FMVantage Point™

Healthcare Transactions

2009

Year in Review

HealthCare Appraisers
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2009 brought about much activity and change in the U.S. healthcare landscape. As a national healthcare valuation firm, HealthCare Appraisers ("HAI") is in a unique position to be privy to, and to play an active role in, a wide array of healthcare transactions across the country. We have the opportunity, and thus the perspective, of working with hundreds of attorneys; hospitals and health systems; life sciences companies; physicians; and healthcare entrepreneurs. We note that there is much common ground with healthcare transactions, but there is also significant diversity in thinking, legal opinions and operational strategies that leads to major differences in how transactions are structured.

This publication is a compendium of key trends that we observed in healthcare transactions during 2009. We trust that you will find this report useful. In the event that we can answer any questions or offer any assistance with respect to the topics covered in this report, please contact us at:

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Disclaimer

The values provided in this report are intended to portray general FMV ranges applicable to a variety of healthcare compensation arrangements. No values from this report should be relied upon to establish or support the FMV of any particular transaction. The appropriate FMV range for any particular transaction is dependent on the facts and circumstances, and notably, the upper limit of FMV for a given arrangement may be significantly lower than the values listed herein.

Trends

The most significant trends in employment arrangements in 2009 can be summed up as follows:

- Hospitals continue to actively seek additional physicians for employment;
- Physicians are actively seeking to align themselves with hospitals; and
- Productivity-based compensation models are in vogue.

Other observations related to physician employment during 2009 include:

- Large cardiology groups are favorite targets for acquisition and employment by hospitals (prompted by impending significant reductions in reimbursement for many cardiology procedures).
- Pay-for-performance programs are increasingly part of physician employment agreements. The methodologies used to provide such incentive compensation were diverse in 2009, reflecting the relative newness of a pay-for-performance focus.
- Notwithstanding the popularity of productivity-based compensation, many hospitals still will agree to relatively high levels of base compensation for well-seasoned physicians.
- "Compensation stacking" became a cautionary phrase to ensure that all sources of physician compensation (*e.g.*, base pay, incentive pay, on-call pay, sign-on and retention bonuses, medical director payments, and quality bonuses) are considered when structuring compliant compensation packages.
- Physician work relative value units ("wRVUs") continue to be an often used measure of productivity. But, we have observed pitfalls to hospitals in using wRVUs including:
  - One hospital confused total RVUs and wRVUs.
  - Errors have resulted by failure to consider CPT code modifiers in computing wRVUs (*e.g.*, a physician is credited with the full wRVUs for a surgical procedure, despite the fact that the physician served as an assistant at surgery).
  - The CMS rebasing of wRVUs in 2007 caused many wRVU-based compensation plans to have unintended outcomes.
- Many hospitals increased the use of employed (and direct billing) mid-level providers. As a result, we noted an increased need for separate compensation arrangements with employed physicians who supervise mid-level providers.

Trends

Ensuring adequate physician specialist coverage for their EDs and inpatient departments continued to be a major challenge for hospitals during 2009. Notable trends that we observed in 2009 include:

- The number of hospitals providing compensation for call coverage increased.
- Compensation rates paid in 2009 generally held fairly constant as compared to 2008.
- The most common compensation methodology continues to be *per diem* payments; however, we saw an increase in the use of *activation payments* (*i.e.*, payments made only upon an actual call event requiring a physician's presence at the ED).
- The prevalence of concurrent call arrangements (whereby two or more related hospitals will coordinate coverage with a single on-call panel without the need for transfer arrangements) has increased.
- There was an uptick in sub-specialties (*e.g.*, interventional neurology, hyperbaric medicine, and detoxification services) receiving compensation for on-call coverage.
- Many hospitals are stepping up their ability to track call frequency and other characteristics of call coverage arrangements to better inform the FMV process in accordance with guidelines gleaned from OIG Advisory Opinion 07-10.

Regulatory Environment

On May 21, 2009, the OIG issued Advisory Opinion 09-05 which addressed an on-call coverage arrangement between physicians and a hospital concerning coverage of emergent, uninsured patients. Under the analyzed arrangement, compensation was to be based on a schedule of specific fee-for-service rates for actual services provided and claims submitted by the physicians related solely to these uninsured patients.

While the OIG indicated in Advisory Opinion 09-05 that it would not impose sanctions on the fee-for-service rates for the specific on-call arrangement, the OIG appeared to comment on *per diem* payments and may regard stipends as perhaps riskier than payments which are tied to actual emergency department treatment encounters. Nevertheless, we still observe *per diem* payment arrangements as the most common form of on-call compensation.

