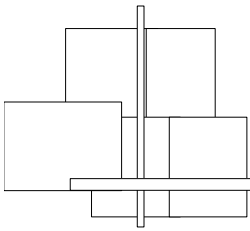


Current Events In the Dynamic World of Healthcare Valuations

2008 AICPA/ASA Business Valuation Conference

November 10-12, 2008 Las Vegas, NV

Sessions #18 & #23



Presenters:

Mark O. Dietrich, CPA/ABV
(508) 877-1999
dietrich@cpa.net

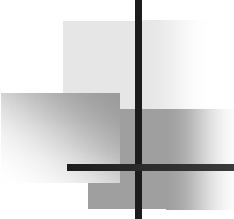
Don Barbo, CPA/ABV
Hill Schwartz Spilker Keller, LLC
(214) 741-5360
dbarbo@hsskgroup.com



Presentation Overview

- I. MedPAC's Crystal Ball: What's on the horizon for Physicians, Imaging, ASCs and Hospitals?
- II. Understanding differences in Geographic Market Pricing
- III. Hospital-Physician Transactions and Joint Ventures: What's in/out
- IV. Standing Firm: When the Deal Heats Up or Blows Up, Real World "Hypothetical Examples"
- V. Ask the Experts



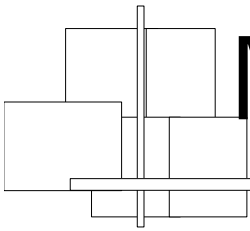


I. MedPAC's Crystal Ball: What's on the horizon for Physicians, Imaging, ASCs and Hospitals?

MEDPAC: Why do we Care?

- MedPAC or the Medicare Payment Advisory Commission is an independent body formed to advise Congress about the Medicare Program and its benefits, payment mechanisms and annual changes in how much should be paid providers for the various covered services.

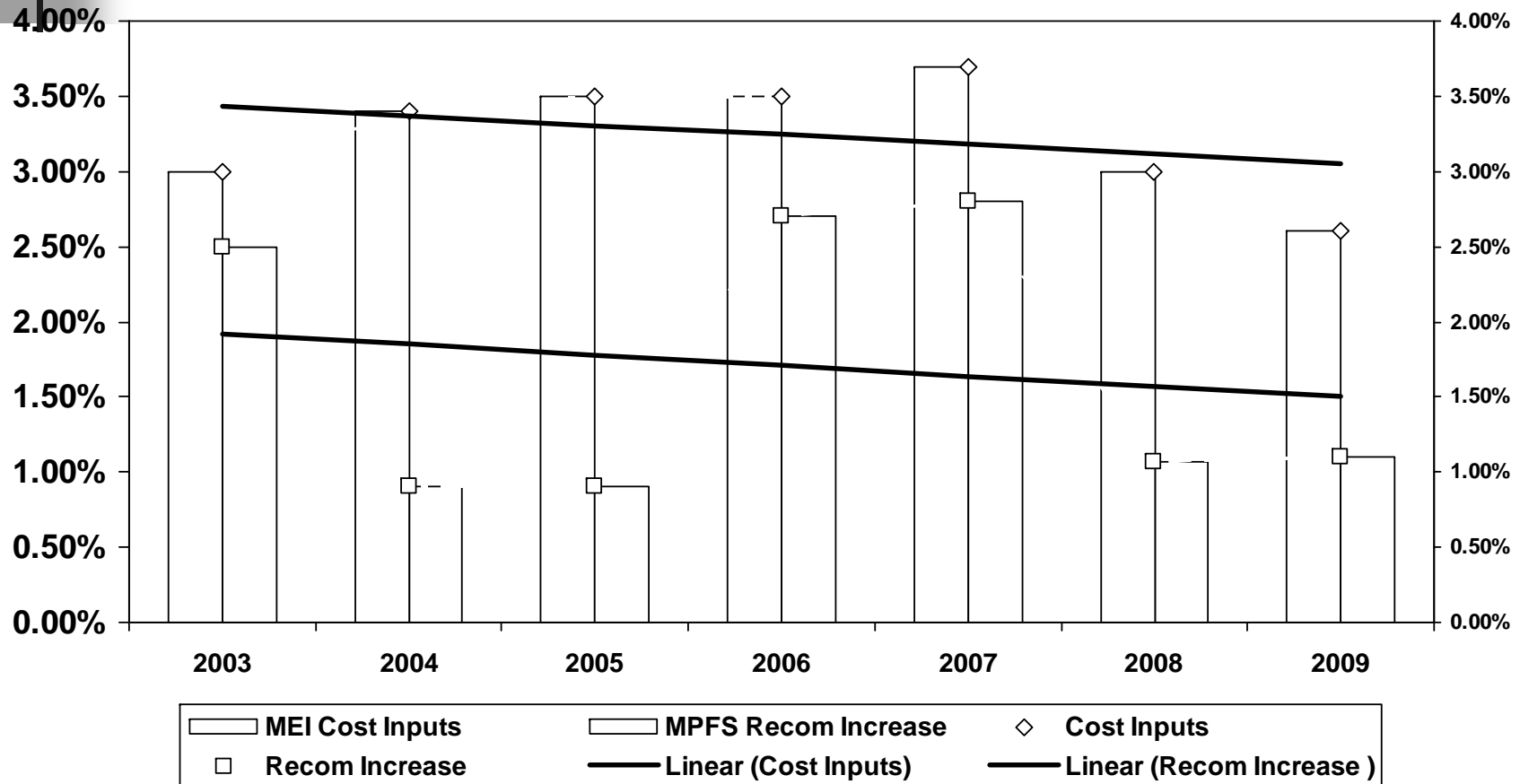
DRAMATIC SHORTAGES IN MEDICARE PAYMENT LEVELS



MEI and MPFS

- The Chart on the next slide compares the Medicare Economic Index – a measure of the annual cost increases for physicians similar to the market basket for hospitals – to the increases in the Medicare Physician Fee Schedule (MPFS) recommended by MedPAC. *Recommended* increases are consistently below cost increases.

MEI INCREASES AND RECOMMENDED MPFS INCREASE



Looking at the Recommended Increase, anyone see a 3% terminal growth rate???

MPFS Increases

- Actual Increases in the MPFS fee schedule are shown on the next slide and are consistently below the recommended increases –which are already well under inflation!

MEDICARE PAYMENT VALUATION²

THE POWER OF TWO IN BUSINESS VALUATION

How It Works - or Doesn't!

Two Key Items

- Conversion Factor multiplied by

- RVUs equals

- Fee

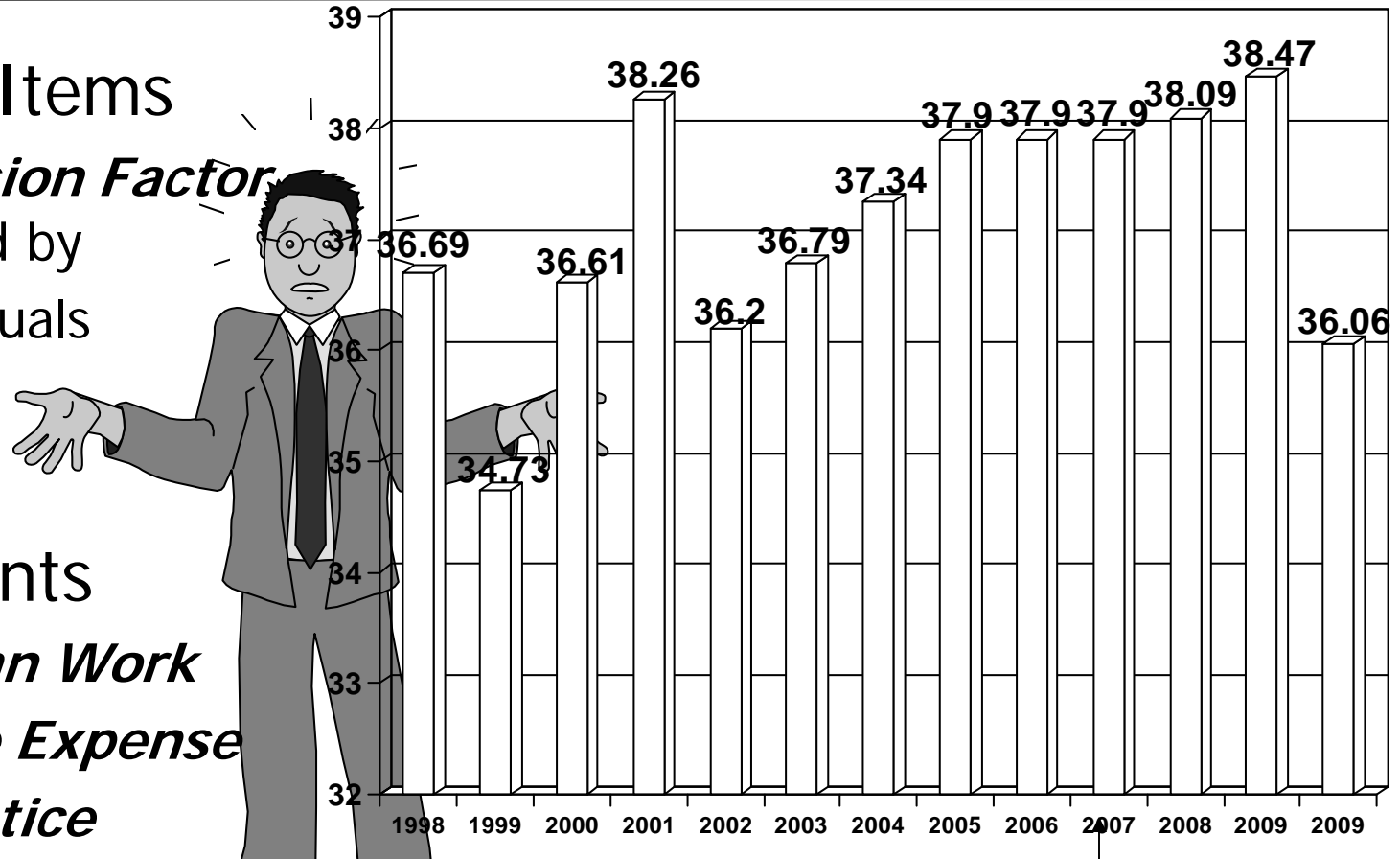
RVUs - 3

Components

- Physician Work

- Practice Expense

- Malpractice Insurance



Anyone see a 3% terminal growth rate here???

MEDICARE PAYMENT VALUATION²

THE POWER OF TWO IN BUSINESS VALUATION

What happened in 2009?

- In prior years, the Budget Neutrality Adjustment reduced Work RVUs prorata; this year, a legislative change required it to be applied to the Conversion Factor. Thus, the Conversion Factor is lower even though there was a 1.1% increase! RVUs are higher, and thus fees went up as shown on the next slide.

Confused?

Table 43: Calculation of the CY 2009 PFS CF

CY 2008 Conversion Factor	\$38.0870
CY 2009 CF Update	1.1 percent (1.011)
CY 2009 CF Budget Neutrality Adjustment	0.08 percent (1.0008)
5-Year Review Budget Neutrality Adjustment	-6.41 percent (0.9359)
CY 2009 Conversion Factor	\$36.0666

Significance of Facility vs Non-Facility is whether or not certain practice expense RVUs of RBRVS are in Fees

CODE	MOD	DESCRIPTION	Facility (e.g., HOPD)			Non-Facility (MD Office)		
			2008	2009	Change	2008	2009	Change
11721		Debride nail, 6 or more	27.42	\$27.77	1%	39.61	40.39	2%
17000		Destruct premalg lesion	46.47	\$48.69	5%	67.41	69.97	4%
27130		Total hip arthroplasty	1,336.09	\$1,359.71	2%	NA	NA	NA
27244		Treat thigh fracture	1,077.10	\$1,144.39	6%	NA	NA	NA
27447		Total knee arthroplasty	1,435.12	\$1,456.37	1%	NA	NA	NA
33533		CABG, arterial, single	1,854.84	\$1,892.05	2%	NA	NA	NA
35301		Rechanneling of artery	1,045.11	\$1,067.93	2%	NA	NA	NA
43239		Upper GI endoscopy, biopsy	156.92	\$165.55	5%	329.07	323.16	-2%
66821		After cataract laser surgery	\$253.53	\$222.81	-12%	\$270.97	\$237.80	-12%
66821		After cataract laser surgery	249.47	\$251.38	1%	266.23	266.53	0%
66984		Cataract surg w/iol, 1 stage	626.15	\$638.74	2%	NA	NA	NA
67210		Treatment of retinal lesion	545.79	\$561.56	3%	567.88	580.67	2%
71010		Chest x-ray	NA	NA	NA	25.52	24.16	-5%
71010	26	Chest x-ray	8.76	\$9.02	3%	8.76	9.02	3%
77056		Mammogram, both breasts	NA	NA	NA	104.74	107.48	3%
77056	26	Mammogram, both breasts	41.9	\$44.36	6%	41.9	44.36	6%
77057		Mammogram, screening	NA	NA	NA	82.65	81.15	-2%
77057	26	Mammogram, screening	33.9	\$35.71	5%	33.9	35.71	5%
77427		Radiation tx management, x5	177.1	\$188.27	6%	177.1	188.27	6%
78465	26	Heart image (3d), multiple	74.27	\$78.99	6%	74.27	78.99	6%
88305	26	Tissue exam by pathologist	36.18	\$37.15	3%	36.18	37.15	3%
90801		Psy dx interview	125.31	\$128.04	2%	147.02	152.92	4%
90862		Medication management	43.8	\$45.08	3%	52.18	55.18	6%
90935		Hemodialysis, one evaluation	65.13	\$66.36	2%	NA	NA	NA
92012		Eye exam established pat	43.04	\$45.80	6%	70.08	70.69	1%
92014		Eye exam & treatment	66.27	\$70.33	6%	101.69	103.15	1%
92980		Insert intracoronary stent	806.3	\$847.93	5%	NA	NA	NA
93010		Electrocardiogram report	8.38	\$9.02	8%	8.38	9.02	8%
93015		Cardiovascular stress test	103.98	\$100.27	-4%	103.98	100.27	-4%
93307	26	Echo exam of heart	47.23	\$49.77	5%	47.23	49.77	5%
93510	26	Left heart catheterization	241.09	\$248.86	3%	241.09	248.86	3%

CODE	MOD	DESCRIPTION	Facility (e.g., HOPD)			Non-Facility (MD Office)		
			2008	2009	Change	2008	2009	Change
98941		Chiropractic manipulation	28.57	\$30.30	6%	33.14	33.9	2%
99203		Office/outpatient visit, new	65.51	\$68.17	4%	91.03	91.97	1%
99213		Office/outpatient visit, est	41.9	\$44.72	7%	59.8	61.31	3%
99214		Office/outpatient visit, est	65.51	\$69.25	6%	89.89	92.33	3%
99223		Initial hospital care	171.77	\$180.33	5%	NA	NA	NA
99231		Subsequent hospital care	35.42	\$37.15	5%	NA	NA	NA
99232		Subsequent hospital care	63.22	\$66.72	6%	NA	NA	NA
99233		Subsequent hospital care	90.65	\$95.58	5%	NA	NA	NA
99236		Observ/hosp same date	200.34	\$207.38	4%	NA	NA	NA
99239		Hospital discharge day	92.93	\$96.30	4%	NA	NA	NA
99243		Office consultation	92.93	\$97.38	5%	122.26	124.79	2%
99244		Office consultation	145.49	\$154.00	6%	179.01	184.3	3%
99253		Inpatient consultation	108.55	\$114.69	6%	NA	NA	NA
99254		Inpatient consultation	156.54	\$165.55	6%	NA	NA	NA
99283		Emergency dept visit	59.03	\$61.31	4%	NA	NA	NA
99284		Emergency dept visit	108.93	\$114.33	5%	NA	NA	NA
99291		Critical care, first hour	204.15	\$212.07	4%	250.99	253.91	1%
99292		Critical care, add'l 30 min	102.45	\$106.04	3%	111.98	114.69	2%
99348		Home visit, est patient	NA	NA	NA	76.17	79.35	4%
99350		Home visit, est patient	NA	NA	NA	155.78	160.86	3%
G0008		Admin influenza virus vac	NA	NA	NA	20.57	20.92	2%
G0317		ESRD related svcs 4+mo 20+yrs	\$283.09	\$245.29	-13%	\$283.09	\$245.29	-13%

