CPA LEADERSHIP INSTITUTE
Promoting Continuous Improvement in CPA Firm Leadership

Valuation of Healthcare Entities and Assets:

The Impact of 2010 Legislation

Webinar By:

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About the Presenter

Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, is President of Health Capital Consultants, (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO. Mr. Cimasi has over twenty five years experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting; and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, including *"The Adviser's Guide to Healthcare*" [AICPA, 2010], as well as numerous chapters, published articles, research papers and case studies, and is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS) and serves on the Editorial Board of the RICS Modus Americas Journal.

Agenda

- Overview of Healthcare Valuation
- What Is Driving Healthcare Reform?
- Valuation of Healthcare Enterprises & Assets
- Concluding Remarks

OVERVIEW OF HEALTHCARE VALUATION

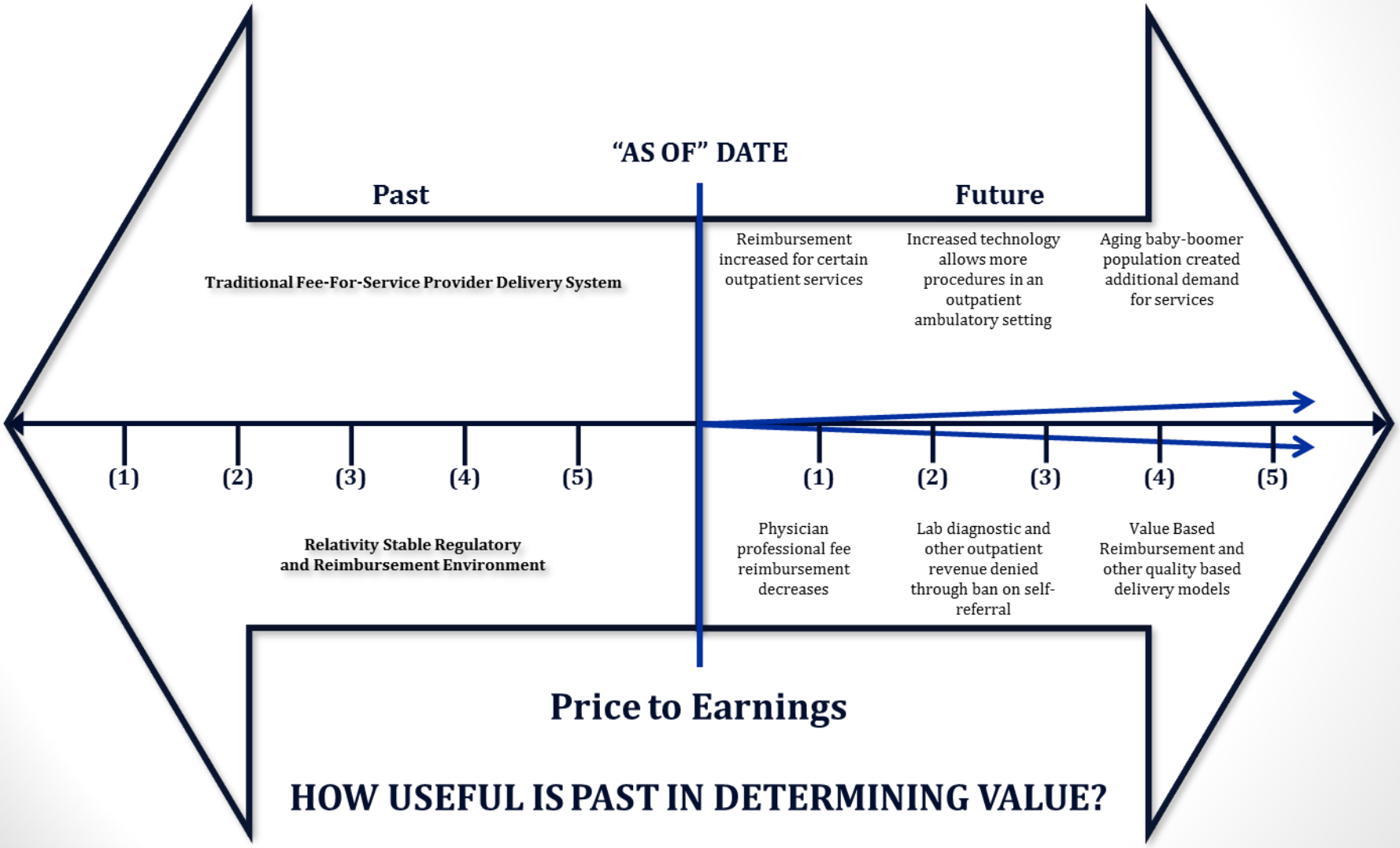
Basic Valuation Tenets

1. All value is the expectation of future benefit; therefore, all value is forward looking.

2. The best indicator of future performance is usually the performance of the immediate past.

3. Historical accounting and other data are useful primarily as a road map to the future.

Reliance on Historical Data for Valuations

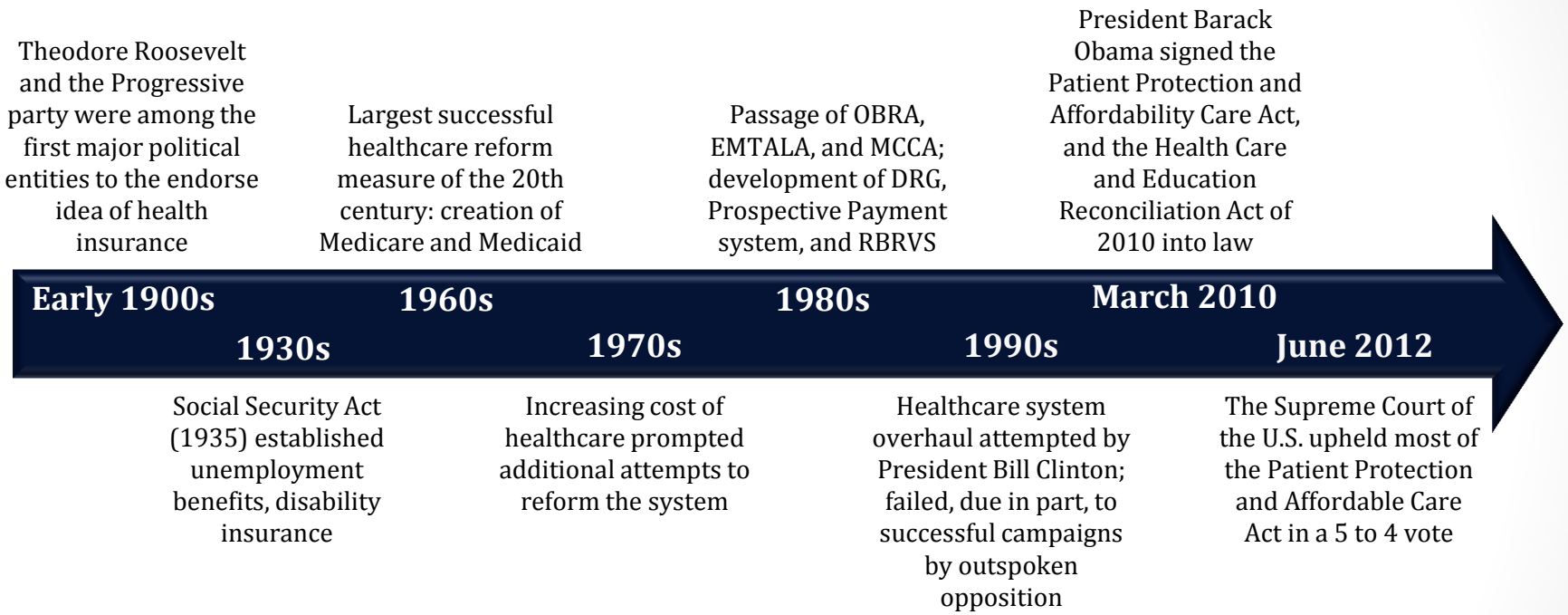


Reliance on Historical Data for Valuations

- Traditionally, healthcare valuation methods heavily relied on the analysis of historical accounting as predictive of future performance and value
- The status of the turbulent healthcare industry has introduced intervening events and circumstances that may dramatically affect the revenue, benefit stream, or operating expense and margin outlook for healthcare enterprises, assets, and/or services
- Therefore, the "*road map of historical performance*" has become a less reliable indicator and less predictive of future performance

WHAT IS DRIVING HEALTHCARE REFORM?