Call Coverage By Specialty

Specialty	Weekly Call Events Requiring a Physician's Response to the ED				# of Physicians in the Call Rotation		Range of Unrestricted *Per Diems* ($/day)	
	In Person		Telephonically					
	Low	High	Low	High	Low	High	Low	High
Cardiology	<1.0x	11.0x	<1.0x	13.0x	1	10	$410	$1,590
Cardiothoracic Surgery	<1.0x	2.0x	<1.0x	18.5x	1	4	$410	$2,110
ENT	<1.0x	14.0x	<1.0x	21.5x	1	10	$330	$1,100
Gastroenterology	<1.0x	>20.0x	<1.0x	25.0x	1	12	$300	$1,390
General Surgery	<1.0x	18.0x	<1.0x	18.0x	3	30	$270	$2,130
Hand Surgery	<1.0x	9.0x	<1.0x	0.5x	1	8	$150	$ 650
Internal Medicine	4.0x	>20.0x	<1.0x	>30.0x	7	10	$270	$1,150
Intervent. Cardiology	1.5x	20.0x	<1.0x	10.5x	2	12	$420	$1,920
Neurology	<1.0x	>20.0x	<1.0x	20.0x	1	8	$210	$ 800
Neurology - Stroke	1.0x	6.0x	<1.0x	13.0x	3	10	$210	$ 600
Neurosurgery	<1.0x	11.0x	<1.0x	11.0x	1	20	$530	$2,080
OB-GYN	<1.0x	15.0x	<1.0x	21.0x	3	25	$240	$1,170
Ophthalmology	<1.0x	5.0x	<1.0x	17.5x	1	9	$ 90	$ 720
Oral Surgery	<1.0x	13.5x	<1.0x	1.0x	2	9	$250	$ 510
Orthopedic Surgery	<1.0x	>20.0x	<1.0x	>30.0x	1	20	$420	$1,700
Pediatrics	<1.0x	>20.0x	1.5x	>30.0x	4	9	$210	$ 950
Pediatric Surgery	<1.0x	11.5x	<1.0x	8.0x	1	3	$260	$1,660
Plastic Surgery	<1.0x	2.0x	<1.0x	2.0x	3	5	$350	$ 670
Psychiatry	<1.0x	9.0x	<1.0x	>30.0x	1	40	$130	$ 750
Pulmonary Medicine	<1.0x	5.0x	<1.0x	>30.0x	1	4	$230	$ 730
Trauma Surgery	4.0x	>20.0x	<1.0x	26.0x	4	6	$180	$2,320
Urology	<1.0x	9.0x	<1.0x	9.0x	2	15	$350	$ 940
Vascular Surgery	<1.0x	1.0x	<1.0x	1.0x	2	7	$290	$ 460

The above data is based upon a review of HAI's proprietary database of on-call transactions in 2009.

Trends

Medical director arrangements have been "tried and true" for many years, and we saw few major changes during 2009. However, some notable trends and observations include:

- Compensation rates and the compensable hours for medical directorship positions remained fairly stable as compared to prior years.
- The types of directorships also remained fairly stable. In addition to our own observations, we note that the Integrated Health Strategies™ *Medical Director Survey* reported 70 position titles in 2009 vs. 68 in 2008.
- The overwhelming majority of medical directorships contemplate an hourly rate of payment for hours worked and documented (up to a stated maximum). A small proportion of medical directorships are based upon fixed annual payment rates.
- An increasing number of medical directorships are including quality/pay for performance aspects. The incentive pay is typically handled either as a premium to the hourly rate, or a holdback from the hourly rate.
- A significant number of medical directorships are being eliminated in favor of more comprehensive "co-management arrangements." (Please see the *Service Line Co-Management Arrangements* section of this publication.)
- An increased awareness of *compensation stacking* has prompted more hospitals to focus on their employed physicians' total compensation (*i.e.*, including medical director payments along with all other sources of income).
- While physicians' administrative and consultative time is compensated by both hospitals/health systems and life sciences companies, we note that compensation provided by life sciences companies oftentimes materially exceeds the rates paid by hospitals/health systems.

The following table summarizes hours and compensation rates observed for the most frequently analyzed arrangements in 2009 (see facing page).

Medical Directorships By Specialty

Specialty	Maximum Hours Per Month	Range of Hourly Rates	
		Low	High
Anesthesiology	52	$144	$246
Bariatric Surgery	32	$170	$239
Breast Health Center	>60	$141	$176
Cancer Center/Oncology	35	$152	$210
Cardiology-Invasive	>60	$159	$287
Cardiology-Non-Invasive	52	$133	$540
Cardiovascular Surgery	25	$200	$287
Chief Medical Officer	>60	$ 78	$204
Chief of Staff	40	$124	$185
Dialysis/Nephrology	>60	$150	$209
Emergency Medicine	20	$ 95	$156
Family Medicine	60	$ 80	$150
General Surgery	>60	$131	$233
Geriatrics	20	$ 94	$150
Hospitalist	>60	$110	$156
Infectious Disease	>60	$109	$169
Information Services	>60	$ 95	$167
Intensive Care Unit	>60	$119	$194
Medical Education	52	$ 95	$164
Neonatology	28	$134	$175
Neurology	>60	$ 98	$217
Neurosurgery	23	$229	$329
OB/GYN	27	$132	$179
Orthopedics	20	$142	$284
Palliative Care	30	$120	$168
Pathology	>60	$135	$213
Pediatrics	60	$ 80	$159
Psychiatry	>60	$ 88	$174
Pulmonary/Respiratory	>60	$119	$177
Quality Mgmt/Util Rev	60	$ 99	$159
Radiation Therapy	50	$192	$281
Radiology	25	$150	$250
Rehabilitation	>60	$110	$159
Sleep Center	24	$128	$211
Sports Medicine	10	$150	$221
Stroke	25	$115	$202
Surgery Dept	50	$218	$261
Transplant Surgery	35	$150	$217
Trauma Surgery	20	$150	$217
Urology	52	$169	$203
Vascular Lab	32	$131	$228
Wound Care	52	$125	$172

The above data is based upon a review of HAI's proprietary database of medical directorship transactions in 2009.

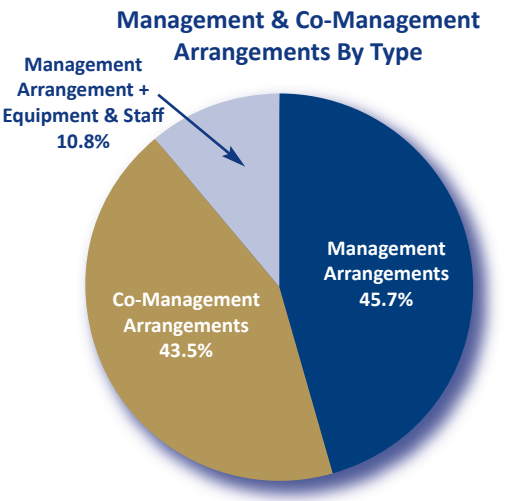
Service Line Co-Management Arrangements

In 2009, the most notable observation regarding service line co-management arrangements was the increase in their overall prevalence in the marketplace. (As these arrangements are still relatively new, please see *What is a Service Line Co-Management Arrangement?* on page 10.)