MEDICARE PAYMENT VALUATION²

THE POWER OF TWO IN BUSINESS VALUATION

Winners and Losers

<u>Specialty</u>	<u>Allowed Charges -mil</u>	<u>RVU Changes*</u>	<u>Budget Neutrality</u>	<u>Statutory 1.1%</u>	<u>Total***</u>
Total	81,669	0%	0%	1%	1%
Allergy/Immunology	184	1%	-3%	1%	-1%
Anesthesiology	1,966	-1%	3%	1%	3%
Cardiac Surgery	400	0%	1%	1%	2%
Cardiology	7,775	-2%	-1%	1%	-2%
Colon And Rectal Surgery	136	0%	1%	1%	2%
Critical Care	224	0%	2%	1%	3%
Dermatology	2,557	2%	-2%	1%	1%
Emergency Medicine	2,451	0%	3%	1%	4%
Endocrinology	385	0%	0%	1%	2%
Family Practice	5,354	0%	0%	1%	2%
Gastroenterology	1,883	2%	1%	1%	3%
General Practice	842	0%	0%	1%	2%
General Surgery	2,408	1%	1%	1%	3%
Geriatrics	175	0%	2%	1%	3%
Hand Surgery	88	-1%	-1%	1%	-1%
Hematology/Oncology	2,019	-1%	-2%	1%	-1%
Infectious Disease	561	1%	2%	1%	4%

MEDICARE PAYMENT VALUATION²

THE POWER OF TWO IN BUSINESS VALUATION

Winners and Losers

<u>Specialty</u>	<u>Allowed Charges -mil</u>	<u>RVU Changes*</u>	<u>Budget Neutrality</u>	<u>Statutory 1.1%</u>	<u>Total***</u>
Internal Medicine	10,662	0%	1%	1%	2%
Interventional Radiology	228	-1%	0%	1%	0%
Nephrology	1,840	-1%	1%	1%	2%
Neurology	1,489	0%	0%	1%	1%
Neurosurgery	620	-1%	0%	1%	0%
Nuclear Medicine	79	-1%	-2%	1%	-1%
Obstetrics/Gynecology	654	0%	0%	1%	0%
Ophthalmology	5,026	0%	0%	1%	0%
Orthopedic Surgery	3,454	0%	0%	1%	0%
Otolaryngology	984	-1%	-1%	1%	-1%
Pathology	1,007	0%	0%	1%	1%
Pediatrics	72	1%	0%	1%	2%
Physical Medicine	850	0%	1%	1%	1%
Plastic Surgery	288	0%	0%	1%	1%
Psychiatry	1,169	1%	2%	1%	4%
Pulmonary Disease	1,828	1%	1%	1%	3%
Radiation Oncology	1,854	-1%	-3%	1%	-3%
Radiology	5,554	0%	-1%	1%	0%
Rheumatology	521	0%	-1%	1%	-1%
Thoracic Surgery	431	0%	1%	1%	2%

MEDICARE PAYMENT VALUATION²

THE POWER OF TWO IN BUSINESS VALUATION

Winners and Losers

<u>Specialty</u>	<u>Allowed Charges -mil</u>	<u>RVU Changes*</u>	<u>Budget Neutrality</u>	<u>Statutory 1.1%</u>	<u>Total***</u>
Urology	2,146	0%	-1%	1%	0%
Vascular Surgery	685	0%	-1%	1%	1%
Audiologist	33	-9%	-2%	1%	-10%
Chiropractor	768	-1%	2%	1%	2%
Clinical Psychologist	571	-2%	3%	1%	2%
Clinical Social Worker	378	-1%	3%	1%	3%
Nurse Anesthetist ←	846	0%	4%	1%	5%
Nurse Practitioner	963	1%	1%	1%	3%
Optometry	867	0%	-1%	1%	0%
Oral/Maxillofacial Surgery	38	1%	-1%	1%	1%
Physical/Occupational Therapy	1,772	2%	0%	1%	3%
Physician Assistant	711	0%	1%	1%	2%
Podiatry	1,727	1%	-1%	1%	1%
Diagnostic Testing Facility	1,186	-2%	-5%	1%	-6%
Independent Laboratory	878	5%	-4%	1%	2%
Portable X-Ray Supplier	87	2%	-4%	1%	-2%

* PE changes are CY 2009 third year transition changes. For fully implemented CY 2010 PE changes, see CMS-1403-FC.

** Prior to the application of the OPPI imaging caps under DRA 5102

***Components may not sum to total due to rounding

MedPAC Physician Cost Analysis



**TABLE
2B-6**

Forecasted input price increases and weights for physician services for 2009

Input component	Price increases for 2009	Category weight
Total	2.6%	100.0%
Physician work	2.7	52.5
Wages and salaries	2.4	42.7
Fringe benefits (nonwage compensation)	3.5	9.7
Physician practice expense	2.4	47.5
Nonphysician employee compensation	2.9	18.7
Wages and salaries	2.9	13.8
Fringe benefits (nonwage compensation)	2.8	4.8
Office expense	2.1	12.2
Professional liability insurance	2.3	3.9
Medical equipment	0.7	2.1
Drugs and supplies	3.0	4.3
Pharmaceuticals	1.7	2.3
Medical materials and supplies	3.9	2.0
Other professional expense	2.1	6.4

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight (as listed in the Medicare Economic Index) by its price proxy. Forecasted price changes are not adjusted for productivity. Numbers may not total exactly due to rounding.

Source: Unpublished estimates from CMS, dated December 4, 2007.

Anyone see a 3% terminal growth rate here???

UNDERSTANDING GROWTH RATES

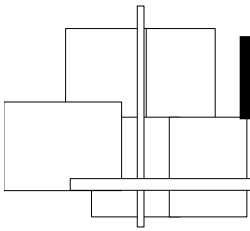
- “With the current estimate of input cost changes in 2009 of 2.6 percent and the Commission’s productivity adjustment of 1.5 percent, the Commission’s [MedPAC] recommended 2009 update would be 1.1 percent.”
- *Quoted from MedPAC 2008 Report to Congress*

Anyone see a 3% terminal growth rate here???

WHAT DOES THIS MEAN?

- The Table on the previous slide and the increase recommendation are what drive reimbursement decisions and therefore potential future cashflow growth rates. Bottom line is that the indicated 2.6% estimated increase in costs leads to a 1.1% increase in fees because of increased utilization; thus, increased utilization is offset by decreased fees because costs are (allegedly) recovered over a higher volume!

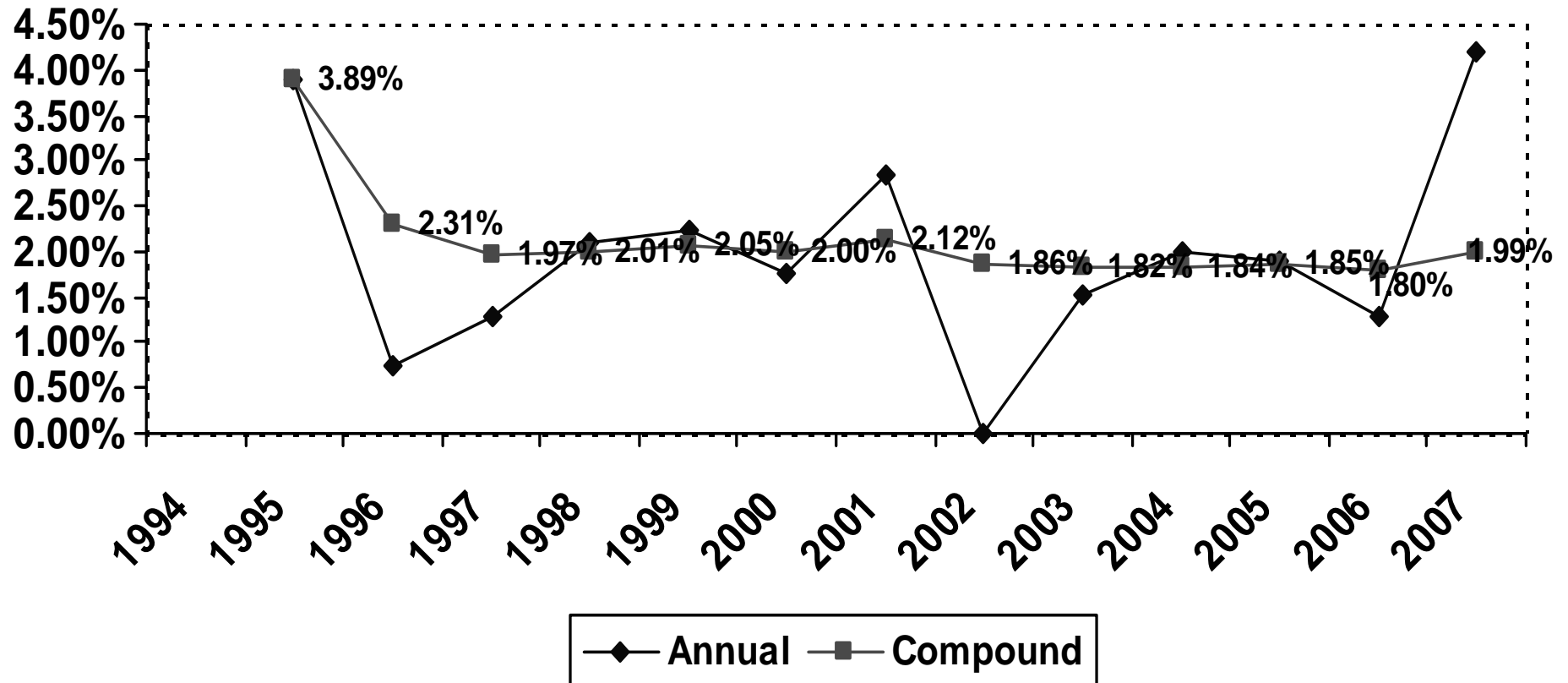
2007 WAS A BETTER YEAR FOR NON-MEDICARE PAYORS!



But the Historical Trend is Likely
To Persist

PHYSICIAN PPI

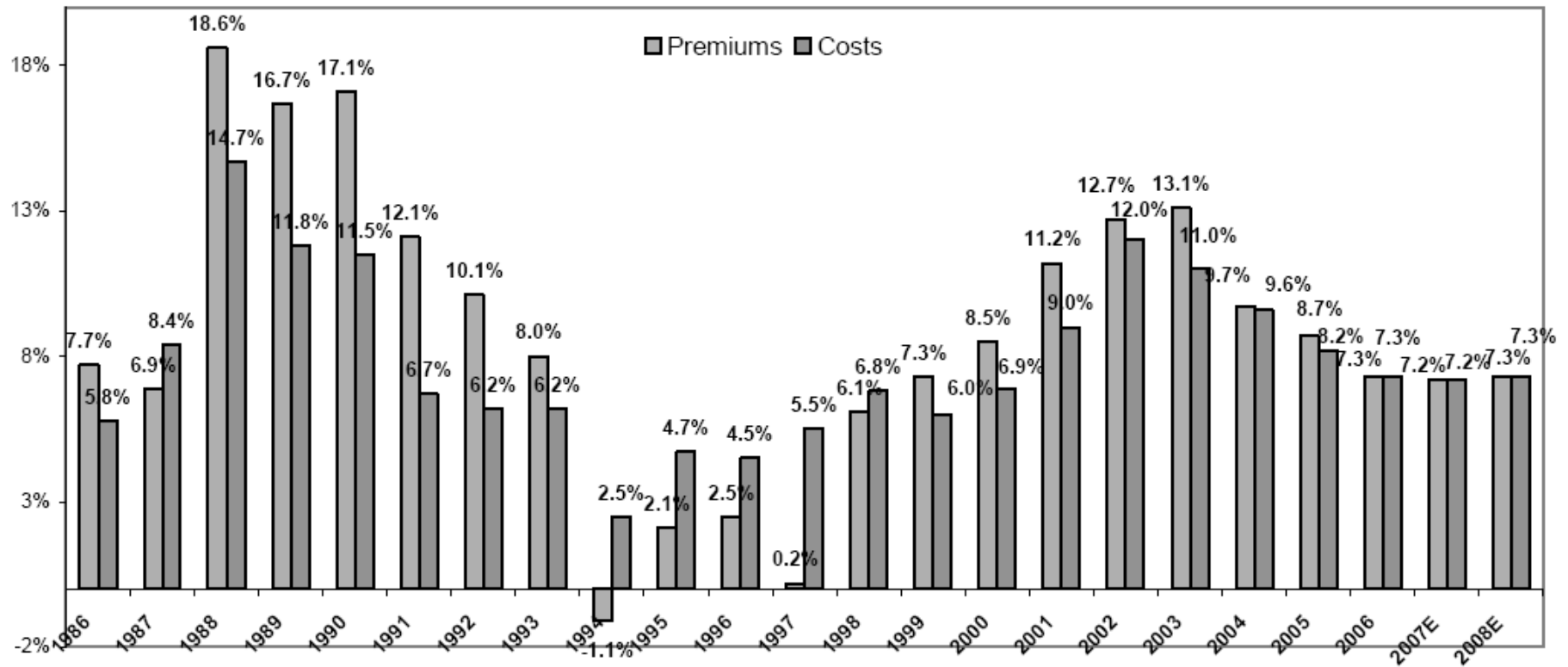
BLS PPI-Physician Services, Annual



Anyone see a 3% terminal growth rate here???