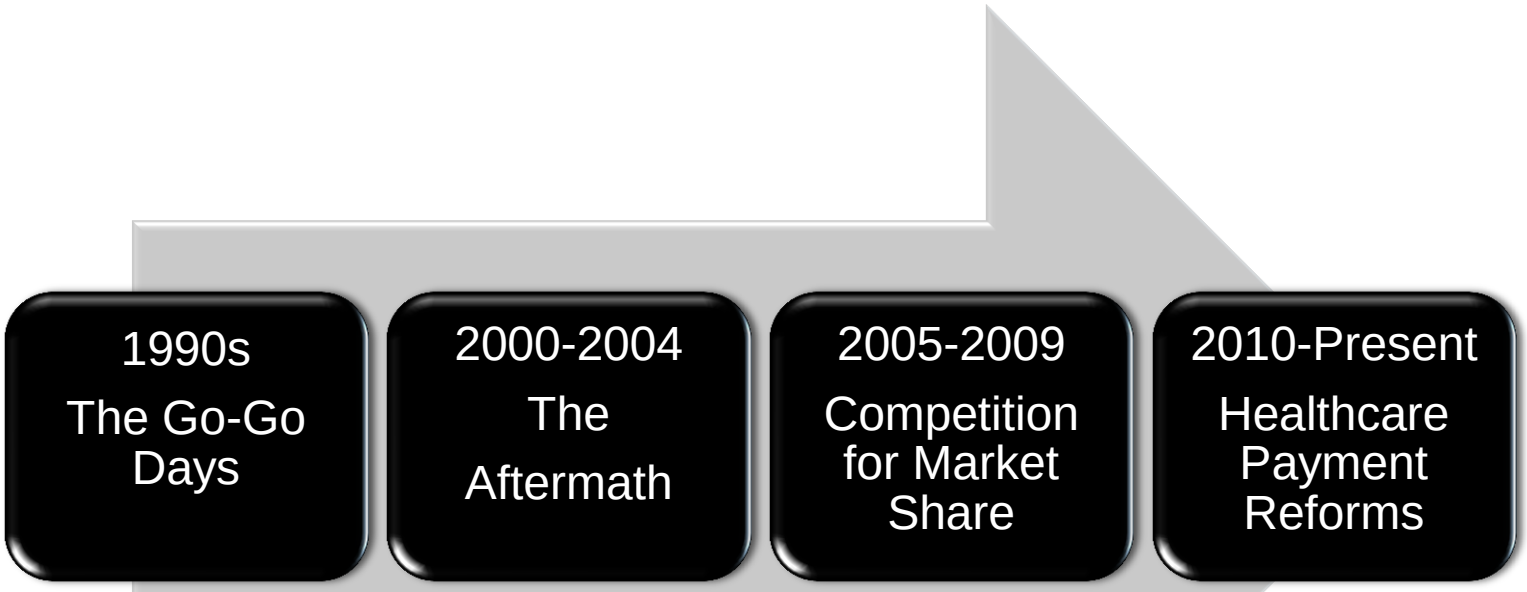
Timeline of Healthcare Reform



"*The only thing new in the world is the history that you don't know*."

- Harry S. Truman

History of Provider Alignment



Incentives for hospitals and physicians are leading to changes in where and how healthcare is delivered

"The End of Us vs. Them" By Philip Betbeze, HealthLeaders, April 2012, p. 11.

Healthcare Reform
Supreme Court Decision

- In March 2012, several states brought actions against the U.S. Department of Health and Human Services (HHS) regarding various provisions of the Patient Protection and Affordable Care Act (ACA)
  - Most cases were dismissed, but
  - Some district courts did publish decisions on the merits of the law
- Two of these cases were accepted to be heard by the U.S. Supreme Court
  - *National Federation of Independent Business v. Kathleen Sebelius*
  - *State of Florida v. United States Department of Health and Human Services*

"A Guide to the Supreme Court's Review of the 2010 Health Care Reform Law", Kaiser Family Foundation, January 2012, http://www.kff.org/healthreform/upload/8270-2.pdf (Accessed 5/31/2012); National Federation of Independent Business, et al., v. Kathleen Sebelius, Secretary of Health and Human Services, et al, Writ of Certiotari, Motion No. 11-393, November 14, 2011; Florida, et al., v. Department of Health and Human Services, et al., Writ of Certiotari, Motion No. 11-400, November 14, 2011.

