



Performance, Efficiency, Achievement, Knowledge

Should You Develop an ASC or Hospital? Weighing the Pros and Cons

Presented by Kenneth Hancock
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13th Annual Ambulatory Surgery Center Conference & Exhibits

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Overview

Surgical Facility Evolution

The ABCs of ASCs and SSHs

The Questions that Need to be Answered

Regulatory and Political Environment



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Surgical Facility Evolution

Surgical Facilities – Evolution

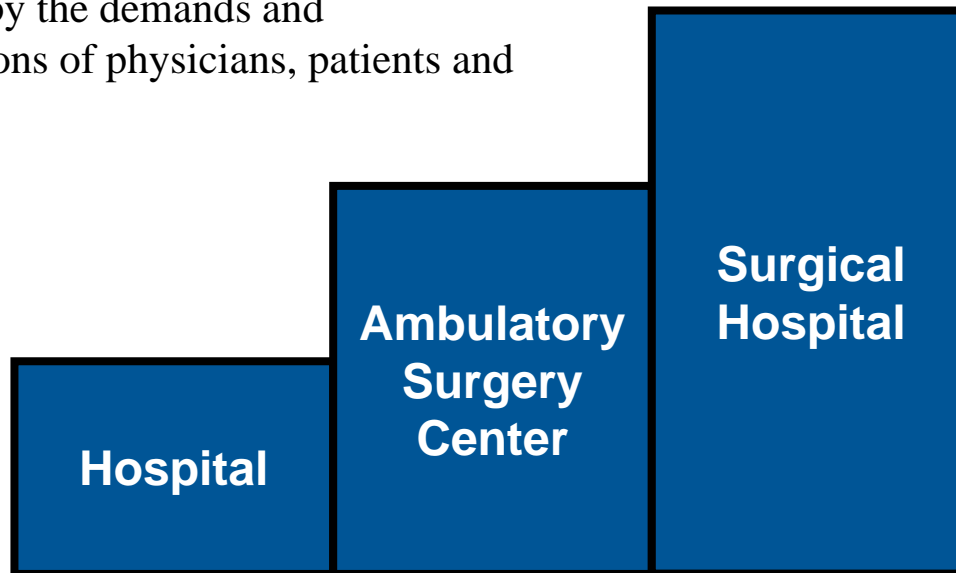
“Health care may be the most entrenched, change-averse industry in the United States.”

▪ **The First Step – Surgery Centers**

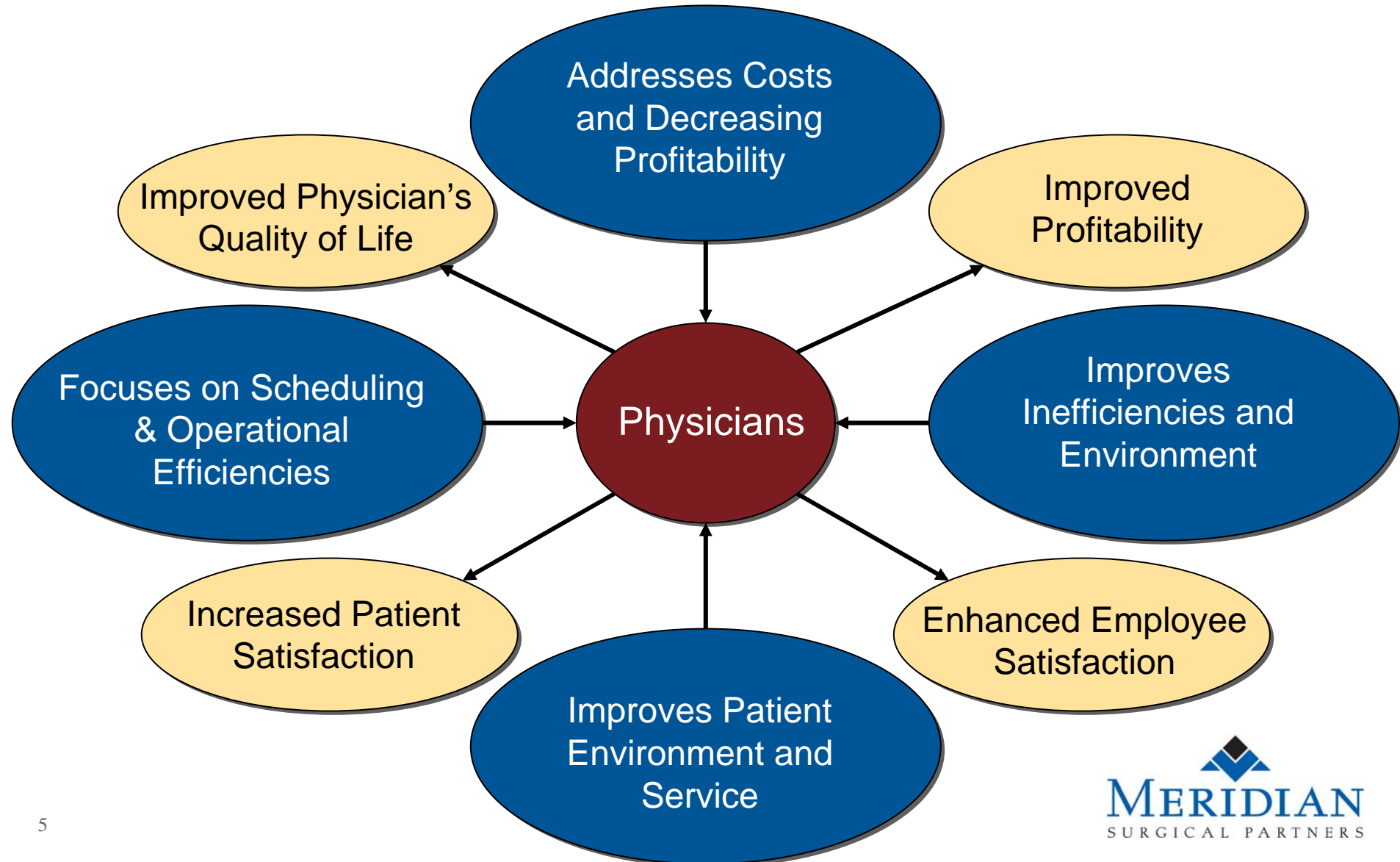
- A common-sense response to a mature health care delivery system immersed with inefficiencies
- Driven by the demands and frustrations of physicians, patients and payors