UNDERWRITING CYCLE

Figure 6: Commercial Pricing Yields and Cost Trends: 1986-2008E

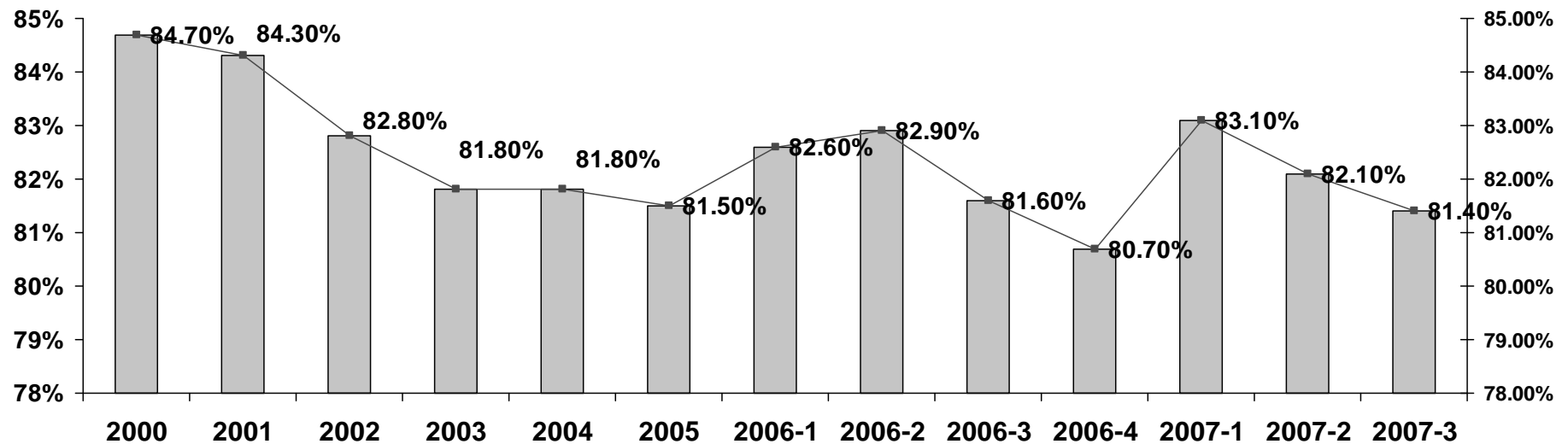


Source: Milliman, CMS, company documents and Lehman Brothers estimates

Medical Loss Ratio: The portion of Premium spent on Insured's Care

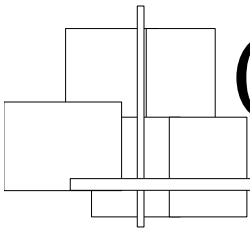


Trend in MLR



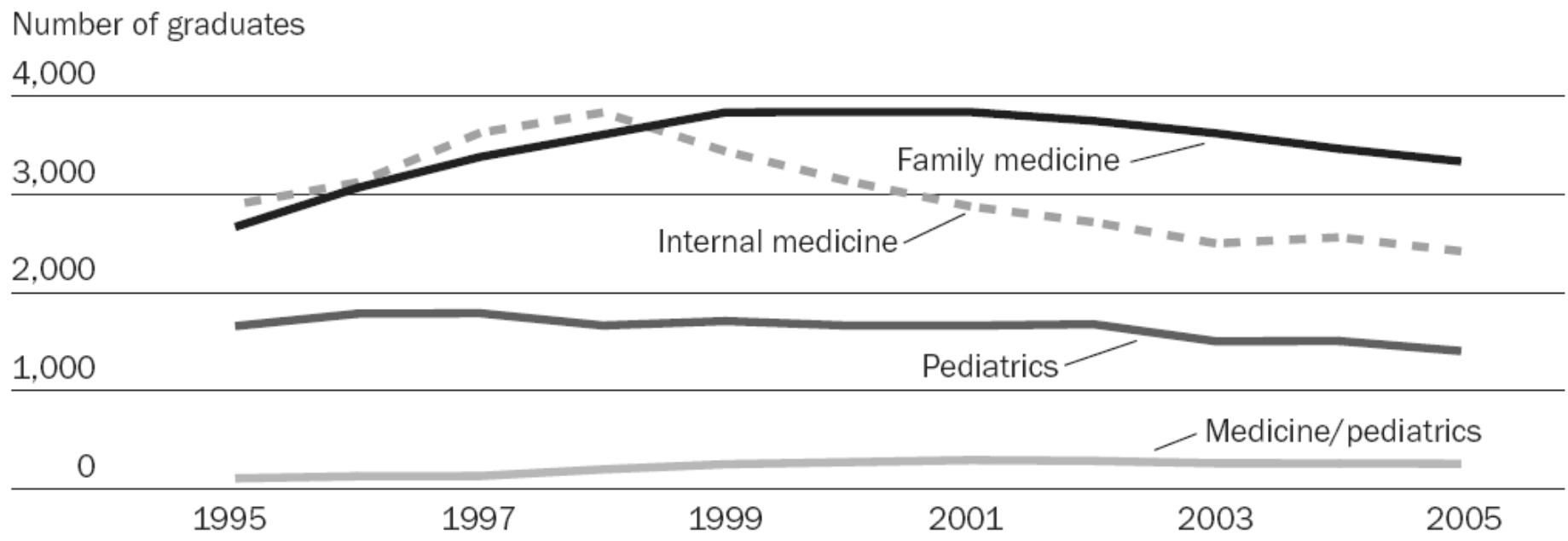
One of several key issues in the National Debate over Healthcare and particularly the Medicare Advantage program. Cost has to go somewhere.

EQUALLY DRAMATIC PHYSICIAN SHORTAGES COMING



PHYSICIAN SHORTAGES

Number Of Generalist Physician Graduates, By Specialty, 1995-2005

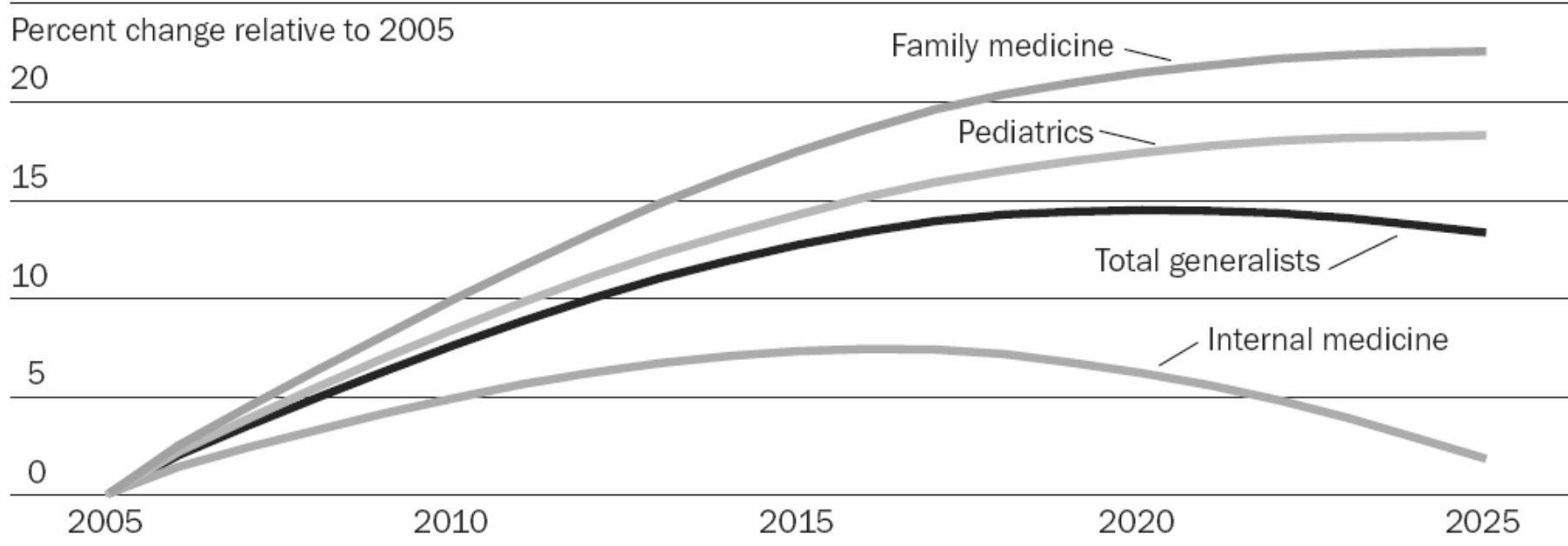


SOURCES: American Academy of Family Physicians, American Board of Internal Medicine, American Board of Pediatrics, and American Osteopathic Association.

NOTES: Figures include both allopathic and osteopathic physicians. Generalist physician graduates are calculated as residency graduates minus first-year fellows and those changing specialties.

PHYSICIAN SHORTAGES

Projected Percentage Change In Number Of Generalist Physicians, By Specialty, 2005-2025



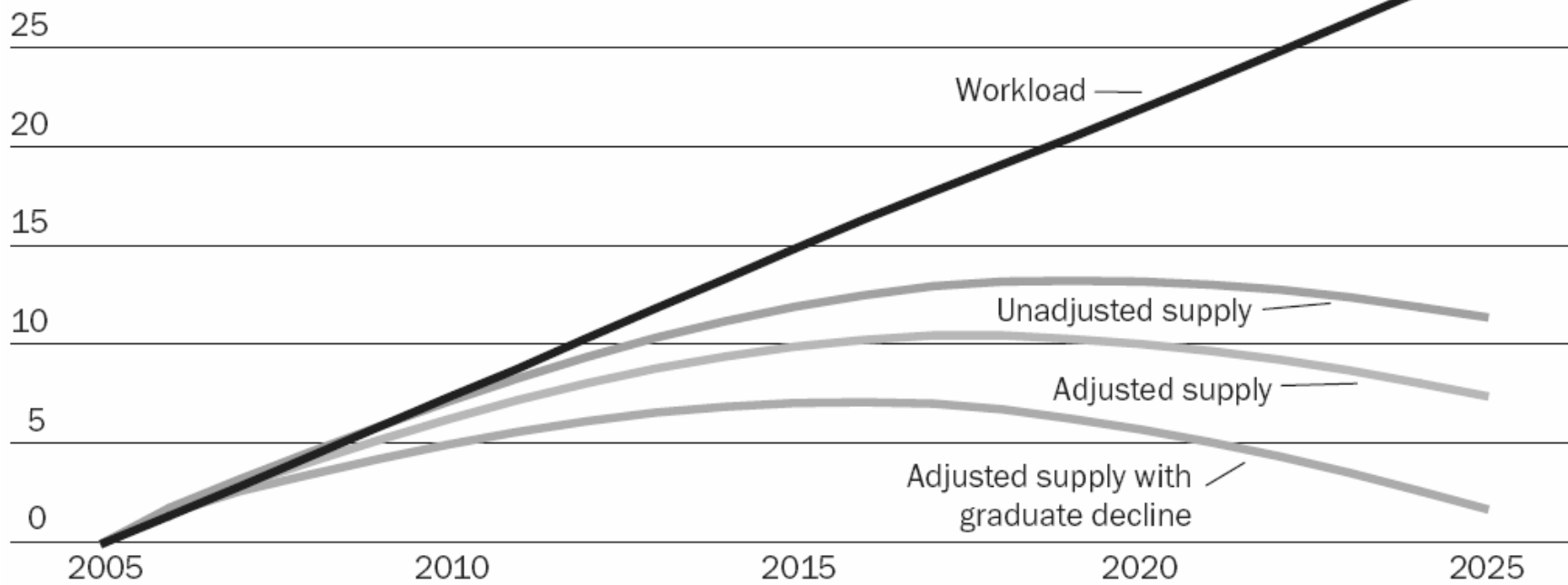
SOURCE: Authors' calculations using the Physician Supply Model, Bureau of Health Professions.

NOTE: Physician supply is unadjusted.

PHYSICIAN SHORTAGES

Care For Adults: Projected Percentage Change In Workload And Number Of Generalists, 2005-2025

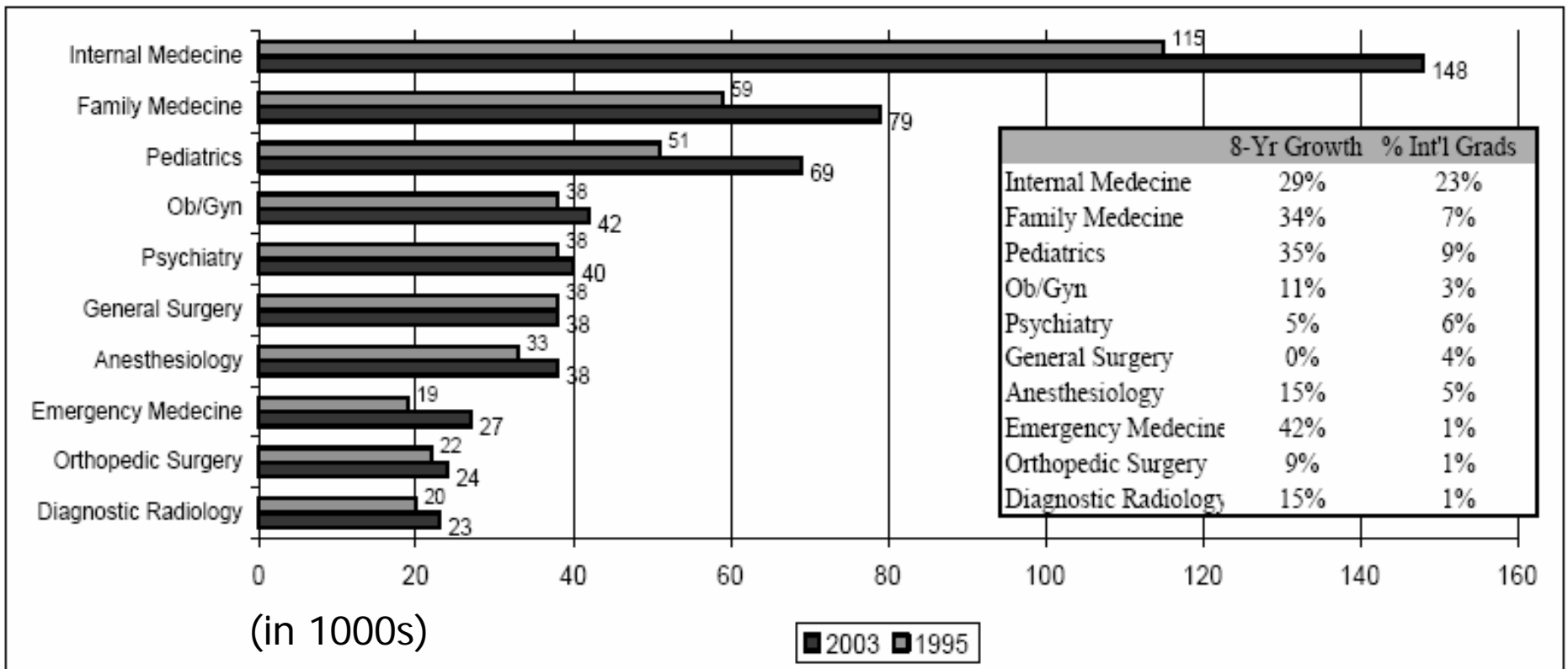
Percent change relative to 2005



SOURCES: Data on workload (visits) are from the authors' analysis of data from the National Ambulatory Medical Care Survey (NAMCS), combined 2003-2005 data. Data on supply are from the authors' calculations using the Physician Supply Model, Bureau of Health Professions.

NOTES: Adjusted supply denotes adjustment for age and sex. Graduate decline extends the 2002-2005 rate of decline in graduates through 2008.

CHANGES IN DISTRIBUTION OF PHYSICIANS BY SPECIALTY



With Lehman gone, Raskin is now at Barclays!

Source: American Medical Graduates

DISTRIBUTION OF PHYSICIANS BY REGION

Part B practitioners/CMS region

	Active practitioners	Practitioners per 100,000 population
All regions	¹ 1,226,327	414
Boston	95,316	669
New York	145,680	457
Philadelphia	130,492	453
Atlanta	218,627	381
Chicago	208,189	406
Dallas	116,451	327
Kansas City	61,934	467
Denver	45,527	456
San Francisco	149,235	326
Seattle	54,876	456

¹Non-Federal physicians only. Includes limited licensed, non-physician practitioners. Unduplicated count (may include practitioners practicing in multiple sites or States). Unknown provider States distributed. NOTES: Physicians as of March 2007. Civilian population as of July 1, 2005. Resident population for outlying areas and the Virgin Islands are not available.

SOURCES: CMS, ORDI, and the Bureau of the Census.

PHYSICIAN SHORTAGE VALUATION²

THE POWER OF TWO IN BUSINESS VALUATION

IMPACT ON VALUE

- In standard Economic Theory, what happens when there is a shortage of buyers for a product? Price drops to meet available demand!
- In business in general, Value is *also* driven by such factors, as well as ease of entry into the market – a high demand for services and few providers leads to long waits and ease of entry – developing a patient base is easier!
- High recruiting salaries and incentives decrease the potential “profit” or added earnings from buying a practice!