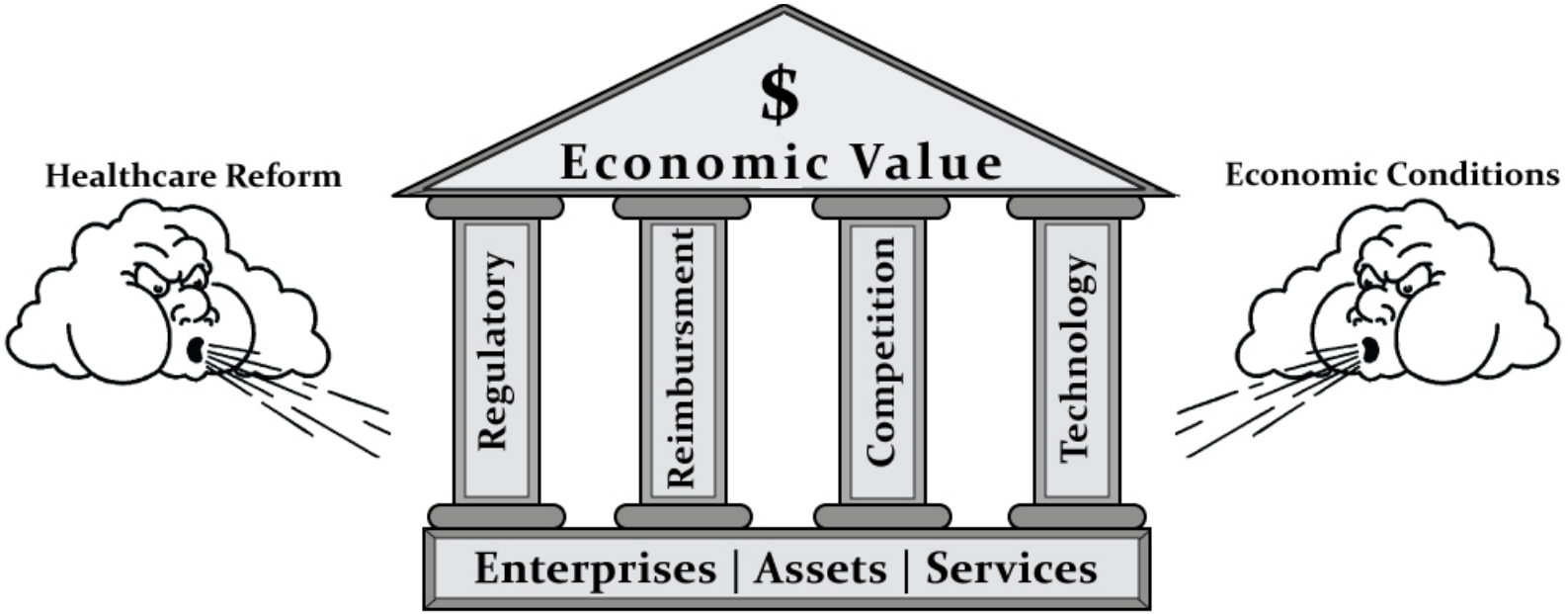
Healthcare Reform
Supreme Court Decision

June 28, 2012 - the Supreme Court of the United States upheld most of the 2010 Patient Protection and Affordable Care Act in a Five to Four ruling

- The ACA as a whole is constitutional
- Individual Mandate Upheld
  - The penalty (as termed in the ACA) is a Tax
  - Upheld under Federal taxing authority
  - Will go into effect in 2014, and will require all applicable individuals to obtain health insurance
- Medicaid Expansion is Upheld, but is now Voluntary
  - Congress cannot threaten to remove existing Medicaid funding
  - States may choose to expand Medicaid eligibility to 133 percent of the Federal Poverty Line (FPL) in exchange for federal funding assistance

National Federation of Independent Business et al., v Sebelius, Nos. 11-393, 11-398, and 11-400 (U.S. June 28, 2012).