▪ **The Next Step – Surgical Hospitals**

- The efficiencies of specialization achieved by ASCs begged for the inclusion of inpatient services



Operations Process - Putting it all Together



Surgical Facilities – Driving Forces

- **Demographics**

- The aging of the baby boomers will create significant growth in the “Over 55” segment of the US population and be a driving force in the demand for surgical services.

- **Technology**

- Advances in medical technology and improvements in anesthesiology allow for more procedures to be performed outside of a traditional hospital setting

- **Preference**

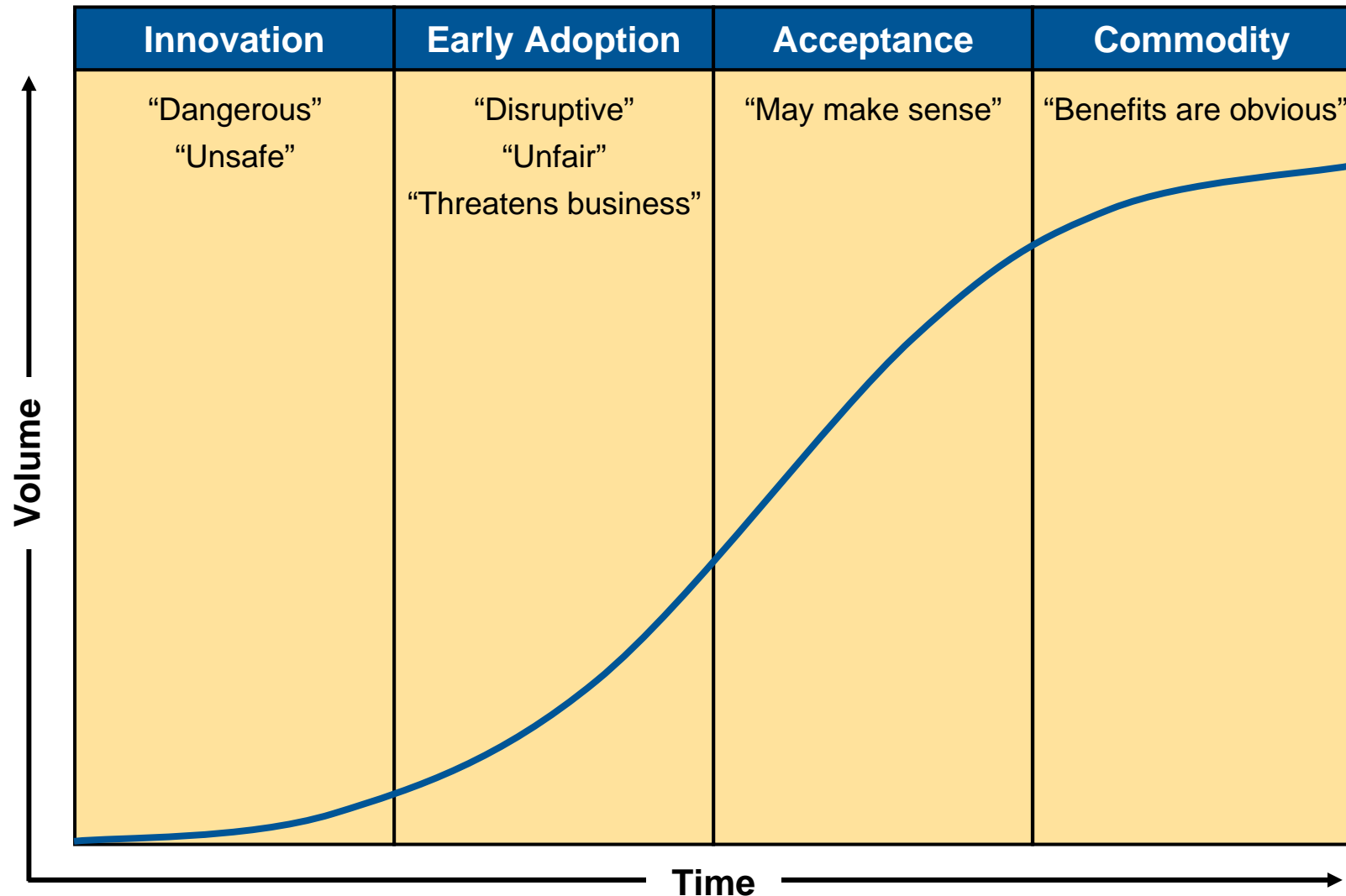
- Patients, Physicians, and Payors are choosing specialized facilities as their preferred venue for surgery as they embrace the efficiencies provided by a focused care model