2008 SURVEY

- Hospitals represent an increasing share of the recruitment market

Medical Settings of Physician Search Assignments

	<u>2007/08</u>	<u>2006/07</u>	<u>2005/06</u>	<u>2004/05</u>
Hospital	1,416 (45%)	1,297 (43%)	654 (23%)	510 (19%)
Group	1,170 (37%)	1,058 (35%)	1,136 (40%)	1,290 (48%)
Solo	159 (5 %)	244 (8 %)	483 (17%)	492 (18%)
Partnership	226 (7%)	238 (8%)	454 (16%)	242 (9%)
Association	29 (1%)	99 (3%)	28 (1%)	48 (2%)
Other	134 (4%)	74 (2%)	85 (3%)	105 (4%)
HMO	12 (1%)	6 (1%)	0 (0%)	0 (0%)

2008 SURVEY

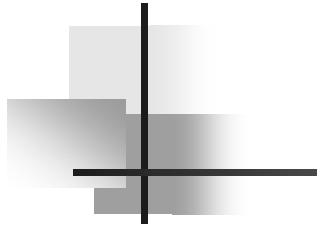
- Primary care MDs represent an increasing share of the recruitment market

	<u>2007/08</u>	<u>2006/07</u>	<u>2005/06</u>	<u>2004/05</u>
Family Practice*	492	303	257	166
Internal Medicine	314	273	274	188
Hospitalist	208	194	112	62
OB/GYN	159	111	83	103
Orthopedic Surgery	145	172	207	210
Radiology	109	187	237	218
Psychiatry	106	69	80	54
Emergency Medicine	90	91	91	47
Neurology	84	58	69	56
General Surgery	81	121	165	116

2008 SURVEY

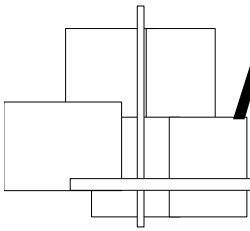
- Curiously, Cardiologist recruitment at this firm has dropped considerably

Urology	74	63	75	59
Pediatrics	72	63	41	48
Cardiology	69	163	174	231
Gastroenterology	68	78	105	94
CRNA	61	61	117	102
Anesthesiology	52	46	70	64
Pulmonology	48	29	n/a	n/a
Otolaryngology	47	56	57	54
HEM/ONC	46	59	45	n/a
Dermatology	35	45	39	n/a



	<u>Low</u>	<u>Average</u>	<u>High</u>
Family Practice			
2007/08	\$120,000	\$172,000	\$275,000
2006/07	\$120,000	\$161,000	\$250,000
2005/06	\$115,000	\$145,000	\$220,000
2004/05	\$125,000	\$150,000	\$200,000
Family Practice with Obstetrics			
2007/08	\$140,000	\$184,000	\$275,000
2006/07	\$145,000	\$159,000	\$200,000
2005/06	\$140,000	\$158,000	\$180,000
2004/05	N/A	N/A	N/A
Internal Medicine			
2007/08	\$125,000	\$176,000	\$330,000
2006/07	\$135,000	\$174,000	\$275,000
2005/06	\$130,000	\$162,000	\$250,000
2004/05	\$130,000	\$161,000	\$210,000
Hospitalist			
2007/08	\$150,000	\$181,000	\$300,000
2006/07	\$145,000	\$180,000	\$250,000
2005/06	\$140,000	\$175,000	\$190,000
2004/05	\$150,000	\$171,000	\$210,000
OB/GYN			
2007/08	\$160,000	\$255,000	\$405,000
2006/07	\$200,000	\$247,000	\$345,000
2005/06	\$175,000	\$234,000	\$450,000
2004/05	\$200,000	\$247,000	\$320,000

OPPORTUNITIES TO ENHANCE INCOME THROUGH ANCILLARIES ARE DECLINING



IMAGING, IMAGING, LESS IMAGING?!

**TABLE
2B-4**

Use of physician services per fee-for-service beneficiary continues to increase

Type of service	Change in units of service per beneficiary		Change in volume per beneficiary*		Percent of total volume*
	Average annual 2001-2005	2005-2006	Average annual 2001-2005	2005-2006	
All services	4.5%	0.9%	5.2%	3.6%	100.0%
All services excluding outpatient rehab	3.4	2.1	4.9	4.1	97.8
Evaluation and management	1.7	1.1	3.3	2.8	39.5
Office visit—established patient	1.7	1.5	3.1	2.8	16.9
Hospital visit—subsequent	1.3	2.1	2.6	3.0	7.7
Consultation	3.1	-6.7	4.7	-0.7	5.5
Emergency room visit	1.9	-0.7	4.8	1.6	2.6
Nursing home visit	1.1	3.9	2.8	15.5	2.0
Hospital visit—initial	0.6	-0.3	1.2	0.1	1.8
Office visit—new patient	0.4	1.2	0.6	1.4	1.8
Imaging	5.5	3.2	9.1	6.2	16.6
Advanced—CT: other	12.1	10.0	15.3	11.6	2.4
Standard—nuclear medicine	8.9	2.1	12.6	3.8	2.4
Echography—heart	7.5	4.6	9.5	5.5	2.3
Advanced—MRI: other	14.6	8.0	15.7	8.5	2.0
Standard—musculoskeletal	4.0	1.8	4.6	2.3	1.2
Advanced—MRI: brain	8.8	4.3	10.1	4.0	1.1
Echography—other	7.0	7.4	11.1	7.7	0.8
Imaging/procedure—other	12.4	2.3	10.8	13.5	0.7
Standard—breast	11.2	6.9	-5.2	5.2	0.7
Standard—chest	1.1	-0.6	0.5	-1.4	0.6
Echography—carotid arteries	5.6	3.5	9.5	6.4	0.6
Advanced—CT: head	6.3	6.8	7.8	8.3	0.6

IMAGING, IMAGING, VALUATION² *LESS* IMAGING?!

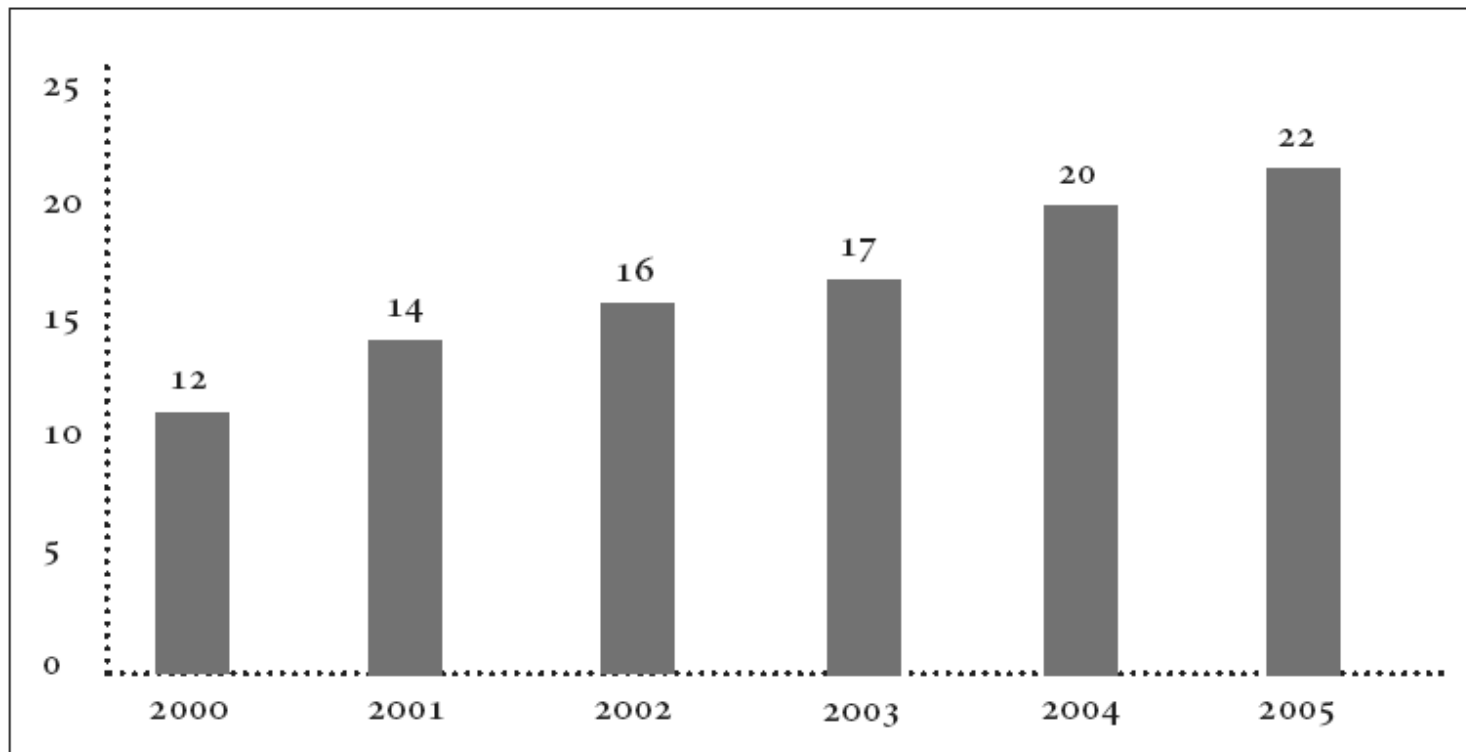
THE POWER OF TWO IN BUSINESS VALUATION

- “The two variables that proved most predictive of variations in state-level Medicare radiology utilization per 1000 enrollees were the total number of Medicare providers in the state and the number of radiologists per state population.” [1]
- “In the state-level analysis, we found that a high utilization per 1000 Medicare enrollees in any year was strongly correlated with a low compound average annual rate of increase in utilization per 1000 enrollees in the ensuing years.”
- [1] Utilization of Radiology Services in the United States: Levels and Trends in Modalities, Regions, and Populations, Bhargavan & Sunshine, *Radiology*, March 2005

IMAGING, IMAGING, VALUATION² LESS IMAGING?!

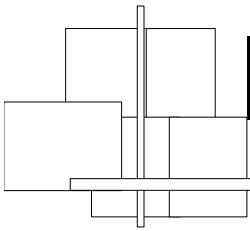
VALUATION²
THE POWER OF TWO IN BUSINESS VALUATION

CT Scans in the United States for All Payers, per 100 Population



Source: McKinsey Global Institute, *Accounting for the Cost of Health Care in the United States*, January 2007

Nonradiologist Usage Driving Growth Rates Due To Incentives From Self-referrals



From Recent Trends in Utilization of the Major
Imaging Modalities, David Levin, MD
RBMA 2007 Summit, St Louis

IMAGING, IMAGING, VALUATION² *LESS* IMAGING?!

- “Utilization of CT in the Medicare population grew from slightly more than 300/1000 beneficiaries in 2000 to about 473/1000, a 49% growth rate, in 2004
- Radiologist utilization of CT in the Medicare population grew 53% between 2000 and 2004 (from under 300/1000 to about 450/1000)
- Nonradiologist utilization of CT in the Medicare population grew 92% between 2000 and 2004 (from a little more than 6/1000 to just under 12/1000)
- Independent diagnostic testing facility (IDTF) share of the Medicare CT market grew 338% between 2000 and 2004 (from less than 2/1000 to less than 8/1000)

IMAGING, IMAGING, VALUATION² *LESS* IMAGING?!

- Radiologist utilization of MRI examinations in the Medicare population grew by 68% between 2000 and 2004 (from about 80/1000 to just under 140/1000)
- Nonradiologist utilization of MRI examinations in the Medicare population grew 119% between 2000 and 2004 (from less than 4/1000 to nearly 8/1000)
- IDTF share of the Medicare MRI market grew 175% from 2000 to 2004 (from about 5/1000 to just less than 14/1000)

IMAGING, IMAGING, *LESS* IMAGING?!

- Growth Rates in In-Office MRI
 - Radiologists: 80%
 - Orthopedists: 408%
 - Neurologists: 170%
 - PCPs: 250%
 - Internal Medicine sub-specialists (excluding cardiologists): 2100%

GAO STUDY: JUNE, 2008

- Substantial Variation of In-Office Imaging Use across Geographic Regions Raises Concerns about Appropriate Use
- “We found that per beneficiary spending on imaging services provided in physician offices varied almost eight-fold across the states in 2006—from \$62 in Vermont to \$472 in Florida.”
- And more on that in the Markets segment!

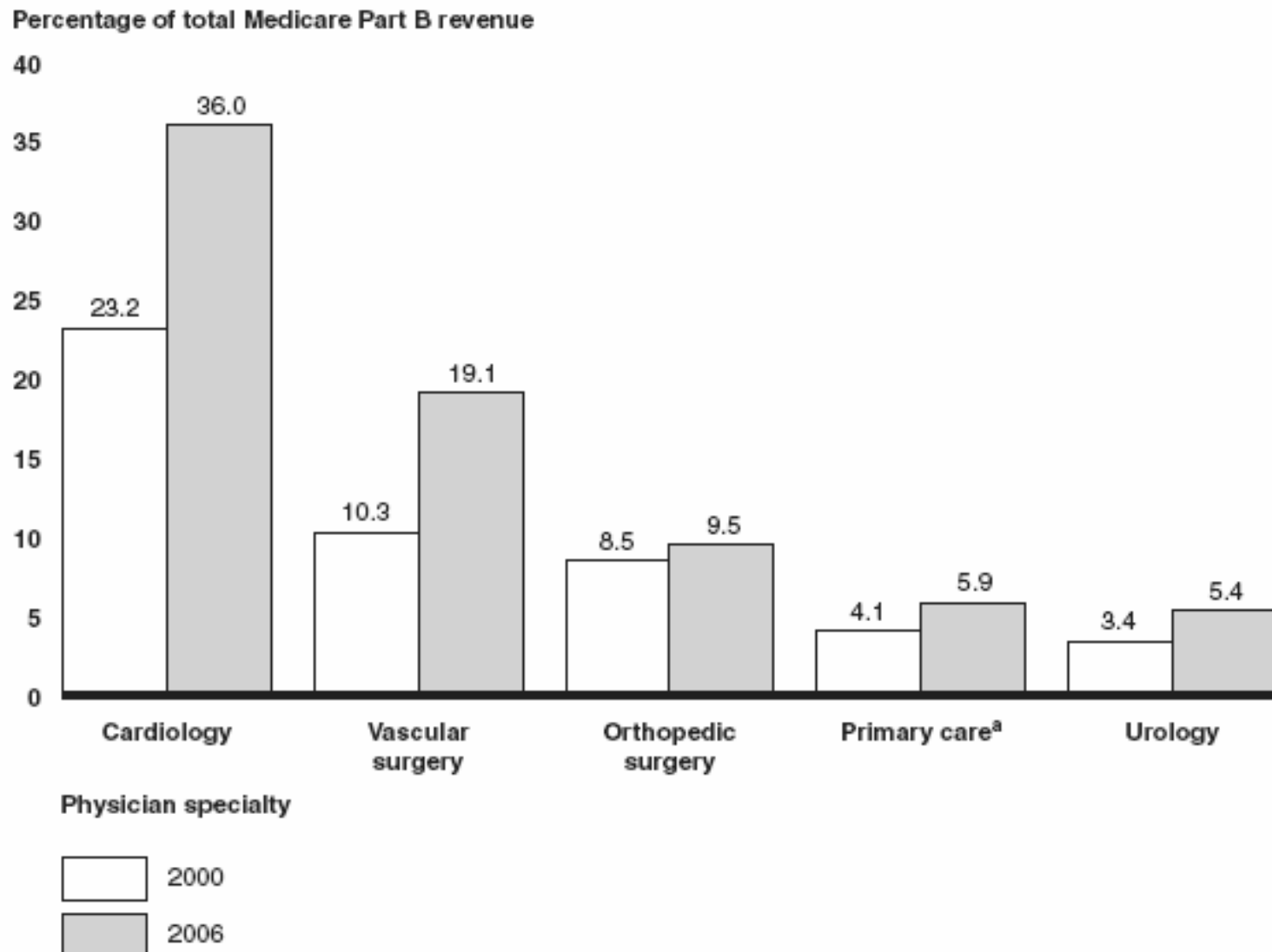
Figure 5: Per Beneficiary Spending on In-Office Imaging Services, 2006



More later!

GAO
 J
 u
 n
 e
 ,
 2
 0
 0
 8

Figure 4: Share of Total Medicare Part B Revenues Derived from In-Office Imaging Services by Physician Specialty, 2000 and 2006



Medicare Spending on Imaging Services Paid for under the Physician Fee Schedule by Modality, 2000 through 2006



Dollars in millions

Imaging modalities	2000	2001	2002	2003	2004	2005	2006
CT	975	1,205	1,308	1,521	1,818	2,076	2,171
MRI	1,002	1,316	1,451	1,768	2,155	2,738	2,982
Nuclear medicine	973	1,263	1,439	1,735	2,080	2,303	2,418
Ultrasound	1,842	2,116	2,204	2,490	2,823	3,208	3,334
X-ray and other standard imaging	1,711	1,925	2,013	2,189	2,391	2,464	2,485
Procedures that use imaging	386	473	555	686	840	708	715
Total for advanced imaging	2,951	3,783	4,197	5,025	6,052	7,116	7,571
Total for standard imaging	3,939	4,515	4,771	5,366	6,054	6,380	6,534
Overall total	6,891	8,298	8,969	10,390	12,106	13,496	14,105

Source: GAO analysis of Medicare Part B claims data.