The Four Pillars of the Healthcare Industry



The Four Pillars of the Healthcare Industry

- **Changing reimbursement environment** and current downshift in reimbursement yield
- **Increasing regulatory scrutiny** by state and federal agencies
- **Changing competitive landscape** due to increase regulation from various healthcare legislation
- **Technological and clinical advancements** contributing to the restructuring of the healthcare industry

Changing Reimbursement Environment
The Sustainable Growth Rate Saga

- The Sustainable Growth Rate (SGR) is designed to control aggregate growth in Medicare expenditures by raising or lowering the proposed payment target to reflect actual cumulative expenditures
- Since 2002, actual expenditures have exceeded target expenditures
- Congressional action to suspend the impending cuts to payments every year since 2003 has resulted in a widening gap between the cumulative spending and cumulative target
- On February 17, 2012, Congress again passed legislation to prevent scheduled payment cuts of 27.4% from going into effect, but with the SGR still in place, a reduction of 32% is scheduled to take effect on January 1, 2013

"Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System," By Jim Hahn, Congressional Research Service, August 6, 2010, (Accessed 8/15/2011), p. 3; "House Approves Tax/Jobs Bill with Medicare Provisions; Fate Uncertain" by Debra A. Mccurdy, Reed Smith LLP, Posed on Health Industry Washington Watch, December 13, 2011, http://www.healthindustrywashingtonwatch.com/2011/12/articles/legislative-developments/house-approves-taxjobs-bill-with-medicare-provisions-fate-uncertain/ (Accessed 12/19/2011); "Medicare Physician Pay Frozen Until 2013" By Charles Fiegl, American Medical News, February 17, 2012, http://www.ama-assn.org/amednews/2012/02/13/gvsg0217.htm (Accessed 6/1/2012).

Changing Reimbursement Environment

Downshifting Reimbursement

Annual Updates to the MPFS CF (CMS Final Rule v Congressional Action), 1997-2013

A	B	C	D	E
Year	SGR	CF	Physician Fee Schedule Update Under CMS Final Rule	Physician Fee Schedule Update After Congressional Actions
1998	1.5%	$36.6873	2.3%	N/A
1999	0.0%	$34.7315	2.3%	N/A
2000	3.0%	$36.6137	5.5%	N/A
2001	5.6%	$38.2581	5.0%	N/A
2002	5.6%	$36.1992	-4.8%	N/A
2003	7.6%	$34.5920	-4.4%	1.6%
2004	7.4%	$35.1339	-4.5%	1.5%
2005	4.3%	$37.8975	1.5%	1.5%
2006	1.7%	$36.1770	-4.4%	0.0%
2007	2.0%	$35.9848	-5.0%	0.0%
2008	-0.1%	$34.0682	-10.1%	0.5%
2009	7.4%	$36.0666	1.1%	1.1%
2010 (Jan - May)	-8.8%	$28.4061	-21.2%	0.0%
2010 (June-Dec)				2.2%
2011	-13.4%	$25.5217	-24.9%	0.0%
2012	-16.9%	$24.6712	-27.4%	0.0%
Proposed 2013	-18.9%	$24.8441	-27.0%	

Of note is that the SGR (Column B) is used to determine the conversion factor (Column C), which is then used in the calculation of the physician fee schedule update under the CMS Final Rule (Column D), however, congressional actions forgo these calculations and simply established a physician fee schedule update (Column E).

Changing Reimbursement Environment
The Sustainable Growth Rate Saga

- In May 2012, U.S. Representatives Allyson Schwartz and Joe Heck introduced *The Medicare Physician Payment Innovation Act of 2012,* a bipartisan bill aimed at eliminating Medicare's Sustainable Growth Rate (SGR), the payment system component long criticized for the uneven results it has produced in setting physician payment rates under Medicare
- The bill would provide an initial five-year period of stability for physician payment rates, and would also require the Centers for Medicare and Medicaid Services (CMS) to develop at least four alternatives to the existing payment system by October 2016
- The bill acknowledges that Congress must first act to prevent the January 2013 cuts from going into effect and provides for physician payment rates increasing 0.5% annually for four consecutive years
- The bill would increase primary care service fees by an annual rate of 2.5% from 2014 through 2017