Surgical Facilities – Value Proposition

- **Physician Values**
 - Efficient environment
 - Control over schedule
 - Involvement in governance
 - Focused delivery model
 - Specialized staffing
 - Income generation
- **Patient Values**
 - Less institutional setting
 - Convenient locations
 - Simplified admissions process
- **Payor Values**
 - Lower cost
 - Alternative to traditional hospital

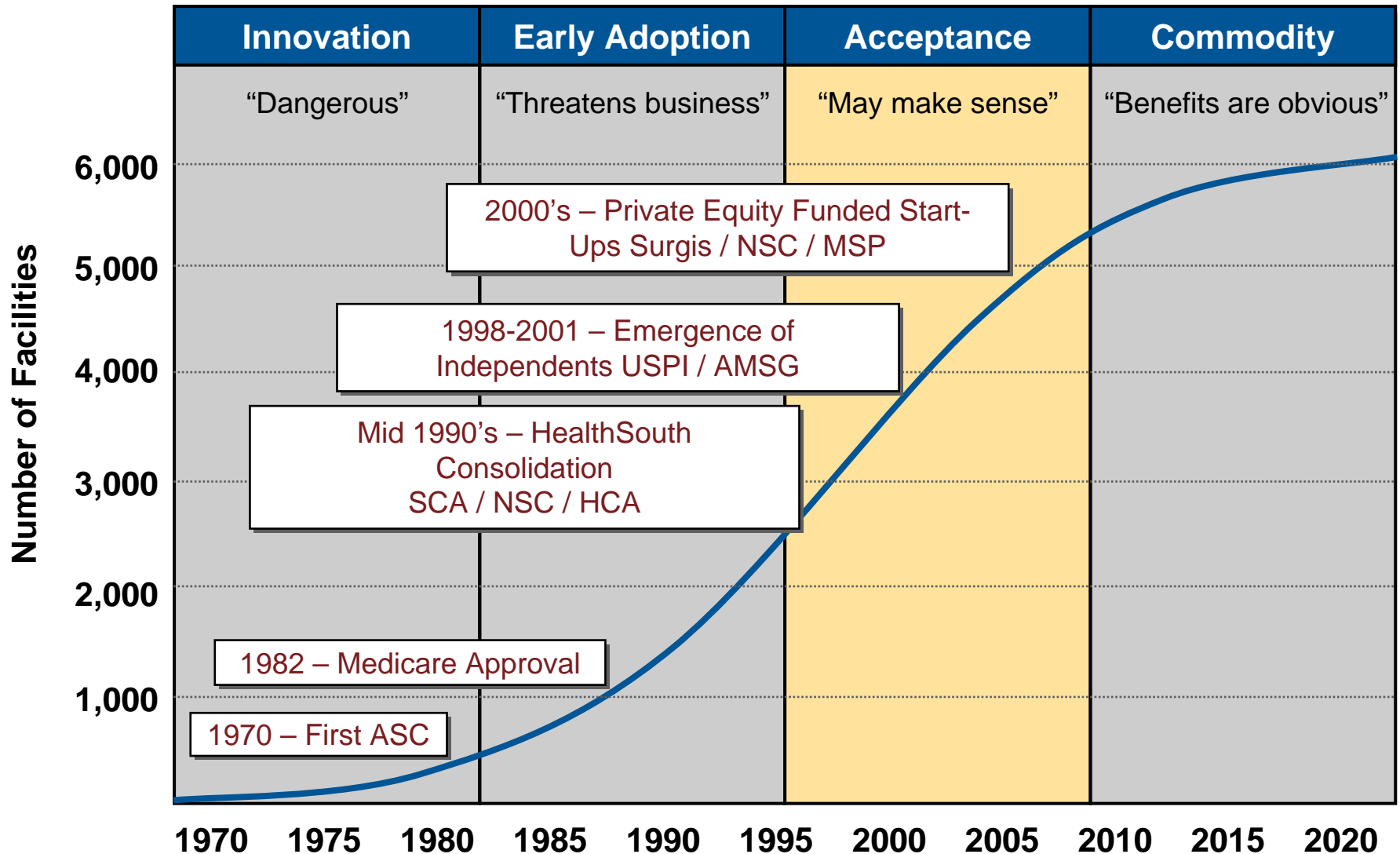
The Product Life Cycle

The classic product life cycle dictates that all products progress through a sequence of stages and corresponding reactions from competitors



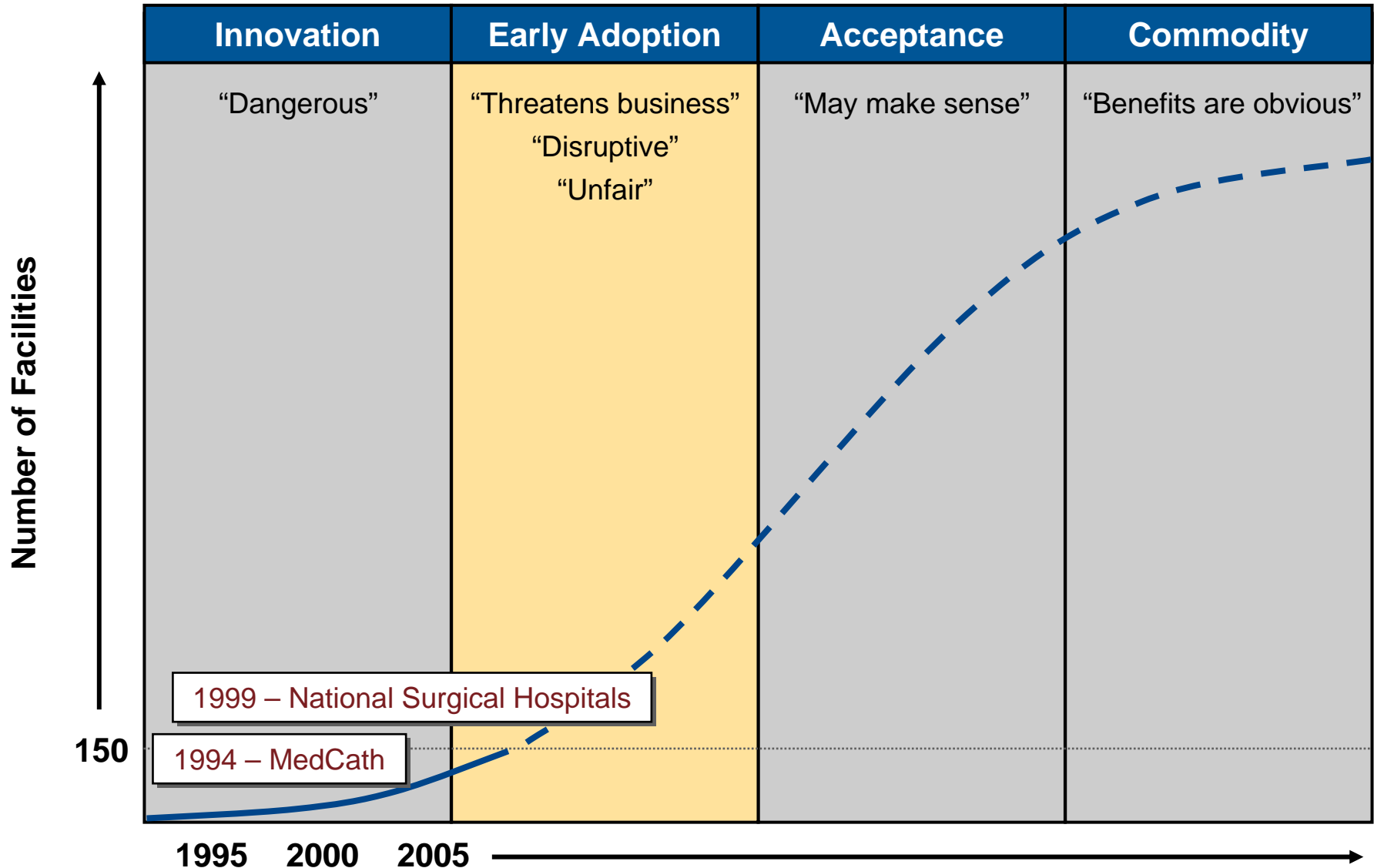
The Product Life Cycle – Surgery Centers