Trends

We continued to see these arrangements structured in a variety of manners as described below:

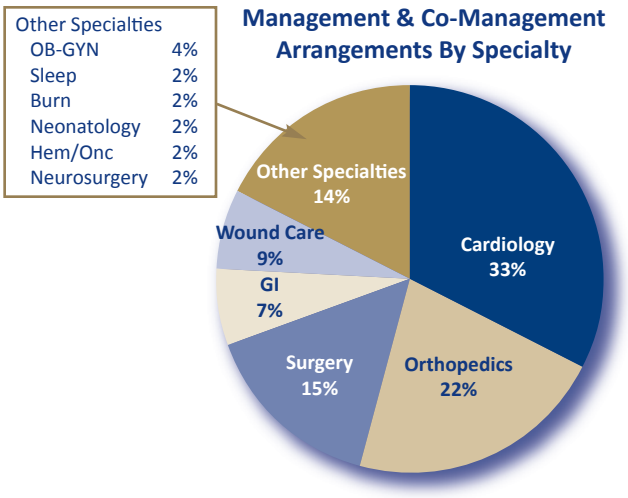
- Service line co-management arrangements may be formed in one of the following three ways:
  - A joint venture is created (*e.g.*, an LLC) consisting of both the hospital and the participating physicians as investors.
  - A joint venture is created consisting solely of participating physicians (*i.e.*, no hospital involvement). This newly created physician-owned entity allows physicians from a number of professional practices to have a single contracting entity for purposes of the service line co-management arrangement.
  - No new entity is created, typically in a case where the service line co-management agreement would involve an already organized group of physicians (whether or not under common ownership).
- When a JV consisting of the hospital and physician investors is formed, there is most often a 50% (hospital) /50% (physicians) ownership split. Less frequently, we noted larger ownership positions for the physicians, ranging up to 75% physician ownership.
- Certain service line co-management arrangements contemplate that the hospital and physicians will share in the efforts and the compensation payable under the agreement. Other arrangements place the management burden entirely on the physicians, who in turn receive all of the related base and incentive compensation. The latter arrangements are sometimes referred to as "management," rather than "co-management," arrangements.
- Frequently, these arrangements are broadened to encompass specialist ED call coverage. By aggregating call coverage (and the associated compensation) into the service line co-management agreement, hospitals are able to obtain continuous call coverage as one of the obligations of the physician managers. For those hospitals that do not routinely provide *per diem* payments for specialist call coverage, they believe that the use of the service line co-management vehicle helps avoid the precedent of *per diem* payments.
- For service line co-management arrangements involving freestanding centers (*e.g.*, a sleep lab or wound care center), the management services may be expanded to include the physicians' provision of leased space, equipment, and/or non-clinical staffing.
- For 2009, the following chart depicts the approximate breakdown between the three possible structural combinations:



Service Line Co-Management Arrangements

Service Line Specialties

Service line co-management arrangements can be implemented for almost any hospital service line, as they are intended to enhance opportunities for hospital/physician alignment. Based on our observations in 2009, the chart to the right illustrates the approximate volumes (by percentage of overall analyses) for each applicable specialty:



Service Line Co-Management Arrangements By Specialty

Service Line	Service Line Net Revenue Up To	FMV Range of Total Management Fees Low	High
Cardiology	$142,000,000	$187,000	$4,066,000
Orthopedics	$ 82,000,000	$182,000	$2,500,000
Surgery (IP & OP)	$ 73,000,000	$653,000	$2,432,000
Surgery (OP & Amb only)	$ 21,000,000	$289,000	$ 758,000
GI	$ 2,500,000	$109,000	$ 353,000
Wound Care	$ 5,200,000	$71,000	$ 266,000
OB-GYN	$ 10,300,000	$267,000	$ 350,000
Sleep Clinic	$ 1,900,000	$154,000	$ 163,000
Burn	$ 3,900,000	$203,000	$ 255,000
Neonatology	$ 10,800,000	$302,000	$ 396,000
Hematology/Oncology	$ 16,700,000	$486,000	$ 665,000
Neurosurgery	$ 5,100,000	$ 91,000	$ 128,000

The above data is based upon a review of HAI's proprietary database of service line co-management arrangement transactions in 2009.

Service Line Co-Management Arrangements

Basis of Compensation

Service line co-management arrangements typically include both fixed and incentive-based compensation as components of the total management fee.

- In our experience in 2009, the large majority of the arrangements we observed included an equal split (*i.e.*, 50/50) between the base (or fixed) fee and incentive fee; however, we observed some arrangements with base fees ranging from 25% to 75% of the total compensation.
- Our analyses of proposed service line co-management arrangements in 2009 included service lines ranging from $1 million to over $140 million. While the revenue size of the service line is only one of numerous metrics considered in the analysis of individual transactions, the table on page 9 provides a summary comparison of service line net revenue and total management fees from our database, listed by specialty.
- As a final observation during 2009, the term "co-management agreement" has become a buzzword to an extent, and is unfortunately oftentimes used to describe any number of hospital-physician management arrangements which may bear little or no resemblance to the traditional structural characteristics described above.

What is a Service Line Co-Management Arrangement?

