to view the differential outside of this framework. Because the continued success of an ASC depends so much on the continued support of its physician owners, most ASC operating or partnership agreements include provisions that

1. Provide liquidity to non-controlling equity interest holders through formulas or requirements for the completion of an independent fair market value opinion.
2. Clearly define discretionary cash flows, but require periodic distributions. ASC operating agreements or partnership agreements typically require cash distributions on a monthly or quarterly basis.

Within the levels of value framework from general valuation theory, a premium for control implies an inverse discount for lack of control. However, the difference in values for a controlling equity interest and a non-controlling equity interest may be more appropriately, and perhaps more specifically, attributed to ASC owner/operators, or the typical buyers of a controlling equity interest:

- obtaining a management fee;
- having better access to, and a lower cost of, capital; and
- having the ability to successfully manage and expand ownership.

Based on these factors and because ASC operating and partnership agreements provide some level of built-in liquidity, we prefer to simply view the valuation of a non-controlling equity interest as entirely separate rather than starting with a controlling equity interest valuation and applying marketability and lack-of-control discounts typically utilized in valuations.

Cost approach. Like for a controlling equity interest, the application of the cost approach for a non-controlling equity interest provides a "floor" or lowest minimum value. However, for a non-controlling equity interest, specific facts and circumstances may ultimately impair the value of any intangible assets.

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Market approach. ASC owner/operators observed that transactions for non-controlling equity interests in ASCs occur at 2.5 to 4.0 times EBITDA less interest-bearing debt. Interestingly, for non-controlling interest buy-ins and buy-outs, more than half of the respondents (8 of 13) rely on a formula to determine pricing, while only 4 rely on independent fair market value opinions.⁵ This is not surprising considering that a large share of ASC operating or partnership agreements typically include formulas in the buy/sell provisions.

Based on our experience, a slightly smaller, but nonetheless large percentage of comprehensive valuations fall above or below the 2.5 to 4.0 times EBITDA range. In addition, the appropriate multiple to apply may vary widely within the range. Because the range is broad, and because of the lack of detailed information from both public and private sources, we typically use the market approach secondarily when valuing a non-controlling equity interest.

Discounted cash flow. The overriding distinguishing feature in the valuation of a non-controlling interest is that the projected volumes and revenues do not anticipate the change in ownership associated with the potential transaction. For example, if a non-controlling equity interest is being valued for the purposes of allowing a new physician buy-in, the projections would not include any consideration of the case volumes that the physician would likely perform following the purchase of an interest in the ASC.

Further, while an ASC owner/operator may take into account the potential loss of volumes to either existing or potential competitors, a non-controlling equity owner, on the other hand, is not in a position to do so. Plus, the typical buyer or seller of a non-controlling equity interest may have a higher cost of equity in comparison to the typical buyer or seller of a controlling equity interest.

Conversion of an HOPD

The purpose of the valuation of an ASC being converted from an HOPD to a free-standing center is generally to estimate the fair market value of a non-controlling equity interest. Though the application of the three approaches to value is generally the same as the application of the approaches to value for a non-controlling equity interest, modeling the expected financial performance of an ASC that has historically operated as a HOPD can be particularly challenging.

With this in mind, rather than explore the valuation of an ASC converting from a HOPD to a free-standing entity based on the application of the approaches to value, it seems appropriate to expand on the challenges an appraiser faces in modeling this type of center's expected financial performance.

There are three primary challenges, driven by the fact that the financial performance of a HOPD, as presented in the historical accounting for a department of a hospital, bears little resemblance to the financial performance of the operation of the unit as a free-standing entity:

1. Proper volume assumptions
2. Proper reimbursement assumptions
3. Proper operating-expense assumptions

While the cost accounting may be very complex, the historical accounting for a department of a hospital requires a maze of assumptions and allocations that cannot be used in estimating the performance of the business unit as a free-standing entity.

Volume assumptions. The level of difficulty in projecting volumes for this type of ASC depends on whether the volumes expected to transition come from the main operating rooms in the hospital or from a separate outpatient unit. As a result, the first consideration in estimating proper volume assumptions involves carving out the outpatient volumes expected to transition to the free-standing entity.