The product life cycle of ASCs is now evident and can be traced by examining the growth of the number of facilities



The Product Life Cycle – Surgical Hospitals

The product life cycle of surgical hospitals appears to be following a parallel path to that of the ASCs and could be poised for similar growth





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The ABCs of ASCs and SSHs

Definition of Specialty Hospital

Specialty Hospital

- A hospital which is primarily or exclusively engaged in the care and treatment of one of the following categories:
 - a) patients with a cardiac condition;
 - b) patients with an orthopedic condition;
 - c) patients receiving a surgical procedure; and
 - d) any other specialized category of services that is designated as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section

- A hospital is deemed specialized if:
 - a) at least 45% of its discharges are in one area of specialization, or
 - b) at least 66% of its discharges are in two areas of specialization

1. Centers for Medicare & Medicaid Services

2. MedPAC

Comparison of Alternatives

	Traditional Hospital	Surgery Center	Surgical Hospital
Equity Participation for Physician Investor	No	Yes	Yes
Development and Operations Complexity	Extreme	Low	High
Generate Revenue from Ancillary Business	None	No	Yes
Cost to Build	Extreme	Low	High
EBITDA Margins	Low	Excellent	High
Regulatory Risk - Reimbursement	None	Moderate	High
Political Risk	None	Low	Extreme
Operational Efficiency	Low	Excellent	High
Reimbursement Levels	Varies	Low	High
Competition	Moderate	High	Low
Expected Returns	N/A	Moderate	High

Surgery Center vs. Surgical Hospital

	Average Surgery Center	Average Surgical Hospital*
Physician Owners	12 Partners	25 Partners
Average Ownership	3.0%	3.0%
Inpatient Beds	-	14
Net Revenue	\$4.0 MM	\$17.0 MM
EBITDA	\$1.2 MM	\$4.2 MM

* Average Surgical Hospital information includes only Orthopedic and Surgical hospitals and excludes heart specialization.

New Albany Surgical Hospital



96,000 Square Feet

8 ORs / 42 Guest Suites

Total Cost of \$60 Million

Imaging, Pharmacy, Lab, Food Service, MOB

338 Employees / 104 RNs

32 Partners - 100 Credentialed Physicians

NASH Milestones

- 05/02 – Ground Breaking
- 12/03 – Opening
- 04/04 – JCAHO Accreditation – 100% Score
- 06/04 – Cash Flow Positive
- 08/04 – Press Ganey - #1 Patient Satisfaction



New Albany Surgical Hospital



Surgical Hospital Example – PCMC



48,000 Square Feet

4 ORs, 5 pre-op/8 PACU, 18 Guest Suites

Total Cost of \$19 Million – Land/Bldg \$10mm

Imaging, Pharmacy, Lab, Food Service, MOB

100 Employees / RNs

40 Physician Partners - 200 Credentialed

PCMC Milestones

- 1/04 – Ground Breaking
- 2/05 – Opening
- 7/05 – JCAHO Accreditation
- 00/00 – Cash Flow Positive

PCMC



Types of ASC Ownership

- Physician (100%)
- Hospital and Physician
- Corporation and Physician
- Three-Way Partnership



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The Questions that Need to be Answered