Table 2: Medicare Physician Fees for Most Commonly Billed Imaging Services in 2006, by Imaging Modality

Imaging modality	Most commonly billed imaging test	Fee for performing the test	Fee for interpreting the test	Total fee
MRI	MRI brain without and with dye	\$995	\$123	\$1,118
Nuclear medicine	Heart image (3D), multiple	\$471	\$77	\$548
CT	CT of the head/brain without contrast	\$189	\$44	\$233
Ultrasound	Doppler echo examination, heart	\$69	\$20	\$90
X-ray and other standard imaging	Chest X-ray	\$19	\$9	\$28
Procedures that use imaging	Injection for coronary X-ray	*	*	\$22

AMBULATORY SURGERY CENTERS

For the Surgical Specialties,
Something Worth Considering

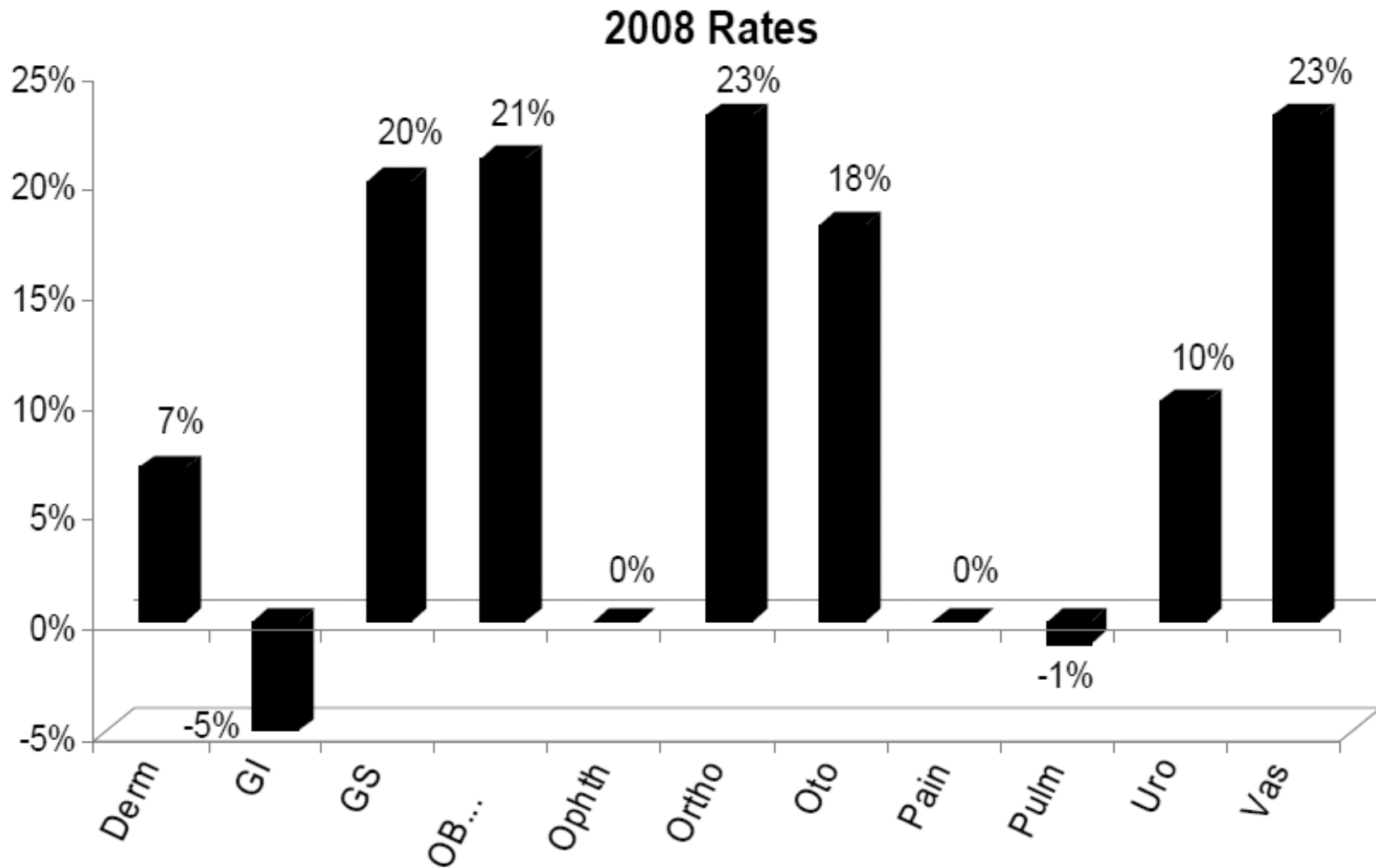


ASCs

- CON states vs Non-CON States
- Hospital Competition
- Hospital Association Lobbying Strength
- Better for Some Specialties than Others
- Changing Physician-Investor Practice Patterns
 - Never ceases to amaze that Physicians continue to use HOPD even after investing their own money!
- Changing Patient Perceptions

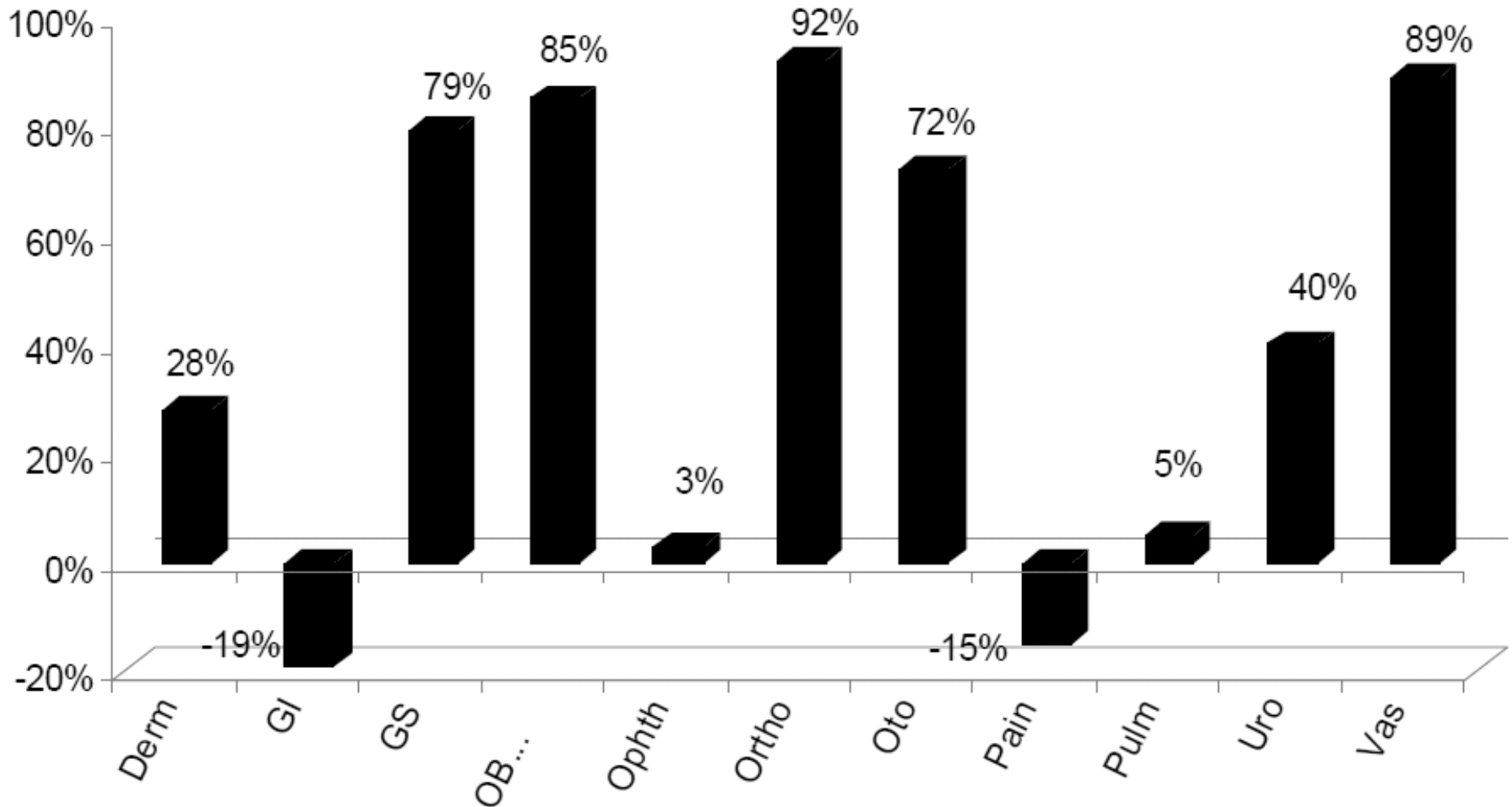
From Todd Sorensen's ASC Chapter in BVR's *Guide to Healthcare Valuation*

WINNERS & LOSERS



WINNERS & LOSERS

2008 Fully Implemented Rates



REVENUE GROWTH HAS SLOWED RECENTLY



Figure 16: ASC Same-Store Revenue Growth

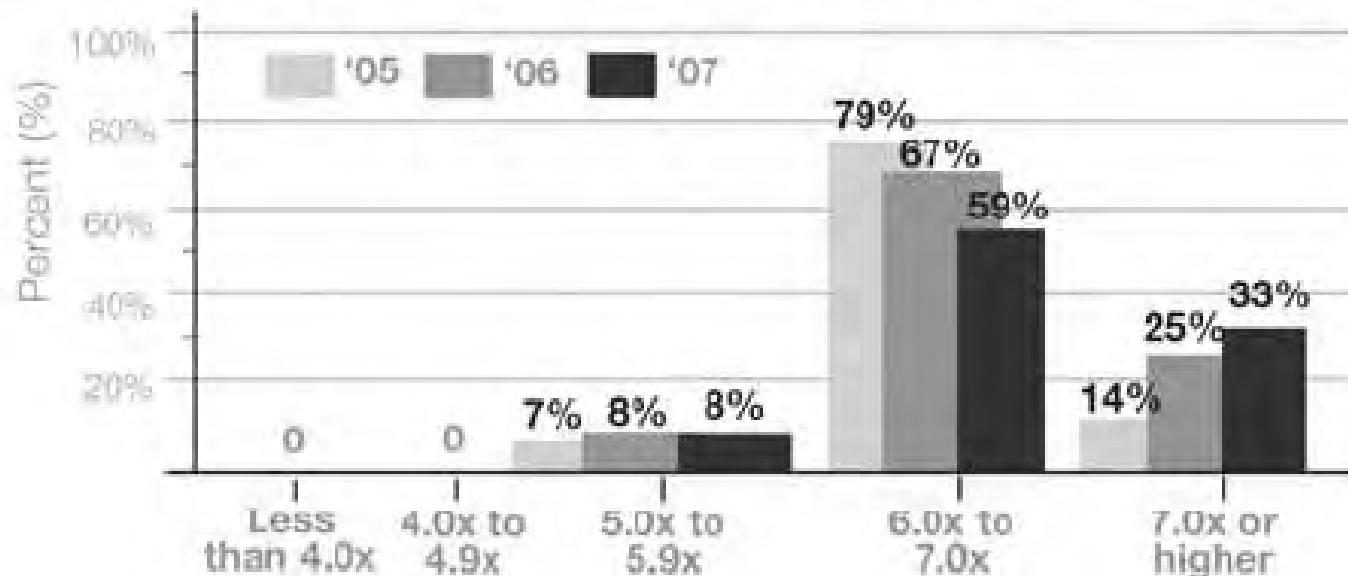
	1Q06	2Q06	3Q06	4Q06	1Q07	2Q07	3Q07	4Q07	1Q08
AMSG	8.0%	5.0%	4.0%	3.0%	3.0%	3.0%	5.0%	7.0%	3.0%
SMBI	5.4%	7.2%	8.7%	7.8%	3.2%	-2.0%	NA	NA	NA
USPI (U.S. only)	9.8%	3.5%	7.8%	13.1%	11.3%	12.1%	8.3%	8.7%	7.9%
Average	7.7%	5.2%	6.8%	8.0%	5.8%	4.4%	6.6%	7.9%	5.5%

Source: Company filings, Lehman Brothers

HEALTHCARE APPRAISERS 2008 ASC VALUATION ANNUAL SURVEY



9. What valuation multiples (i.e., for a controlling interest) have you most typically observed in the marketplace during the past 12 months?



HEALTHCARE APPRAISERS 2008 ASC VALUATION ANNUAL SURVEY



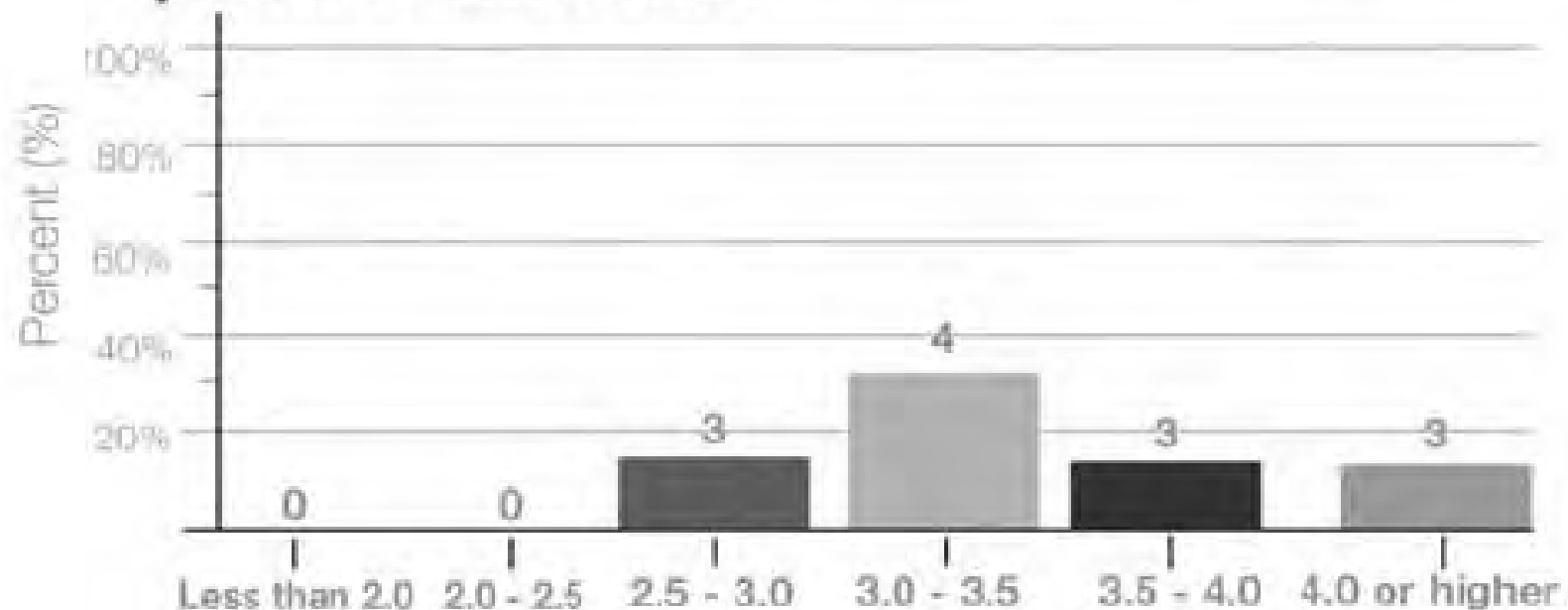
15. How do you determine FMV for buy-in (e.g., new physician investors)?

Formula	7
Independent FMV Opinion	4
Independent Pricing Analysis	0
Board Determined Amount	0
Based on an independent pricing analysis (guidelines)	1
Other	1

HEALTHCARE APPRAISERS 2008 ASC VALUATION ANNUAL SURVEY



16. What valuation multiples (i.e., for minority interest *buy-in*) have you most typically observed in the marketplace during the past 12 months?





II. Understanding Differences in Geographic Market Pricing

Healthcare Market Structure And Its Implication For Valuation Of Privately Held Provider Entities*

OR

If It Works In Miami, It May Not Work In Boston But It
Might Work In Dallas!!