Historical financial and operating data provided by the hospital may include not only cases expected to transition, but the comingling of outpatient volumes not expected to transition to the free-standing ASC and inpatient volumes that have historically been performed in the hospital's main operating rooms or the separate facility. Estimating volumes expected to transition will require analyzing the case volumes by specialty by physician and interviewing the hospital staff, any outside parties assisting the hospital with the development of the free-standing ASC joint venture and the physicians currently performing surgery in the HOPD.

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A second consideration in estimating proper volume assumptions involves evaluating the risk to the hospital of maintaining these volumes. Particularly in states that don't require a CON, a hospital may base its desire to transition an ASC to a free-standing entity entirely on the perception that the physicians currently performing cases in the HOPD have an opportunity to either develop a competitive ASC venture or join an existing one. The volumes assumed in the valuation should consider the probability that these cases will remain with the HOPD being converted to a free-standing entity, absent the anticipated change in ownership. In many cases, hospitals are converting the HOPD to a free-standing ASC joint venture in response to the competitive threat that the physicians currently performing surgeries in the HOPD are entertaining the potential to invest in and move all or a portion of their cases to a competitive ASC. Considering this potential risk may result in a much lower value for the HOPD than might be indicated by the current earnings levels.

Reimbursement assumptions. Generally speaking, hospital reimbursement is significantly higher than ASC reimbursement for the same outpatient procedures. As previously discussed, Medicare reimbursement is transitioning to a payment methodology that will ultimately result in hospitals receiving approximately 150% of the amount that ASCs will receive. In addition, while ASCs usually contract with commercial and managed care payors at rates from a negotiated fee schedule, hospitals usually receive a percentage of charges for outpatient surgery.

Due to this differential in reimbursement, net revenues from the historical data set provided by the hospital for an HOPD must shift to reflect the conversion of the HOPD to a free-standing ASC. Depending on the specialty mix and commercial and managed care reimbursement in the specific market, this could be a significant downward adjustment.

Operating-expense assumptions. Typically, expenses such as supplies and staffing are the only direct expenses that a hospital can identify in its departmental financial information. The remaining operating-expense information is not extremely useful in projecting the performance of an HOPD as a free-standing entity.

Fortunately, hospitals often include a developer or an ASC owner/operator in the joint-venture process who will work with the hospital to make financial projections to be included in the offering documents. Because the projections usually anticipate the change in ownership, they may include case volumes from physicians not currently doing cases in the HOPD and/or case volumes not adjusted for the potential risk of maintaining the case volumes if there is not a joint-venture opportunity. Operating-expense assumptions should be analyzed and/or developed specifically based on volume and specialty mix.

Data request

As we have discussed throughout this chapter, the analysis of volumes and revenue by specialty, by physician are critical to the valuation of any interest in an ASC. Since all ASCs bill for services on a per-procedure basis using CPT codes, all volumes and revenues should be readily available, though the ease with which the data can be prepared depends on the sophistication of the information system.

In any event, the nature of billing for ASC services puts all ASCs on a common framework for analysis of both revenues and expenses. Exhibit 14 is an example data request for the valuation of either a controlling or non-controlling equity interest.

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Exhibit 14 Free-Standing ASC Data Request