Surgical Facility – Decision Tree

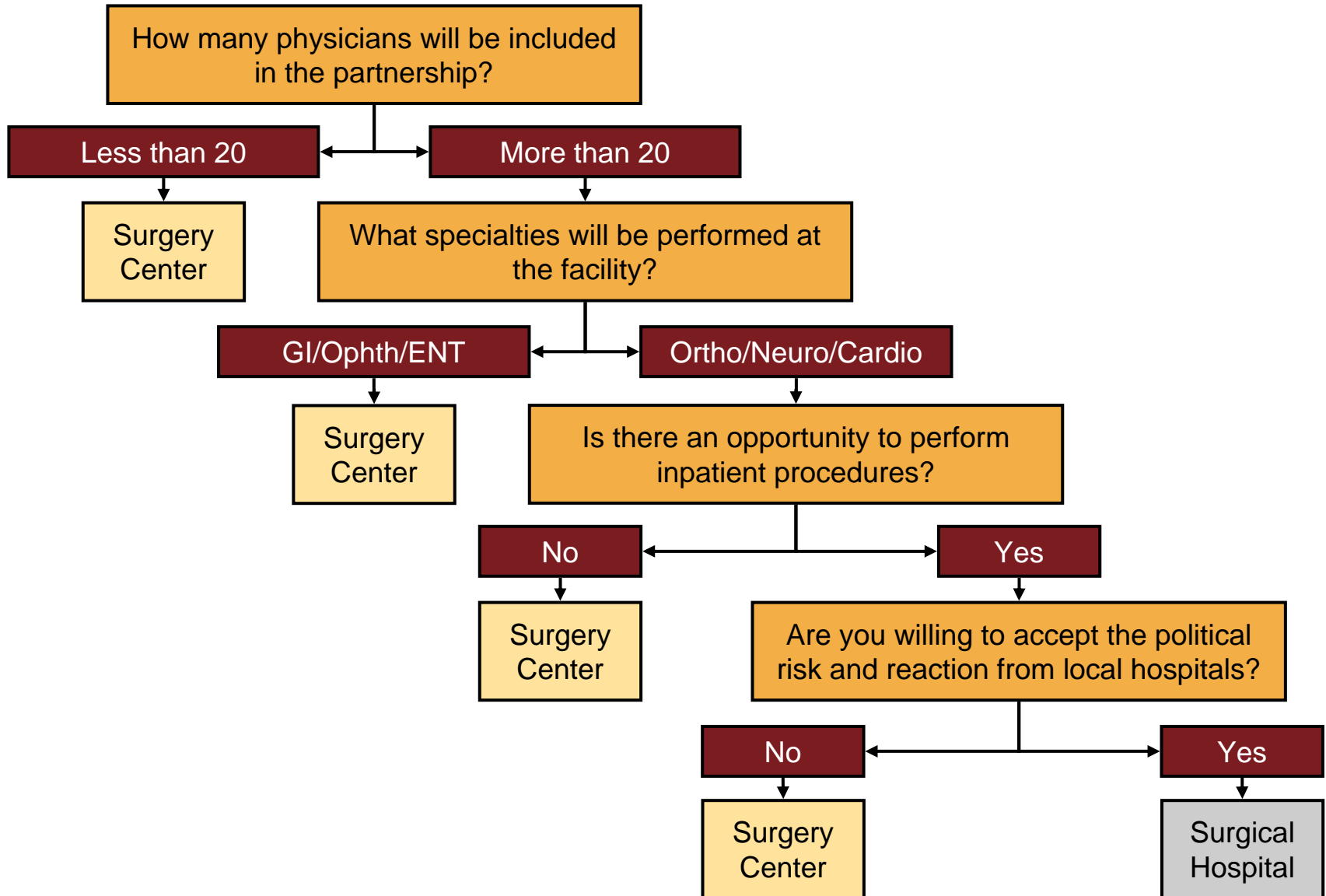
How many physicians will be included in the partnership?

What specialties will be performed at the facility?

Is there an opportunity to perform inpatient procedures?

Are you willing to accept the political risk and reaction from local hospitals?

Surgical Facility – Decision Tree



Surgery Center vs. Surgical Hospital

Cost Comparison	Average Surgery Center	Average Surgical Hospital
Land Required	1.5 – 2.5 Acres	4.25 – 5.00 Acres
Average Size	10,866 sqft	48,000 sqft
Operating Rooms	2 – 3	2 – 5
Patient Beds	0	17
Construction Costs	\$209 / SqFt	\$260 / SqFt
Equipment Costs	\$900,000 per OR	\$1,100,000 per OR
Soft Costs – A/E Fees	\$286,000	\$1,375,000
Total	\$5,224,000	\$19,355,000