Mark O. Dietrich, CPA/ABV

* *Business Valuation Review*, Summer, 2008, Peer Reviewed



Importance

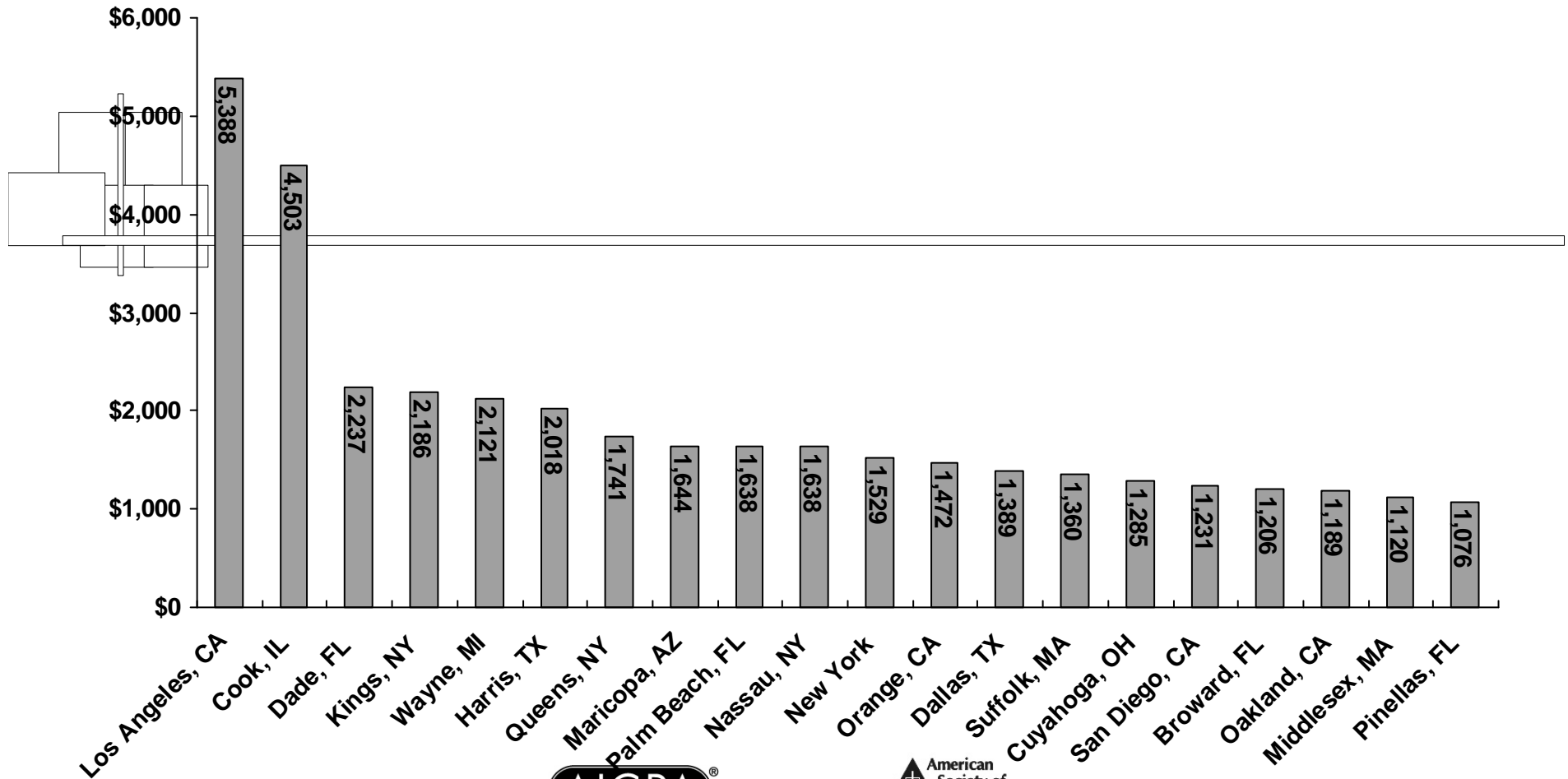
- Healthcare Industry strategies tend to originate in one area and spread to others: Managed Care & Integrated Delivery Systems started on the West Coast, for example. Sort of an “Old Economy” version of Viral Marketing.
- Although Strategies, like Viruses, may be successful at their origin point, they are not always successful everywhere!
- In the Business of Healthcare, specific Market Conditions suggest whether a Strategy can be replicated, much the same way that Environmental Conditions affect the ability of a Virus to replicate and spread

The Factors

- High Medicare Spending
- Presence and market strength of **Blue Cross** plans
- Overall Health Insurer Concentration
- Degree of market strength of local **Nonprofit Health Insurers** versus **For-profit Health Insurers**
- The degree of market strength of local **Nonprofit Hospitals** versus **For-profit Hospitals**
- Certificate of Need laws and
- Other local demographic and economic factors

High Medicare Spending

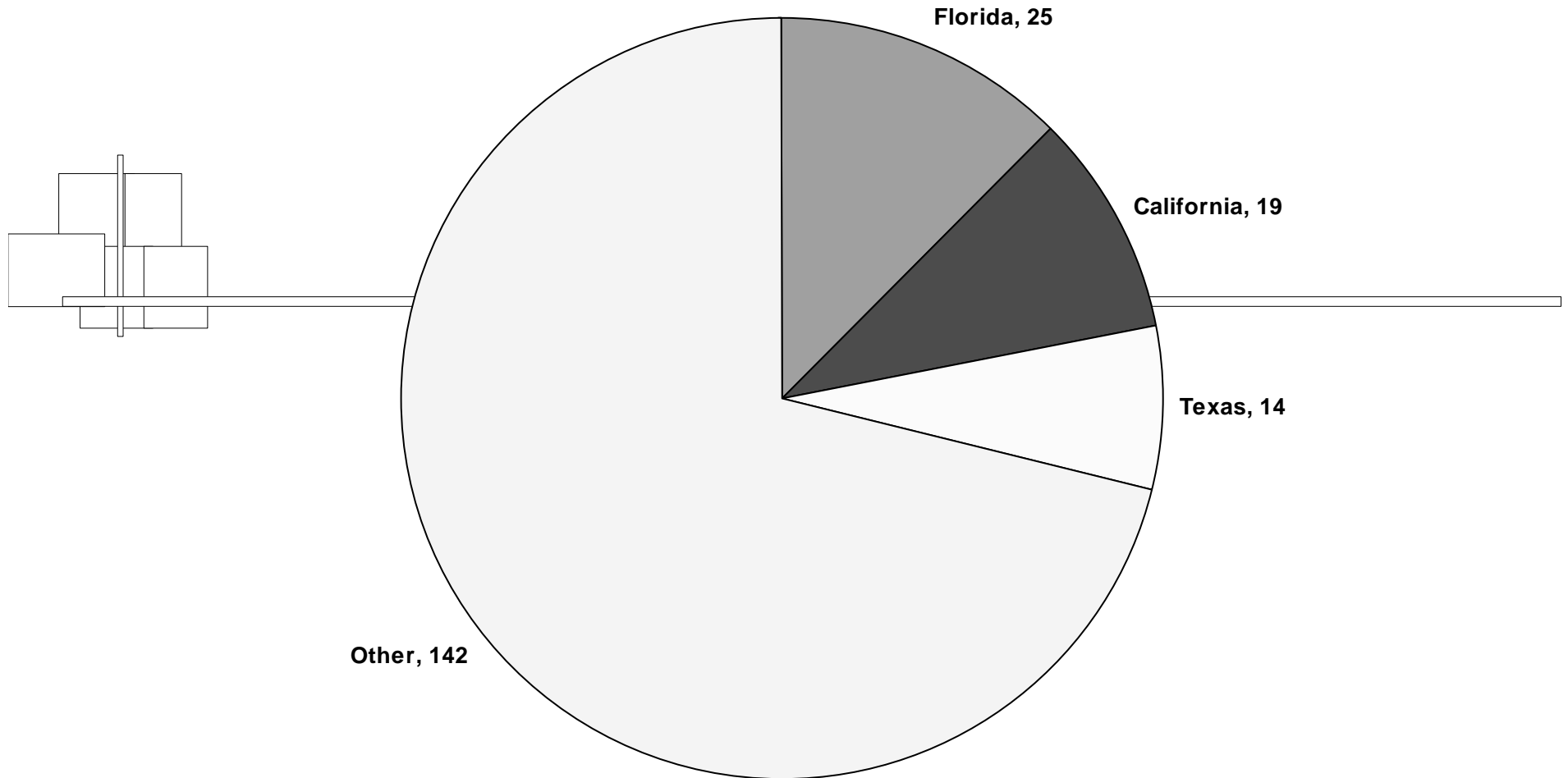
20 Largest Counties for 2005 Medicare Spending (\$Billions)



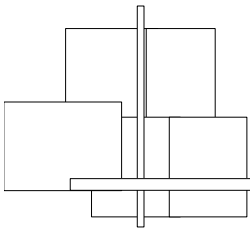
AICPA
California, Florida, New York, Texas, Massachusetts



of Top 200 Counties for Part A & B Total Spending



Market Strength Of Blue Cross Plans & Overall Health Insurer Concentration



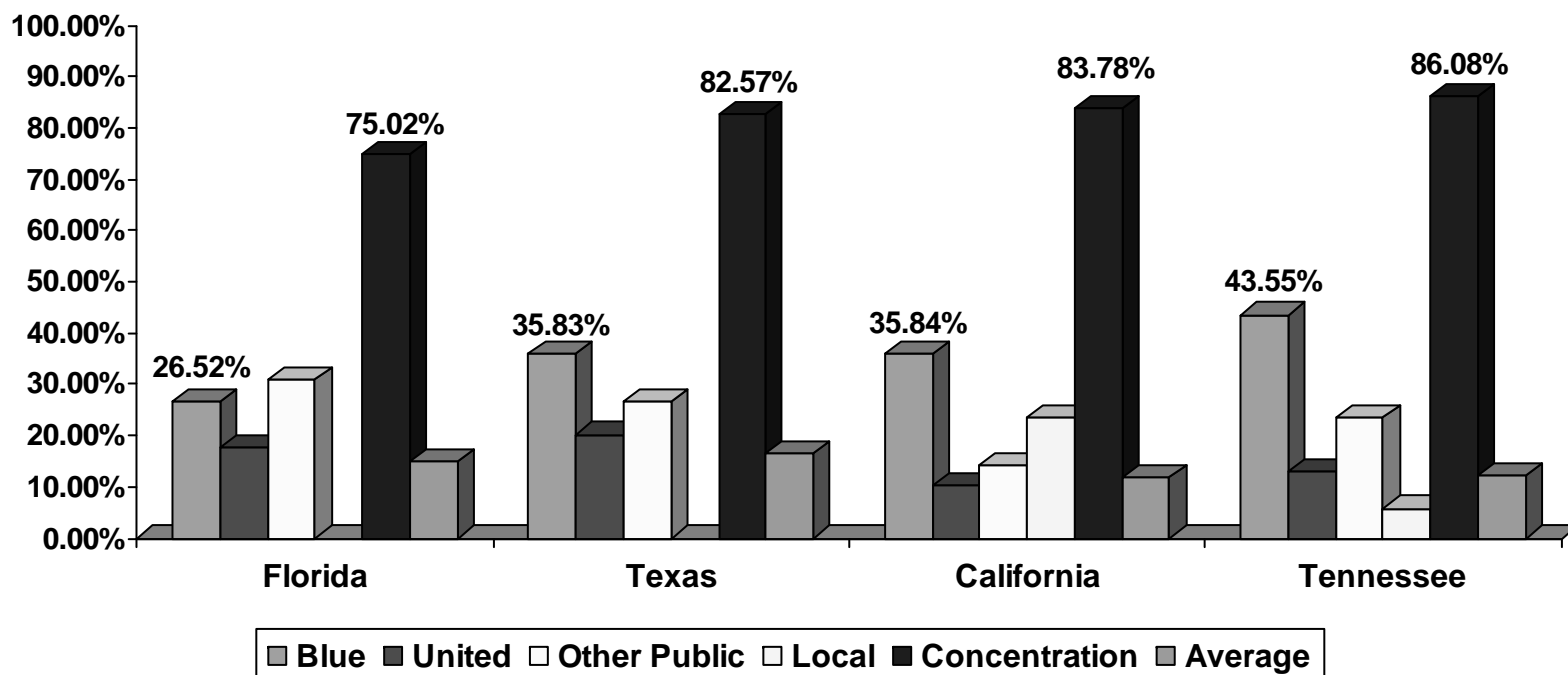
Market Concentration is defined here as the total market share of the Blue Plans, Public Health Insurers and large local health insurers

And a Tip of the Hat to JD Epstein!



Blue Plans and Monopsony* Concentration

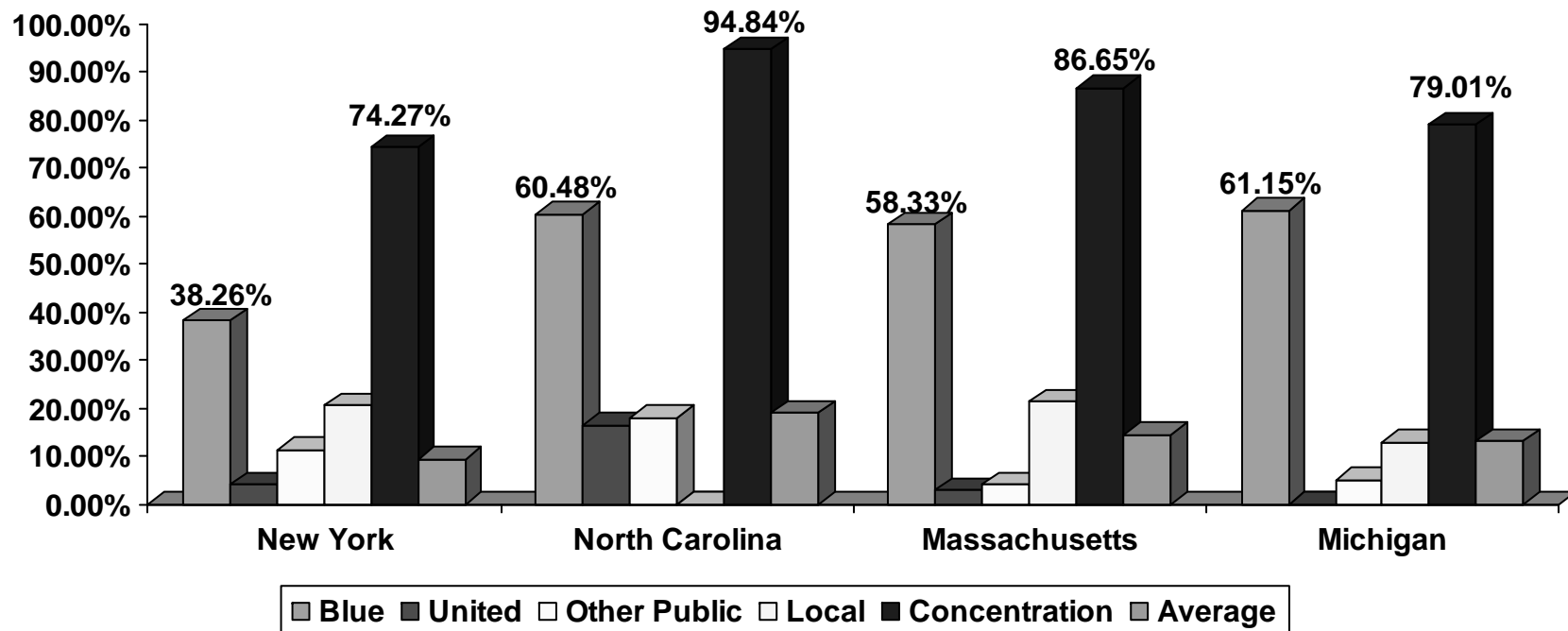
Insurance Market Concentration in States Where For-Profit Providers are Prevalent