Service line co-management arrangements are relatively new pay-for-performance programs whereby hospitals engage physicians to manage and improve entire hospital service lines (*e.g.*, cardiovascular, orthopedics, etc.). These arrangements place emphasis on achievement of pre-established quality and performance metrics and can offer significant improvements over traditional physician medical director involvement in hospital operations. Under this type of arrangement, a hospital enters into a formal agreement with certain of its medical staff physicians to manage a designated hospital service line. The primary purpose is to align physician and hospital objectives while recognizing and appropriately rewarding participating physicians for their efforts in managing and improving the overall quality and efficiency of the service line.

The core elements of these arrangements are built on the belief that well-defined operational goals can be achieved when physicians and a hospital work collaboratively. Therefore, incentive-based management programs must be designed with very specific objectives and clearly defined metrics. Typically, service line co-management arrangements include:

- The **Base Fee** is a fixed payment, typically paid monthly, that provides compensation for the day-to-day time and effort of the participating physicians in overseeing, managing and improving the service line.
- The **Incentive Fee** is at risk and is payable to the extent that pre-determined service line objectives are met.

Trends

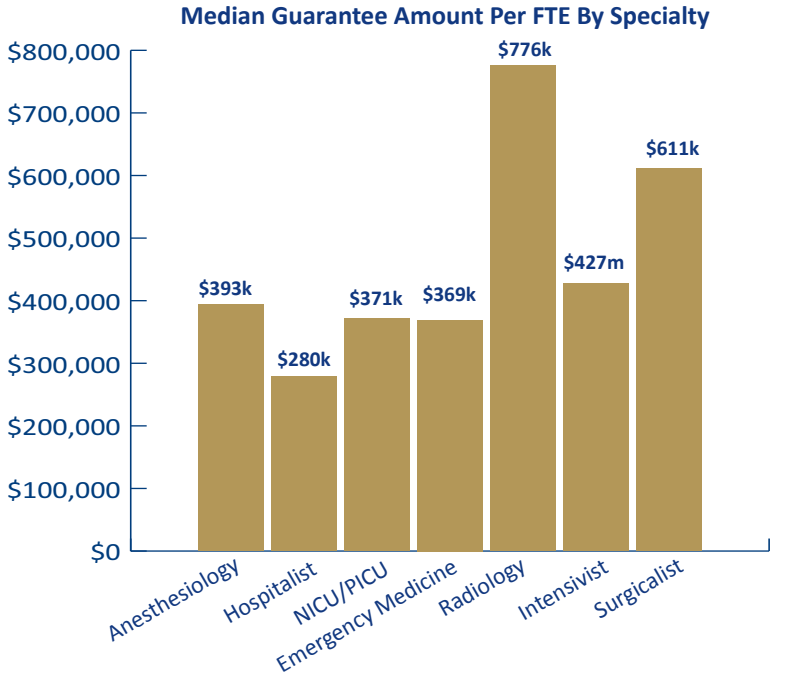
During 2009, we noticed three significant trends in structuring collections guarantees:

- **In-Sourcing.** Consistent with hospitals' increased interest in physician employment, we observed that many hospitals are opting to employee hospital-based physicians as well. By so doing, they eliminate the need to provide income support through a collections guarantee to independent physician group practices.

- **Quality Incentives.** We have encountered an increasing number of collections guarantee arrangements that include quality incentives to ensure that provider groups are not paid for substandard performance, or to allow rewards for provider groups that provide above-average performance.

  - Oftentimes, an agreement with a quality incentive component is structured in two parts. First, the physician group receives a base compensation amount for the provision of the basic coverage services. Typically, this amount ranges from 60% to 75% of the total guarantee amount.
  - Additionally, the hospital and the provider group develop a set of quality metrics for inclusion in the agreement by which the group's performance will be measured. The group can earn a portion or the entire incentive component of the compensation (*i.e.*, the remaining 25% to 40% of the total guarantee amount) only by meeting the specified metrics.
  - The quality metrics used typically conform to the best practices for the particular specialty. For example, we encountered many arrangements which relied on core measures as specified by The Joint Commission.
  - Of key importance, the total guarantee amount (*i.e.*, the base component plus the incentive compensation), is limited to the group's reasonable (*i.e.*, FMV) costs for providing the services less anticipated collections for professional services.

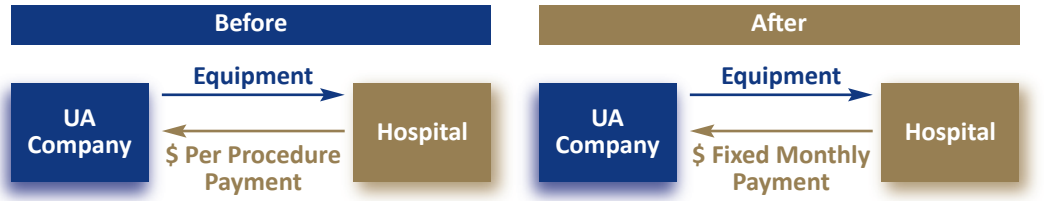
- **Aggregation of Services.** 2009 reflected interest by health systems in contracting for multiple hospital-based services within a single contract in hopes of offsetting a profitable hospital-based physician service against a losing service. For example, an emergency medicine staffing arrangement (which might be profitable) could be contracted together with an anesthesia staffing arrangement (which might be unprofitable) to result in a lower net collections guarantee exposure. Obviously, this contracting aggregation will only work when one entity is able to provide multiple service lines (such as a corporate hospital-based physician staffing company).