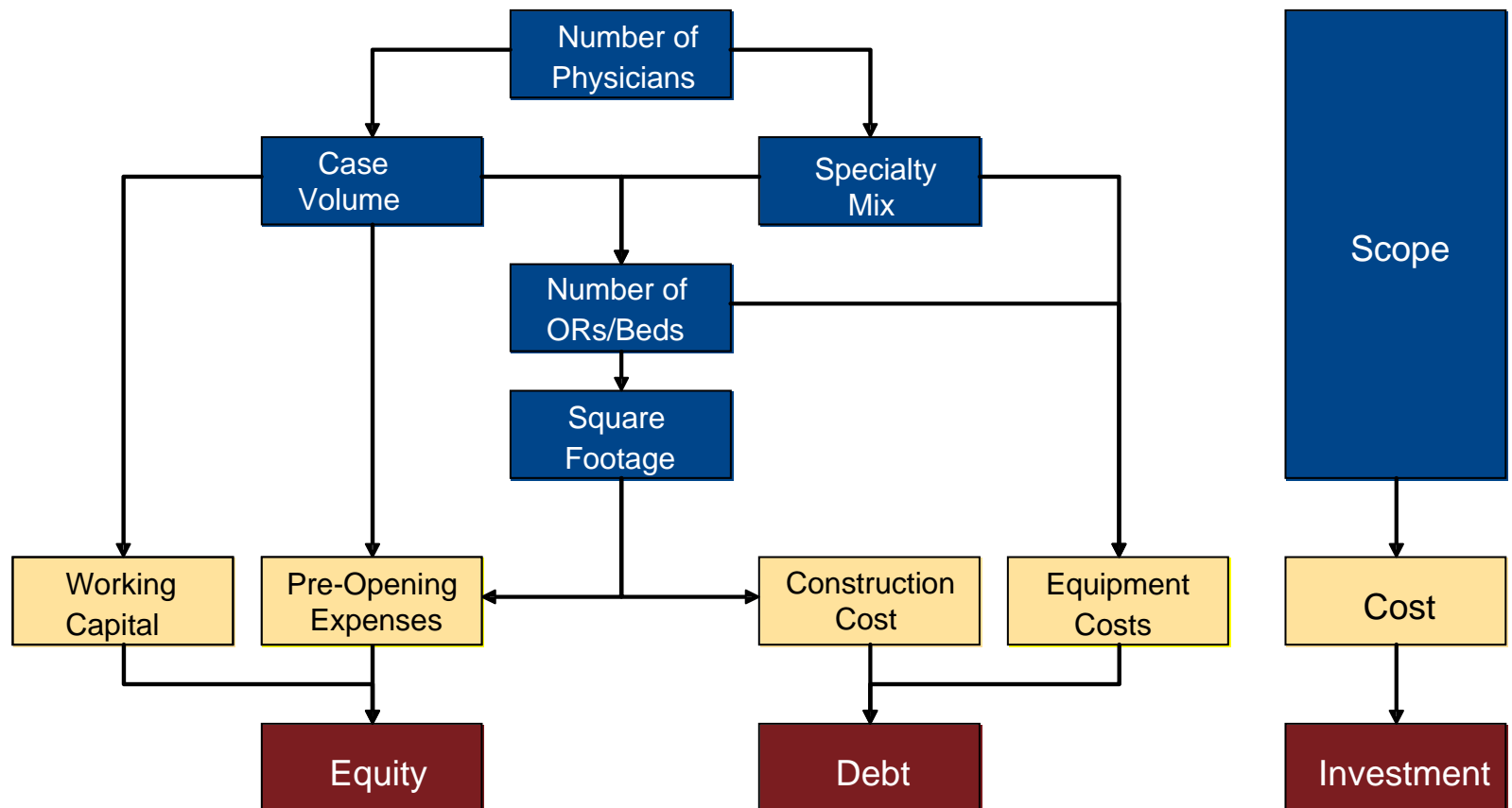
Other Costs

- Technology
- Imaging
- Food Service

* Total excludes land acquisition costs

Surgical Facility – Project Planning

- Determine the Scope of the Project
- The Scope Determines the Cost
- The Cost Determines the Investment



Surgical Facility Project Planning

Critical Points to Consider

- Surgical Case Volume
- Insurance Contracting
- Ancillary Business
- Project Scope
- Partnership
- Equity
- Debt



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Regulatory and Political Environment

Opposition to Surgical Hospitals

The “Cherry Picking” or “Cream Skimming” Argument

- *Surgical hospitals siphon off the most lucrative patients and procedures robbing the hospital of revenue needed to cross-subsidize unprofitable departments*
 - The real issue here is reimbursement for unprofitable departments
 - The solution is not to force surgical hospitals to lose money too, but rather for the general hospital to stop accepting payments that are below the cost of care
 - Additionally, not-for-profit hospitals are compensated for this “burden” through tax-exempt status, low interest-rate bond financing, and the freedom to collect tax-deductible donations
 - No hospital has closed as a result of the opening of a surgical hospital in the community