*A market controlled by a large **buyer** as opposed to seller

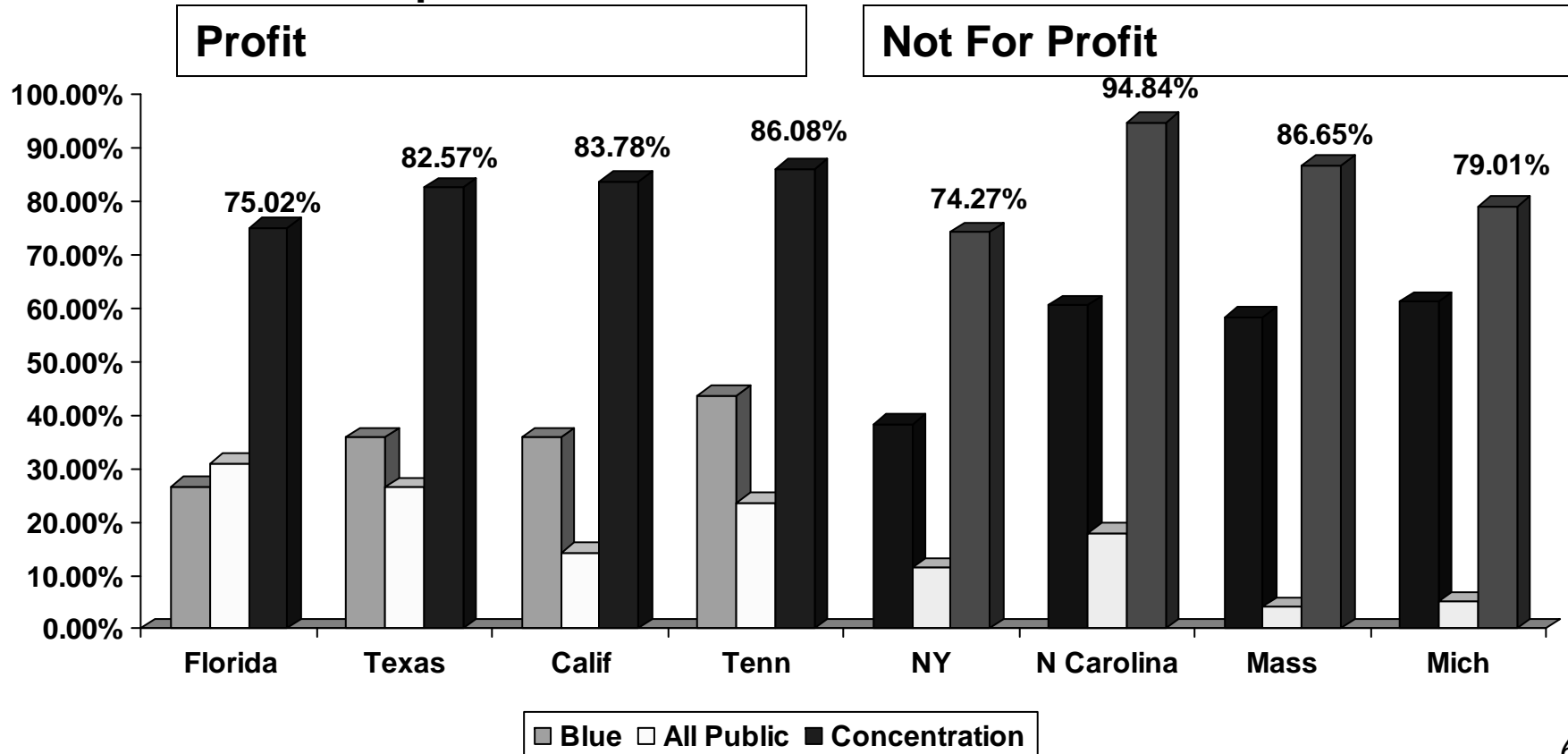
Blue Plans and Monopsony Concentration

Insurance Market Concentration States Where For-Profit Providers are *not* Prevalent



Comparison of Profit & Not For Profit States

Comparative Insurance Market Consolidation

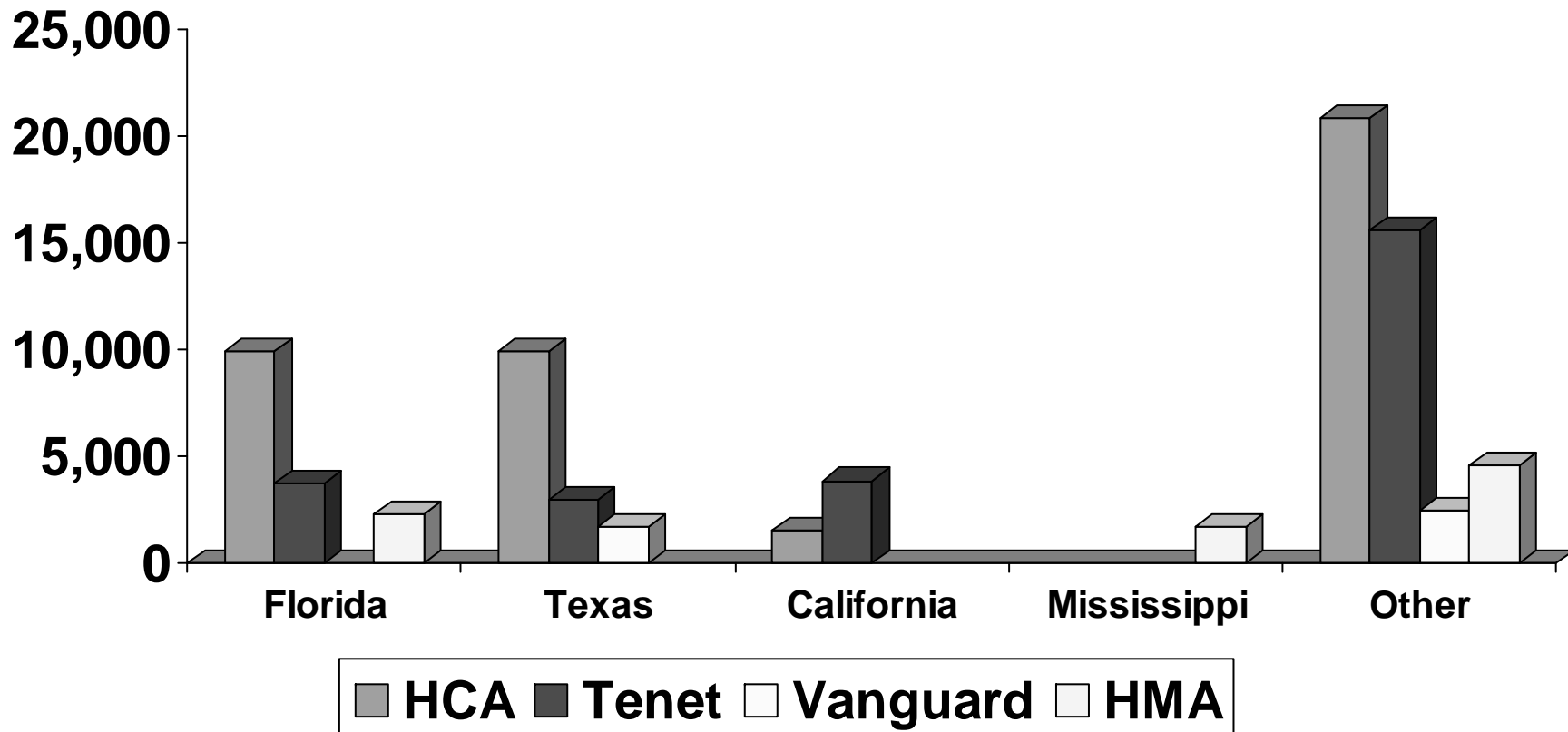


For Profit Hospital States

- Florida
- Texas
- California
- Tennessee
- Others *primarily* south of the Mason-Dixon Line
- Exceptions, of course!

Representative For Profit Hospital Chains

Number of Beds by State



NonProfit Hospital States

- New York
- North Carolina
- Massachusetts
- Michigan
- Illinois
- North Dakota, Iowa
- Exceptions, of course, but less than you would expect!

“Wealthy” Teaching Hospitals

- Harvard-Affiliated Partners Health System in Boston
- Baylor Health Care System in Dallas
- Yale-New Haven Hospital
- New York City: Mt. Sinai Hospital, Beth Israel Medical Center and NYU Medical Center
- The University of Chicago Health System and Northwestern Memorial Hospital and Health System
- Johns Hopkins Hospital and Health System in Baltimore

Query

- When Will a For Profit Hospital Locate in Boston?

- When Pigs Fly!



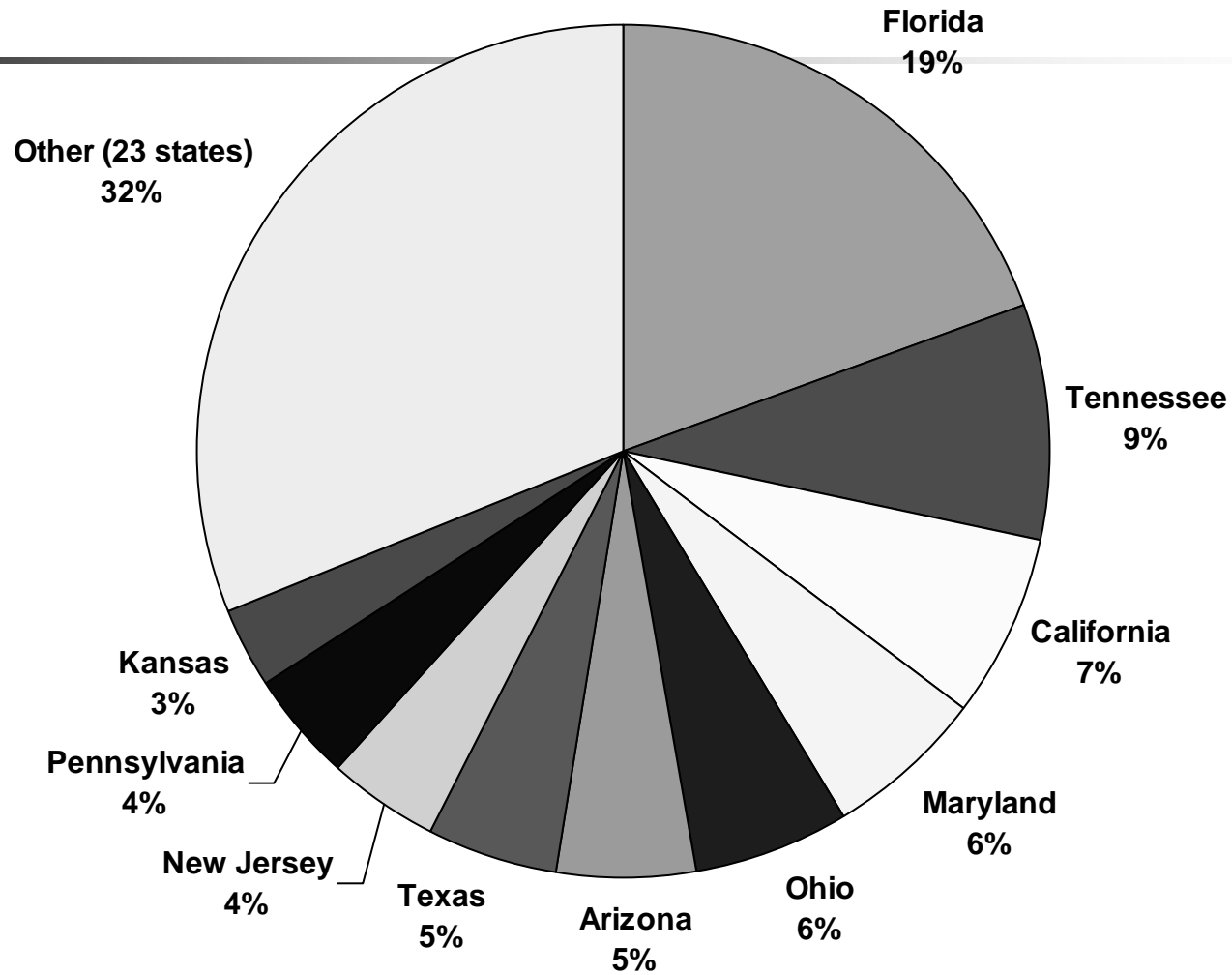
Hospital Market Data

- As Reed Tinsley and I asked in a co-authored article in the December 2006 American Bar Association's *The Heath Lawyer*:
 - "What does [out of market] transaction data say or reveal about the value of a hospital with EBITDA of \$1.0 million located in North Carolina? Does it tell a valuator that it could be worth the median [multiple] value of \$5 million or the [average multiple] value of \$7.5 million – the average being 50% greater than the median? Could it be worth [the highest multiple value of] \$18.2 million? Given the Stark regulations requirement that comparable transactions be in a particular market at the time of acquisition, can any of these [out of market] multiples be used?"

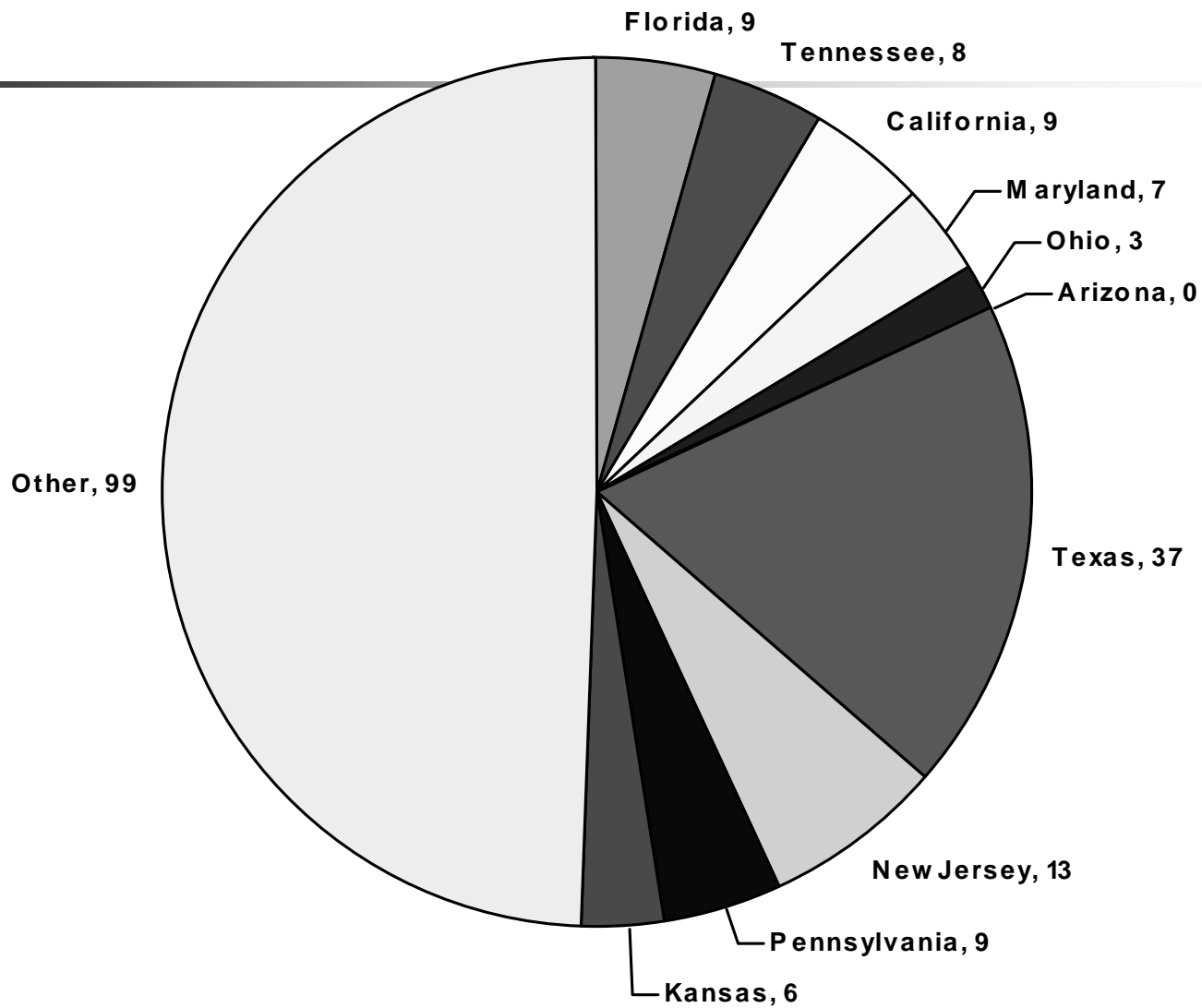
Certificates of Need

- State-issued facility license
- Highly politicized
- **Florida, Texas**, Pennsylvania and **California** do not require a CON for an ASC! (Recognize those **Bold** States?)
- Many of ASC-Consolidator AmSurg's facilities are located in these states!