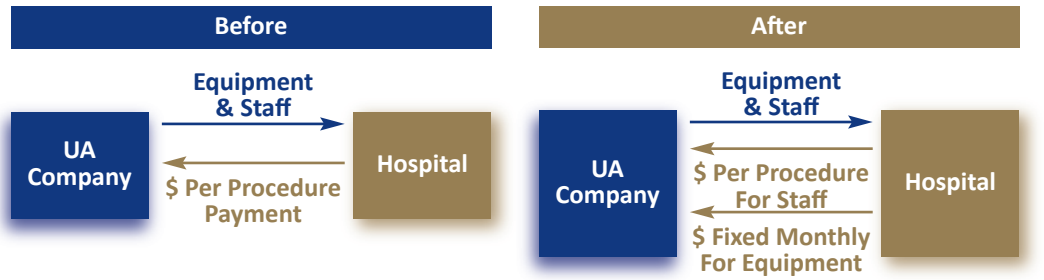
Under-Arrangement Transactions Trends

The most notable trend in 2009 regarding under-arrangement and "per click" transactions came as a result of a regulatory change. As of October 1, 2009, the Center for Medicare and Medicaid Services ("CMS") revised its interpretation of the Federal Physician Self-referral act (the Stark law) regarding under-arrangement and "per click" transactions. These changes required the restructuring or termination of many existing arrangements. Some of the most common structural changes we observed included the following:

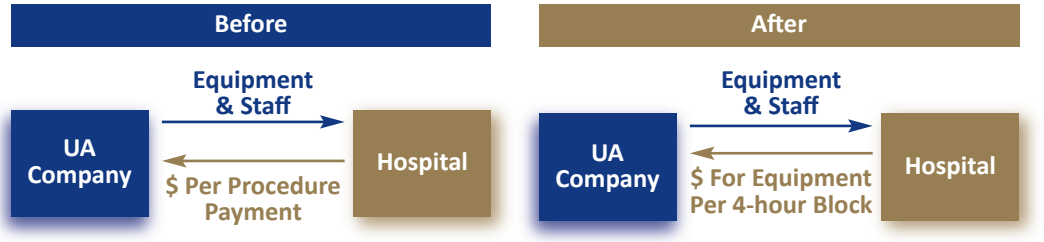
- **Certain arrangements involving equipment provided on a "per click" basis were modified to a fixed payment.** For example, a holmium laser company that provided equipment on a per-use basis restructured the arrangement to provide the equipment on a scheduled basis under a fixed monthly payment.



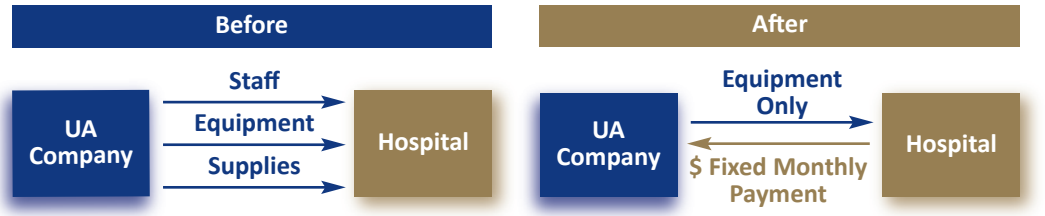
- **Certain arrangements involving equipment and other services were modified to convert the equipment component from a "per click" payment to a fixed payment while other services continued to be compensated on a "per click" basis.** For example, a gamma knife company restructured its payment from a "per click" basis to one where the fee for the equipment is made on a fixed basis, but other resources (*e.g.*, certain staff) continue to be compensated on a "per click" basis.



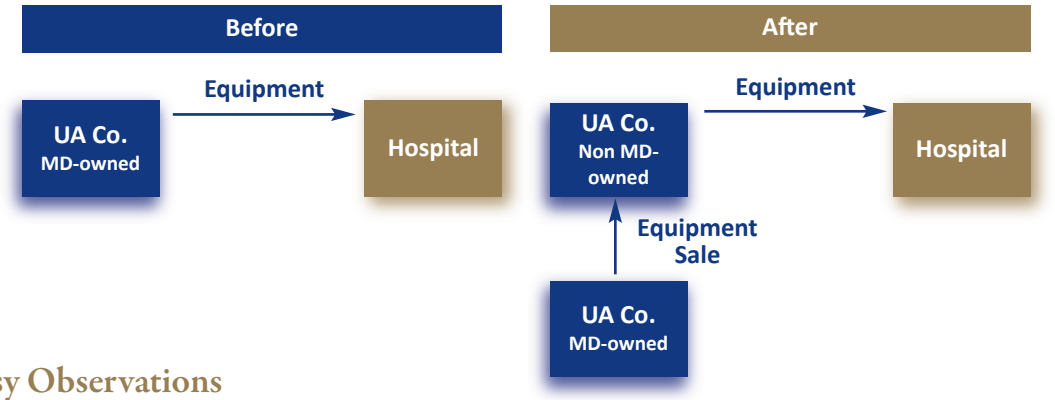
- **Certain arrangements involving equipment and other services were changed from a "per click" payment to a block payment.** For example, a provider of laser services restructured its payment from a "per click" fee to one where the fee for the equipment is fixed for a 4-hour block of time.



- **In certain arrangements, clinical employees previously employed by the under-arrangement or "per click" provider became employees of the hospital.** For example, an under-arrangement company previously providing necessary staff, equipment, and supplies to provide Revolix laser services entered into a traditional equipment lease to provide the equipment, while hospital now employs the staff and obtains the supplies directly.



- **Certain physician-owned under-arrangement or "per click" ventures were sold to non-physician owners.** For example, a physician-owner of a greenlight laser sold the laser to a non-physician.



Lithotripsy Observations

Although the CMS changes instituted on October 1, 2009 ultimately did not impact lithotripsy arrangements, we have observed a number of notable trends during 2009:

- Although lithotripsy ventures dodged the proverbial regulatory bullet, we noted a renewed interest among hospitals in making sure that their lithotripsy arrangements meet regulatory guidelines.
- Certain lithotripsy arrangements that previously consisted of equipment only were restructured to become turnkey service providers, including equipment, staff, supplies and management.
- There was a heightened focus on the possible need to cap annual lithotripsy payments, or to otherwise address possible FMV implications associated with high volume "per click" arrangements.