Opposition to Surgical Hospitals

The “Conflict of Interest” Argument

- *Physicians refer patients to facilities in which they have an ownership interest for personal economic gain*
 - The incremental income from performing a case at a facility in which a physician has ownership is minimal
 - The real reasons doctors refer patients to surgical hospitals
 - Higher quality of care that can be delivered in a specialized facility
 - Patient preference
 - Avoid the bureaucracy that engulfs many general hospitals
 - Higher levels of efficiency – This does lead to “personal economic gain” since a physician is able to perform more procedures in shorter amount of time

Opposition to Surgical Hospitals

- The determination of where a case will be performed is driven by efficiency, not ownership. Consider the following example:
 - A surgeon must determine where to perform a Knee Arthroscopy (#29888)
 - Traditional Hospital
 - Surgical Hospital
 - The increased income derived from ownership (facility fee) is not enough to influence surgical venue determination

	Traditional Hospital	Surgical Hospital
<u>Facility Fee</u>		
#29888 - Knee Arthroscopy	\$ 2,631	\$ 2,631
Assumed Margin	20%	20%
Cashflow	\$ 526	\$ 526
Assumed Ownership	0%	3%
Cashflow to Surgeon	\$ -	\$ 15.79

<u>Professional Fee</u>		
#29888 - Knee Arthroscopy	\$ 1,050	\$ 1,050
Assumed Volume	1.00	1.50
Cashflow to Surgeon	\$ 1,050	\$ 1,575

Opposition to Surgical Hospitals

Opposition Tactics and Strategy

- Promote Limiting Legislation
- Prevent physicians from investing in any type of medical facility
- Require specialty models to add generalist features to “level the playing field”
- Economic Credentialing
- Certificate of Need protection

“Instead of working to preserve the existing systems, regulators...need to ask how they can enable more disruptive innovations to emerge. If the natural process of disruption is allowed to proceed, the result will be higher quality, lower cost, more convenient health care for everyone.”

Regulatory Environment

“Breux Amendment” to the Medicare Prescription Drug Act

- Number 1 agenda for AHA and Federation
- November 2003 – 18 Month Moratorium
- MedPAC Study – Determine impact of surgical hospitals
- September 2004 – Favorable MedPAC Initial Report
- June 2005 – Moratorium Extended to August 2006
- August 2006 – Moratorium Lifted
- August 2006 – Revised and Final MedPAC Report

CMS Final Report

- Issued August 8th
- EMTALA compliance
 - Must accept patient transfers if equipped
- Physician ownership disclosure for all hospitals
- Physician compensation arrangements must be disclosed
- Enforce proper investment (Stark & FA Laws)

Politics and Negative Press

'BOUTIQUE' WOULD HINDER TRAUMA CARE

We don't need a specialty orthopedic hospital!



ACCESS AND QUALITY, NOT PROFITS, SHOULD DRIVE OUR HEALTH CARE

Sunday, May 5, 2002

EDITORIAL & COMMENT 03B

By Joseph Calvaruso

32 *For The Dispatch*

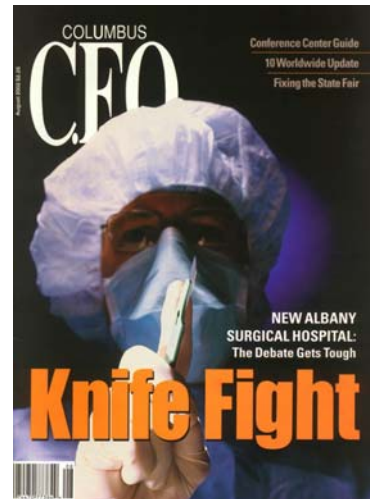
Drawing BLOOD

BY CHRIS MAAG

Specialty hospital spread prompts backlash in Ohio

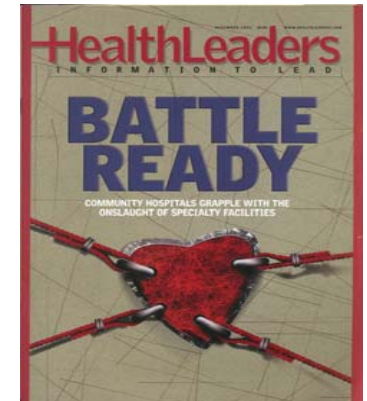
September 24, 2002

Modern Healthcare



For-profit hospitals are a bad Rx for this community

Saturday, August 3, 2002



EDITORIALS

An unprivileged few

Full-service hospitals are right to expel doctors who invest in for-profit

Sunday, July 21, 2002





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