1. Income statements and balance sheets for Fiscal Year (FY) 2004, FY 2005, FY 2006, FY 2007 and year-to-date (YTD) 2008 (including the same period YTD 2007).
2. Copies of any current budgets or projections for the ASC.
3. Data for FY 2004, FY 2005, FY 2006, FY 2007 and year-to-date (YTD) 2008 (including the same period YTD 2007) **by physician, by specialty** detailing the following:
 - Case Volume
 - Gross Charges
 - Contractual Adjustments
 - Net Revenues
 - Collections
 - Medical Supplies Costs (if available)
4. Top ten procedures (based on charges) **by specialty**.
5. For the ASC, Total FY 2007 and year-to-date 2008 data **by payor type** detailing the following:
 - Case Volume
 - Gross Charges
 - Contractual Adjustments
 - Net Revenues
 - Collections
6. Summary of managed care contracts for outpatient surgery. Please provide info regarding the average insurance reimbursement as a percentage of Medicare.
7. Copy of most recent Accounts Receivable Aging summary.
8. A listing of employees for the ASC: (a) name (may be omitted for confidentiality); (b) compensation; (c) average hours worked per week; (d) benefits; (e) responsibility/position description; and (f) tenure / date-of-hire.
9. Copies of facility leases and/or detailed information concerning square footage for the ASC.
10. Summary and/or copies of any furniture or equipment leases for the ASC.
11. A detailed listing of fixed assets for the ASC including the following: original acquisition cost, date of acquisition, and depreciation.
12. A copy of any market research or demographic data for the ASC's service area.
13. A copy of any organizational documents relating to the ASC, including the following:
 - Articles of Incorporation
 - Partnership Agreement
 - Operating Agreement
 - Management Agreement
 - Detailed Ownership Roster
 - Most recent Offering
14. For completed transactions or any offers to buy assets or equity in the ASC during the last 2 years, details regarding any completed transactions or offers to buy assets or equity in the ASC. If no transactions or offers in the last 2 years, please provide details regarding the most recent transaction(s) or offer(s).

Because hospital-based facilities often perform outpatient and inpatient procedures, the data request varies slightly. Exhibit 15 is an example data request for the valuation of either a controlling or non-controlling equity interest in an ASC being converted from an HOPD to a free-standing entity.

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Exhibit 15 HOPD Data Request

1. Departmental income statements and balance sheets for Surgery for Fiscal Year (FY) 2004, FY 2005, FY 2006, FY 2007 and year-to-date (YTD) 2008 (including the same period YTD 2007).
2. Copies of any current budgets or projections for the subject Surgical Department.
3. For inpatient and outpatient cases currently being performed in the Hospital, FY 2004, FY 2005, FY 2006, FY 2007 and YTD 2008 (including the same period YTD 2007) data by physician, by specialty detailing the following:
 - Case Volume
 - Gross Charges
 - Contractual Adjustments
 - Net Revenues
 - Collections
 - Medical Supplies Costs
 - Any additional Operating Expense Information Available

Note: Please provide separate inpatient and outpatient data sets

4. Top ten outpatient procedures (based on charges) by specialty.
5. For outpatient cases in the Hospital, FY 2007 and YTD 2008 (including the same period YTD 2007) data by payor type detailing the following:
 - Case Volume
 - Gross Charges
 - Contractual Adjustments
 - Net Revenues
 - Collections
6. Summary of managed care contracts for outpatient surgery. Please provide info regarding the average insurance reimbursement as a percentage of Medicare.
7. A listing of employees for the Hospital's ORs: (a) name (may be omitted for confidentiality); (b) compensation; (c) average hours worked per week; (d) benefits; (e) responsibility/position description; and (f) tenure / date-of-hire.
8. Copies of facility leases and/or detailed information concerning the space plan (square footage and estimated FMV rental rates) for the ASC JV.
9. Copies of any furniture or equipment leases for OP Surgery and/or the ASC JV.
10. A detailed listing of fixed assets for OP Surgery and/or the ASC JV including the following: original acquisition cost, date of acquisition, and depreciation (if available).
11. A copy of any market research or demographic data for the ASC JV's service area.
12. A copy of any organizational documents relating to the ASC JV, including the following:
 - Offering Documents
 - Partnership Agreement
 - Operating Agreement
 - Management Agreement
 - Detailed Ownership Roster

Conclusion

In this chapter, we provided an overview of the ASC segment, typical ASC legal structures, ASC financial performance and primary value drivers and the most common ASC valuation applications. The operations of an ASC and the framework for the valuation of an ASC are not complex. However, the myriad legal, competitive, reimbursement, out-of-network and other market and industry considerations complicate the analysis of historical data, the projection of future earnings and cash flows and the application of the approaches to value.

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