Annual Lithotripsy Procedure Volume Per Facility

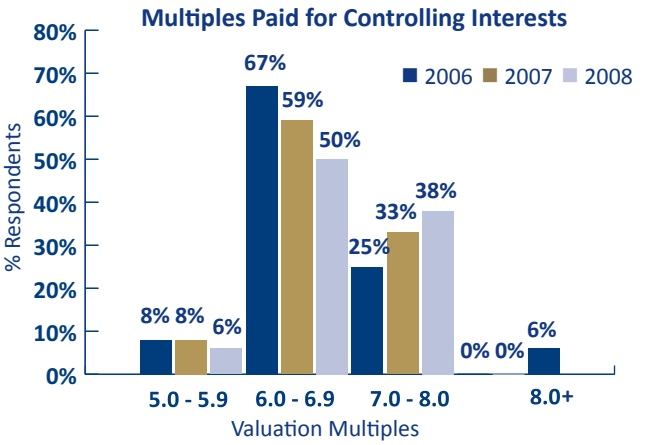
n=	25th Percentile	Median	75th Percentile	90th Percentile	Maximum
39	55	105	190	290	795

The above data is based upon a review of HAI's proprietary database of lithotripsy arrangement transactions in 2009.

The ambulatory surgery center ("ASC") marketplace continued to be highly active during 2009. Our observations of major trends in the ASC industry are listed below.

Multiples for Controlling Interests

Multiples paid for controlling interests are declining. In early 2009, a multi-specialty center might have negotiated up to an 8.0x times trailing 12-month earnings before interest, taxes, depreciation and amortization ("EBITDA"). Now, the same ambulatory surgery center ("ASC") is more likely to negotiate a 6.5x to 7.0x multiple.



What is Driving the Declining Multiples

- Physicians that built their surgery center in the 1980s and 1990s are planning for retirement resulting in more controlling interests for sale.
- More hospitals are entering into the bidding process and are not paying as high as a non-hospital corporate partner.
- With a proliferation in the number of ASCs, fewer opportunities exist to recruit new physicians to the surgery center upon sale to a corporate partner, as many physicians are otherwise involved in competing centers.
- Banks are lowering the EBITDA to leverage ratios within debt covenants, thus limiting corporate buyers' access to funds to purchase centers.
- The stock market is trading public corporate management companies at very low enterprise value to EBITDA margins, reducing the arbitrage achieved by these companies through a purchase.

The combination of reduced access to capital (*i.e.*, which causes buyers to be more disciplined/selective in their acquisition activity), as well as an increase in the number of surgery centers for sale has resulted in a "buyers" market.

Out-Of-Network Strategy

With the increase in the number of centers available for sale, buyers are less likely to explore the purchase of a center with an out-of-network reimbursement strategy. Investors in management companies use "same store sales" as their primary metric in determining the success of the management company. If payers refuse to pay or reduce the payments to centers that are using an out-of-network strategy, the reduction in reimbursement will significantly affect the management company's "same store sales," lower its share price, and might hinder the company's ability to access capital from its investors.

Hospital vs. Management Company

Physicians have a renewed interest in working with hospitals, in part, due to a recent rebirth of hospital/physician employment transactions. A common misconception is that selling an interest to a hospital will allow the surgery center to participate in the hospital's managed care contracts. In general, centers are unable to participate. The hospital may allow the center access to their managed care employees that have experience negotiating with the local payers and may be able to negotiate higher rates at the appropriate time.

Management companies occasionally pay a premium for centers with hospital partnership:

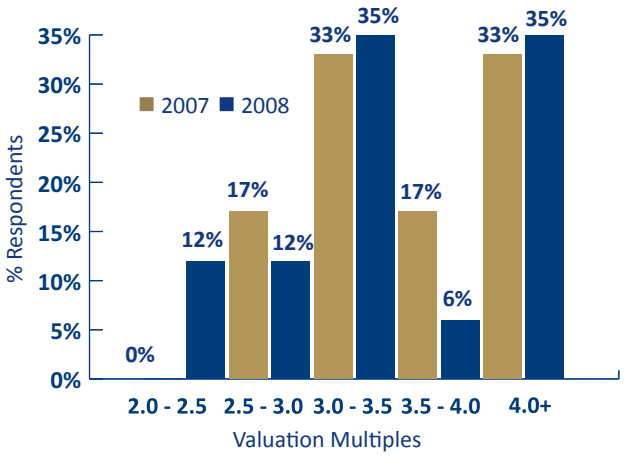
Impact of Hospital Ownership	% Respondents
No Impact	53%
Premium (*i.e.*, adds to value)	23%
Discount (*i.e.*, detracts from value)	18%
Not Applicable	6%

Impact expressed in multiples of EBITDA	% Respondents
<0.25x	14%
0.26x - 0.50x	29%
0.51x - 0.75x	29%
0.76x - 1.0x	14%
>1.0x	14%

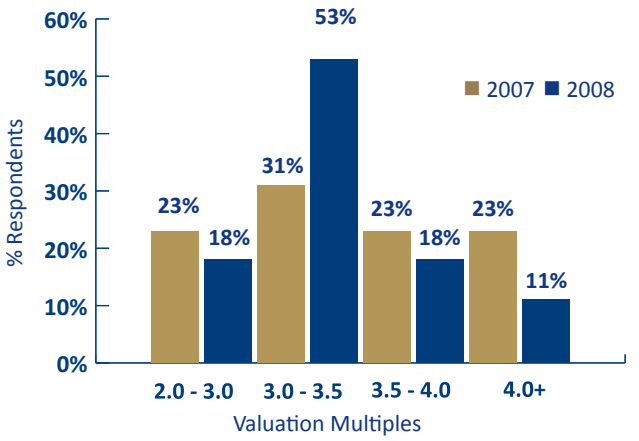
Multiples for Minority Interests

The range of 2.0x to 3.5x EBITDA is still used by surgery centers when determining the price of minority interests sold to or bought from physicians. The following tables present the results from the Survey related to minority interest redemption and buy-ins:

Multiples Paid for Physician-Investor Redemptions



Multiples Paid for Physician-Investor Buy-ins



The Survey reported that 82% of centers were using predetermined formulas for physician minority transactions. The majority of companies are still using formulas. In general, the formula is based on 50% of the control multiple.