AMSG ORs by State



of Top 200 Counties for Part B Per Capita Spending



Other Factors

		RANKINGS					
Top 10 AMSG States	For- Profit Beds %	MD Spending%	For- Profit Beds	Total Healthcare Spending	Metropolitan Pop	MD Spending	Per Capita
Florida	34.60%	31.50%	3	4	6	9	19
Tennessee	24.90%	31.40%	10	15	26	10	21
California	17.10%	33.40%	18	1	2	3	44
Maryland	3.00%	28.70%	34	19	7	20	18
Ohio	1.80%	26.80%	39	7	25	35	15
Arizona	21.00%	33.00%	15	21	14	5	50
Texas	34.30%	30.80%	4	3	11	11	45
New Jersey	2.80%	28.20%	35	9	1	27	13
Pennsylvania	8.50%	26.60%	28	5	22	38	11
Kansas	14.40%	31.50%	22	31	35	8	24
United States	14.10%	28.20%	NA	NA	NA	NA	

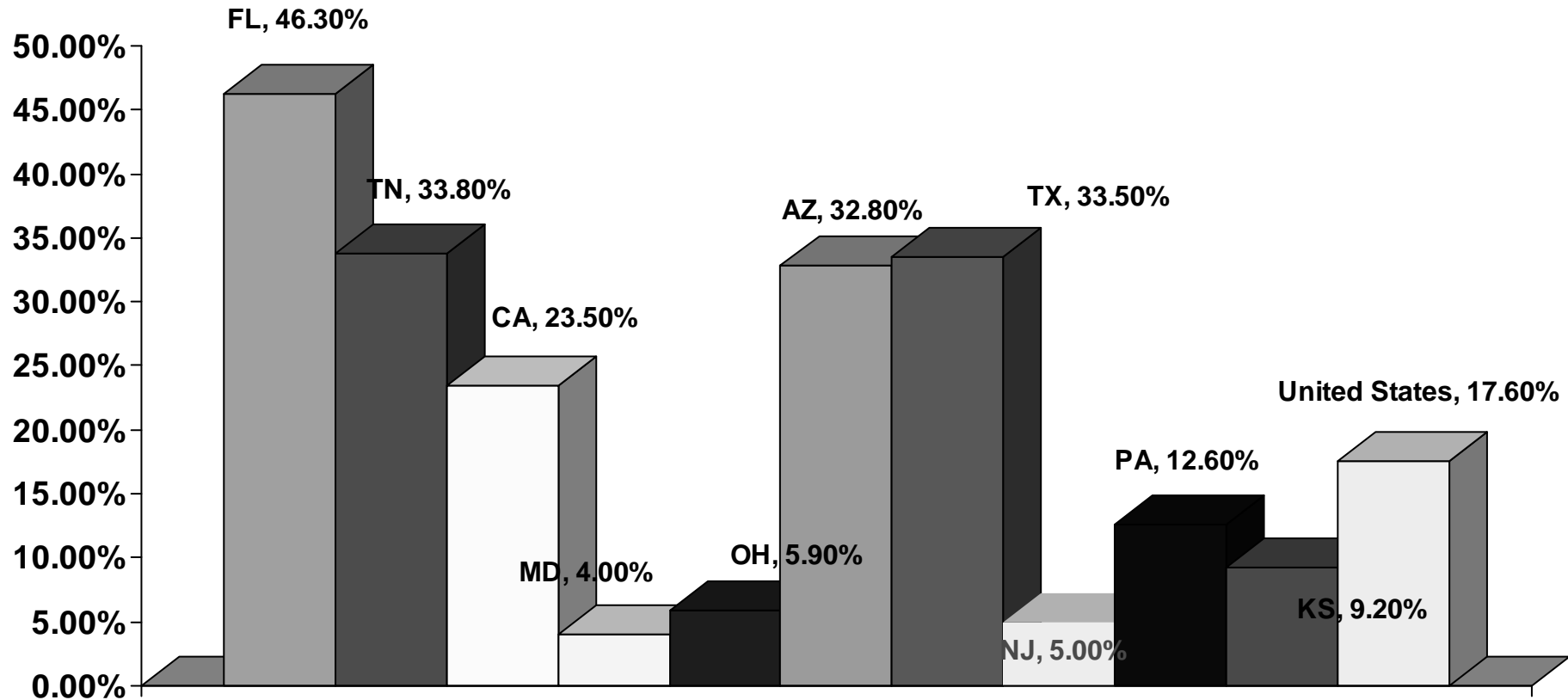
Bold Red items are consistent with AMSG locations

Explanations of Factors

- For-Profit Beds %: The percentage of all hospitals beds owned by for-profit hospitals
- MD Spending %: The portion of the state's healthcare spending that goes to physician services
- Rankings
- For Profit Beds: The rank based on total for-profit beds, with 1 being highest
- Total Healthcare Spending: The rank based upon total dollars spent
- Metropolitan Population: The rank based upon the percentage of the states population located in Metropolitan areas (as opposed to rural)
- MD Spending: The rank based upon total dollars spent
- Per Capita: The rank based upon per capita income

Other Factor Impact on AMSG

Prevalence of For Profit Hospitals For AMSG's Major States



Strategy and Value Implications



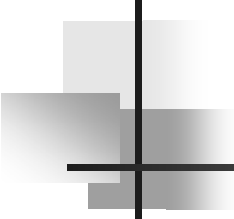
- Does the Enterprise operate in a market with factors analogous to those where acquirers or for-profits are active?
- If there are no or few for-profit providers in a valuation subject's service area, are those transactions or Guideline Public multiples relevant?
- Can acquirer multiples be adjusted to exclude acquisition growth inherent in public company strategies and values?
- If, in fact, relevant, would value determined be accretive to earnings to a public acquirer

Conclusion

- Don't forget the Stark Regulations limitations on use of out-of-market transactions!

Take Away

- “For having lived long, I have experienced many instances of being obliged, by better information or fuller consideration, to change opinions, even on important subjects, which I once thought right but found to be otherwise.”
- Benjamin Franklin



III. Hospital-Physician Transactions and Joint Ventures: What's in/out

Common Healthcare Business Models: Regulatory & Valuation Update



Ref #	Business Model	Key Regulatory Issues	Brief Description of Issue	Outlook	Source of Reg Issue	Valuation Impact/Issues	Impact on Future Valuation Outlook for Business Model
1	Free-Standing Surgery Centers	Reimbursement	Reimbursement is limited to 65% of hospital outpatient fee; revenue impact offset somewhat by expansion of # of eligible procedures	Lower reimb & high cost equipment may make ASC location less desirable relative to HOPD location	2008 ASC Fee Schedule	Difficulty in projecting revenue impact	Can create more uncertainty and risk
			Additional payment for certain imaging or implants	Potential additional revenue sources		Favorable for increasing revenues	Favorable
		Restrictions on Ownership	Few restrictions	Unlikely to be changed in the immediate future -- with limitations on ownership of other types of entities due to the new definition of "entity" under Stark 2009 IPPS, may become more desirable	If technical component is part of facility fee -- not DHS; Anti-kickback safe harbor	Favorable for marketability of ownership interest	Favorable

Key Regulatory and Valuation Update For Common Business Models involving Physicians and Hospital Joint Ventures

Prepared By: Regulatory Issues: Julie Kaas, Healthcare Attorney, Ober Kaler Law Firm
Valuation Issues: Don Barbo, Healthcare Business Appraiser, HSSK, LLC

Preparation Date: As of September 15, 2008

Important Note: The healthcare laws and regulations and business valuation environments are constantly changing. Therefore, the information presented is only a general overview that is subject to change.

Common Healthcare Business Models: Regulatory & Valuation Update (continued)



Ref #	Business Model	Key Regulatory Issues	Brief Description of Issue	Outlook	Source of Reg Issue	Valuation Impact/Issues	Impact on Future Valuation Outlook for Business Model
2	Specialty Hospitals	Reimbursement	Currently reimbursement equal to acute care hospital reimbursement	May be changed by legislation	Hospital outpatient prospective payment system	Negative if reimbursement rates are decreased	Potentially unfavorable
		Restrictions on Ownership	Stark -- Meets whole hospital exception	Current regulatory exception; unlikely to change without new legislation		Favorable for marketability of ownership interest	Favorable
		Moratoriums, other restrictions	Reporting by hospital of physician ownership to all patients	Potential for effective date in 2009	IPPS Final rule 2008 and revisions in IPPS 2009	Reporting requirement not expected to have impact	Neutral
		Other issues	Attempts by Congress to limit physician-owned specialty hospitals; Attempts by Congress and agency to reduce payments to specialty hospitals	Several congressional attempts; difficult to predict outcome in election year	Various industry data	Can create uncertainty and added risk	Potentially unfavorable

Common Healthcare Business Models:

Regulatory & Valuation Update (continued)

Ref #	Business Model	Key Regulatory Issues	Brief Description of Issue	Outlook	Source of Reg Issue	Valuation Impact/Issues	Impact on Future Valuation Outlook for Business Model
3	Imaging Centers	Reimbursement	Reduced payment for multiple tests	Increasing trends to reduce reimbursement for diagnostic services	2008 Physician Fee Schedule	Expected to decrease revenues	Unfavorable
			Lower of the HOPD vs Physician Fee Schedule	Same as above		Expected to decrease revenues	Unfavorable
		Restrictions on Ownership	No physician ownership of freestanding IDTFs that bill on their own; proposal for physicians to dually enroll as IDTFs -- if so, no sharing of equipment or space with others; would need to meet stricter supervision and other IDTF requirements; block leases may be issue	Greater restrictions on transactions through upcoming final physician fee schedule rules to take effect in 2009	Stark 2009 IPPS rules; Proposed physician fee schedule enrollment regulations; OIG anti-kickback opinion 08-10	Restrictions on ownership hinders marketability	Unfavorable
		Other issues	IDTFs not allowed to share space or equipment;	Restrictions are increasing for this business model	2008 Physician Fee Schedule Rule	Decreases flexibility in the utilization of assets, and the business opportunities of IDTFs	Generally unfavorable

Common Healthcare Business Models:

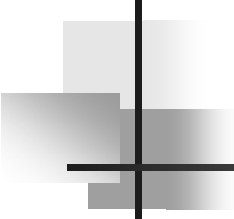
Regulatory & Valuation Update (continued)

Ref #	Business Model	Key Regulatory Issues	Brief Description of Issue	Outlook	Source of Reg Issue	Valuation Impact/Issues	Impact on Future Valuation Outlook for Business Model
4	Cancer Treatment Centers	Reimbursement	Dependent on setting or place of service and nature of service (Ex: Cyberknife vs IMRT/EBRT)	Reimbursement outlook depends on the particular business model		Depends on the business model	Seeing an increase in activity
		Restrictions on Ownership	Ownership by hospitals and radiation oncologists allowed; different rules for medical oncologists; For physician-owned centers, different tests for radiation oncologists and medical oncologists or multi-specialty group ownership--Need to meet Stark in-office ancillary services exception; No more under arrangements between physician joint ventures and hospitals; no per click or percentage leasing arrangements for office space or equipment	Dependent on type of physician providing service and hospital involvement; no changes where radiation oncologists only speciality; must restructuring must occur	Stark 2009 IPPS regulations	Marketability of interests: can be favorable as long as legally compliant	Seeing an increase in activity
		Other issues	No more under arrangements between physician joint ventures and hospitals; no per click or percentage leasing arrangements for office space or equipment	Increasing restrictions	Stark 2009 IPPS regulations	Reduces business opportunities of the model	Generally unfavorable

Common Healthcare Business Models: Regulatory & Valuation Update (continued)



Ref #	Business Model	Key Regulatory Issues	Brief Description of Issue	Outlook	Source of Reg Issue	Valuation Impact/Issues	Impact on Future Valuation Outlook for Business Model
5	Cardiac Cath Labs	Reimbursement	Free-standing reimbursement generally limited to diagnostic procedures only; interventional procedures require an "under arrangements or provide-based model"; "under arrangements" model for interventional procedures require location in hospital; under arrangements with physician-owned joint venture no longer allowed due to change of "entity" definition	At this time, unable to predict if/when interventionals will ever be reimbursable in a free-standing cath lab	Stark 2009 IPPS regulations	Use of free-standing cath lab may be limited if restricted to diagnostic procedures only; may be difficult to attract sufficient volumes to support high capital expenditures	Generally unfavorable
		Restrictions on Ownership	When intervention cath billed as hospital service issue for Stark; also focus on anti-kickback statute			Marketability of interests: generally only involve a limited types of specialties (cardiology, radiologists)	Generally unfavorable
		Moratoriums, other restrictions	New Stark rules create issue for interventional cath joint ventures of "under arrangement" and provider-based rules	New clarifications will generally restrict the types of procedures that can be performed in a cath lab.	Stark 2009 IPPS regulations	Potentially reduce volumes and revenues	Unfavorable
		Other issues	Diagnostic vs therapeutic catheterization	Regulatory Outlook - Uncertain		May restrict free-standing to diagnostic procedures only	Unfavorable



IV. Standing Firm: When the Deal Heats Up or Blows Up, Real World “Hypothetical Examples”

a. Keeping our Eyes on the Ball: Healthcare Fair Market Value Definitions

Fair Market Value Definitions: Commonly Used

1. Per IRS Revenue Ruling 59-60:

"The price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts."

2. Per the American Society of Appraisers, Business Valuation Standards:

"The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm's length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts."

Investment Value

1. Per *Financial Valuation Applications and Models*, 2nd Edition, J. Hitchner

"The value to a particular investor based on individual investment requirements and expectations."

a. Keeping our Eyes on the Ball: Healthcare Fair Market Value Definitions (continued)

Fair Market Value Definitions: Healthcare

1. Stark II Regulations:

“Fair market value” means the value in arm’s length transactions, consistent with the general market value.

“General market value” means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.” 90

(Federal Register, Vol. 69, No. 59, March 26, 2004, page 16128)

a. Keeping our Eyes on the Ball: Healthcare Fair Market Value Definitions (continued)

2. Anti-Kickback Statute: Personal services and management contracts

The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health program.

(AKS, 42 CFR 1001.952, page 1127)

a. Keeping our Eyes on the Ball: Healthcare Fair Market Value Definitions (continued)

Commercial Reasonableness: Healthcare

1. Per Stark I regulations:

“With respect to determining what is “commercially reasonable,” any reasonable method of valuation is acceptable, and the determination should be based upon the specific business in which the parties are involved, not business in general. In addition, we strongly suggest that the parties maintain good documentation supporting valuation.”

(Federal Register, Vol. 66, No. 3, January 4, 2001, page 919)

2. Per Stark II regulations:

“An arrangement will be considered “commercially reasonable” in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals.”

(Federal Register, Vol. 69, No. 59, March 26, 2004, page 16093)

Healthcare Transaction Examples

- b. Physician Practice transaction example “You need me more than I need you!”
- c. ASC Transaction example “Bail Out” Scenario
- d. Under Arrangements Business Model involving a Physician Owned Cath Lab “That’s All Your’re Going to Pay for Our Services?!”
- e. Bergquist Tax Case (Barbo IRS Expert) “If it sounds to good to be true.....”
- f. Derby Tax Case “If it sounds to good to be true....” Part II



V. Ask the Experts “Let’s Have Some Fun!”