Management Fees

Management fees generally range between 3% and 7% of net revenue with the majority between 5% and 6% of net revenue.

Minimum Management Fee (as a % of Net Revenue)

% Net Revenue	% Respondents
3%	11%
4%	11%
5%	39%
6%	22%
7%	6%
Other	11%

Maximum Management Fee (as a % of Net Revenue)

% Net Revenue	% Respondents
3%	0%
4%	0%
5%	6%
6%	55%
7%	22%
Other	17%

This range has stayed fairly consistent. Overall, the majority of respondents to the Survey do not adjust their fee based on revenue levels of the center (*i.e.*, 67%), the level of services provided (*i.e.*, 61%), or the level of equity ownership (*i.e.*, 88%).

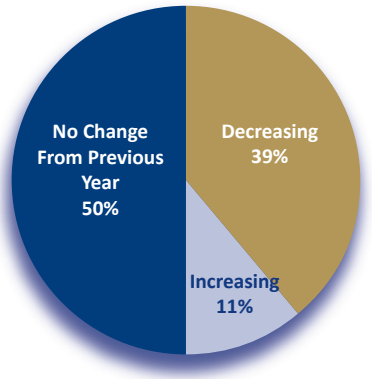
In 2009 HealthCare Appraisers surveyed the Physician Hospital Industry to determine current perspectives among industry participants regarding valuation, transaction activity, and management fees. With the help of Physician Hospitals of America ("PHA"), 30 respondents participated in our survey, representing approximately 100 hospitals throughout the country.

The following summarizes highlights of the survey. (For a copy of the survey, please contact us.)

Transaction Activity

- With the uncertainty surrounding healthcare reform, tightening in the credit markets, and overall economic distress, acquisition activity has waned over the last year with 39% of the respondents reporting declines.

Physician Hospital Acquisition Activity



- For some, this has translated into opportunity, with 32% of respondents reporting that competition for physician hospital investment opportunities has declined, and only 18% reporting that competition has increased.

- When bidding on acquisition targets, half of the respondents report 2 to 3 bidders, and 30% report 4 or more bidders.

- During 2008 63% of respondents reported performing due diligence for physician hospital acquisitions, but only 21% of respondents actually completed one or more acquisitions.

- For 2009, 42% of respondents planned to purchase between 1 to 3 physician hospitals. 65% of respondents stated that they were opportunistic with respect to selecting physician hospital opportunities.

Valuation Multiples and Methodologies

- When purchasing a controlling interest in a physician hospital, 54% of the respondents reported prevailing valuation multiples of 5.0 to 6.9 times EBITDA. 40% of respondents perceive that valuation multiples have stayed consistent with the prior year, while 55% perceive that multiples have decreased.

Multiples Paid for Controlling Interests

Valuation Multiples	% Respondents
<4.0	9%
4.0 - 4.9	19%
5.0 - 5.9	27%
6.0 - 6.9	27%
7.0 - 7.9	9%
8.0+	9%

- Somewhat surprisingly, 72% of respondents reported that political proposals related to banning or limiting self-referral to physician-owned hospitals have no impact on the valuation process primarily because facilities currently in existence would likely be grandfathered. Survey participants overwhelmingly agree that this is a risk factor, with 81% of respondents reporting that President Obama and the Democratic majority in Congress have a negative effect on the outlook for physician hospitals. Because there exists an inverse relationship between risk and valuation (*i.e.*, higher risk equals lower valuation) we would have expected stronger downward pressure on valuation multiples.

Impact of Political Proposals on Outlook

Impact on Outlook	% Respondents
No Impact	11%
Positive	4%
Slightly Positive	4%
Slightly Negative	29%
Negative	26%
Very Negative	26%

Valuation Multiples and Methodologies *(cont.)*

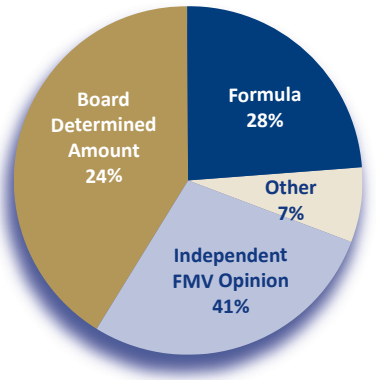
- For minority interests 50% of respondents indicated that when buying out retiring or departing physicians, pricing is set between 3.0 to 4.9 times EBITDA.

Multiples Paid for Minority Interests

Valuation Multiples	% Respondents
<2.0	17%
2.0 - 2.9	8%
3.0 - 3.9	13%
4.0 - 4.9	37%
5.0 - 5.9	17%
6.0+	8%

Mathematically this represents a discount from the controlling interest multiples of approximately 30-40%. When determining the price to pay departing physicians, 52% of respondents base the redemption price on a predetermined formula. For new physician investors, 28% of respondents report using a formula to establish the buy-in price; 24% allow the board to determine the purchase price; and 41% obtain an independent, fair market value opinion.

Determining Purchase Price For New Physician Investors



Regulatory Update

2009 was an especially difficult year for the physician hospital industry. Healthcare reform efforts from both the House and the Senate include bills with negative language regarding physician-owned hospitals. Language generally places the following restrictions on physician-owned hospitals:

Regulatory Update *(cont.)*

- Physician hospitals must have Medicare Certification in place by February 1, 2010 and meet specific requirements within 18 months of the enactment of the legislation to be grandfathered.
- Even if grandfathered, the aggregate percentage of physician ownership cannot increase after the date of the passage of the bill.
- Grandfathered hospitals would still be required to meet 4 specific requirements in order to be allowed to add beds, ORs or procedure rooms. According to PHA there are no physician-owned hospitals that currently meet each of the 4 following requirements:

  1. Hospital is located in a county where the population growth is at least 150% of the state average population growth during a 5-year period.
  2. Hospital has a Medicaid inpatient admission percentage that is greater than or equal to the average of all hospitals located in the county.
  3. Hospital is located in a state that has an average bed capacity below the national average.
  4. Hospital has a bed occupancy rate that is higher than the average occupancy rate for the state.

- If a physician-owned hospital does not have its Medicare Provider Number by February 1, 2010, it is not eligible to be certified and cannot provide services Medicare/Medicaid patients going forward.

The election of Senator Scott Brown in Massachusetts put a temporary halt to the reform efforts, but there is likely to be continued pressure to pass some level of healthcare reform. Though the ultimate outcome of these legislative efforts is unknown, it is likely that physician-owned hospitals will remain under continued scrutiny.

Physician Practice Acquisition Trends

The most notable trend observed during 2009 related to physician practice acquisition is the uptick in acquisition activity by hospitals/health systems. We believe this activity has primarily been driven by three main factors:

- Continued hospital focus on physician alignment and integration to gain competitive advantages;
- A desire by physicians to alleviate the administrative burdens and ongoing capital investment associated with running a professional practice; and
- Ongoing reimbursement pressure and regulatory changes.

Other 2009 trends related to physician practice acquisition include:

Cardiology Practice Acquisitions

- While the proposed change in Medicare reimbursement under the physician fee schedule was delayed at the very end of 2009, there was a decrease in relative value units assigned to certain cardiology related procedures. Implementation of this change caused significant declines in Medicare reimbursement to cardiology practices that offer ancillary services including diagnostic catheterization, nuclear imaging, and echocardiography. This has prompted many hospitals and large cardiologists to enter into acquisition discussions.

- Further compounding this is the fact that most of the physicians that developed outpatient diagnostic catheterization labs or practice based nuclear imaging in the early to mid 1990s have equipment that requires replacement at a cost of $1 million or higher.

- Recent medical school graduates in interventional cardiology are more commonly performing recently developed procedures that can only be performed in a hospital, such as i-flow studies and ablations.

- The consideration of replacing the equipment in conjunction with lower Medicare reimbursement and less utilization of physician owned outpatient centers and modalities by recent graduates is causing physicians to consider alternatives to replacing the equipment. We have observed that as one alternative to a complete "sell-out" of the practice, some practices are divesting just their imaging or diagnostic catheterization business.

OB-GYN Practice Acquisitions

- We also observed an increase in activity related to OB/GYN practices. While the malpractice insurance premium increases of the late 1990s and early 2000s caused a number of obstetric practices to merge, HAI did not see many obstetric practices selling to hospitals at that point. However, as we bring this decade to a close, while malpractice insurance premium increases appear to have "settled" in general, such obstetric practices are now considering alignment with hospitals for the following reasons:

  - With the increase in the number of uninsured patients, hospitals are finding that engaging physicians to provide obstetric coverage for emergent patients is more difficult;

  - Practices are having a difficult time recruiting staff willing to provide hospital coverage as a higher percentage of obstetric medical school graduates are graduating at an age in which they would like to begin a family; and

  - The average number of years that a new medical school graduate spends providing obstetric services before converting their practice to strictly gynecology is declining.

Smaller Physician Practice Acquisitions

- We observed a relatively high volume of physician acquisition activity focused on smaller physician groups (*i.e.*, one to three physicians).
- In an effort to ensure a comprehensive network of physicians, Hospital acquisition strategies appear to focus on smaller primary care physician practices (*i.e.*, family practice and internal medicine) initially, then pursuing surgical specialties as appropriate thereafter.
- Most valuation analyses for smaller practices indicate that the only appreciable value lies in tangible assets (with subsequent employment of the selling physician(s)).
- We have noted that even if the valuator identified some degree of intangible asset value (*e.g.*, patient charts or workforce in place), most hospitals appear unwilling to pay in excess of tangible asset value for these small practices.
- While some physicians are choosing to sell their practice, some practices are choosing an "enterprise model," which might also be known as the "reverse management services agreement." Under these models, the physicians and mid-level providers become employees of the hospital but the practice remains as a separate legal entity. The practice provides the hospital's new practice with certain management services which may include the provision of space, staff, equipment, and supplies. Under this model, the hospital does not "acquire" the previously existing practice.

Overall, we expect to see continued growth in the purchase of smaller primary care practices and large cardiology practices. We also note some trends that might cause other specialties to sell their practice to hospitals and enter into subsequent employment arrangements:

- **Medical Oncology** - The decrease in reimbursement for oncology drugs from average sales price ("ASP") plus 6% to ASP plus 4%.
- **Radiation Oncology** - The change in the equipment utilization factor adjustment that CMS applied to CTs and MRIs was supposed to be applied to therapy equipment over $1 million but was changed prior to final implementation of the 2010 Medicare physician fee schedule. However, radiation oncologists are still concerned about declining reimbursement for the provision of the technical component of radiation oncology services in a physician owned cancer center.
- **Health reform** could possibly be beneficial for certain physician specialties and negative for others. As long as regulation is not complete, physicians will continue to have reason to fear the unknown (*i.e.*, health reform's impact on reimbursement).

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