"H.R. 5707: Medicare Physician Payment Innovation Act of 2012" By Representative Allyson Schwartz and Representative Joe Heck, p.2; "Former Medicare Chiefs Say SGR Must Be Eliminated" By Charles Fiegl, American Medical News, May 21, 2012, http://www.ama-assn.org/amednews/2012/05/21/gvsa0521.htm (Accessed 5/23/2012); "Medicare Physician Payment Innovation Act of 2012: Summary of Provisions" By Representative Allyson Schwartz and Representative Joe Heck, p. 5-6; http://heck.house.gov/sites/heck.house.gov/files/Medicare%20Physician%20Payment%20Innovation%20Act%20Framework.pdf (Accessed 5/29/2012); "Schwartz, Heck Introduce Bill to Repeal and Replace the SGR; Senate Finance Holds SGR Roundtable" American Association of Medical Colleges, May 11, 2012, https://www.aamc.org/advocacy/washhigh/highlights2012/282554/schwartzheckintroducebilltorepealandreplacethesgrsenatefinanceh.html (Accessed 6/1/2012).

Changing Reimbursement Environment
The Sustainable Growth Rate Saga

- The bill requires CMS to test, evaluate, and produce at least four new options for care and payment systems
  - Physicians who have transitioned to one of the "*CMS-approved health care delivery models*" by 2018 will experience stabilized payment rates
- Payments to physicians still practicing under the existing Medicare FFS payment system would begin undergoing 2% reductions in 2019, with a 1% increased reduction for each year thereafter through 2022
- Physicians who are incapable of switching to an approved FFS-alternative may be eligible for an exemption from these cuts, but in any event, "*payments in the straight [FFS] model will be permanently frozen at the 2022 levels.*"

"Medicare Physician Payment Innovation Act of 2012" By Representative Allyson Schwartz and Representative Joe Heck, p.2; "Former Medicare Chiefs Say SGR Must Be Eliminated" By Charles Fiegl, American Medical News, May 21, 2012, http://www.ama-assn.org/amednews/2012/05/21/gvsa0521.htm (Accessed 5/23/2012); "Medicare Physician Payment Innovation Act of 2012: Summary of Provisions" By Representative Allyson Schwartz and Representative Joe Heck, p. 5-6, http://heck.house.gov/sites/heck.house.gov/files/Medicare%20Physician%20Payment%20Innovation%20Act%20Framework.pdf (Accessed 5/29/2012).

Changing Reimbursement Environment

Attack on ASTC Revenue Streams

Professional Component (wRVU)

↓

Medicare reimbursement for wRVUs has been stagnant or decreasing for physician fees since the 1990's

Ancillary Services & Technical Component (ASTC)

↓

Professional practice physician owners looked for *supplementary profits* via the ASTC revenue stream

Ongoing measures have been undertaken to restrict physician investment in ASTC revenue streams

Changing Reimbursement Environment
Attack on ASTC Revenue Streams

- Efforts undertaken at the Federal and State levels restrict physician ownership of/investment in ASTC revenue stream enterprises
  - Surgical/specialty hospitals
  - Ambulatory Surgery Centers (ASCs)
  - Independent Diagnostic Testing Facilities (IDTFs), etc.
- *ACA §6003:* Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services
  - Imaging services included MRI, CT, PET, and other Stark designated health services (DHS) as the Secretary "*determines appropriate*"
  - Applicable to Medicare/Medicaid patients only
  - Must provide patients with written notice, at time of the referral, of alternative imaging providers (located in the area in which patient resides) who perform services for which the patient is being referred

"Patient Protection and Affordable Care Act," Public Law 111-148, (March 23, 2011); "In-office imaging disclosure requirement effective Jan. 1, 2011," Medical Group Management Association, MGMA Washington Connexion, June 30, 2010, http://www.mgma.com/article.aspx?id=34069 (Accessed 1/10/2012).

Increasing Regulatory Pressures

Physician Owned Hospitals

- Hospitals will be grandfathered that were:
  - In existence, as of March 30, 2010, and
  - With Medicare Certification in place by December 31, 2010, and
  - Who met specific requirements by October 22, 2011
- Existing grandfathered hospitals will be required to meet four requirements in order to be allowed to apply to HHS to expand a hospital:
  (1) Located in a county with a population growth rate of at least 150% the state's population growth over the last 5 years
  (2) Have a Medicaid inpatient admission percentage of at least the average of all hospitals in the county
  (3) Located in a state with below-national-average bed capacity
  (4) Have a bed occupancy rate greater than the state average
- The aggregate percentage of physician ownership cannot be increased after the date of the passage of the bill
- Developing physician-owned hospitals without a Medicare Provider Number on December 31, 2010 will not be grandfathered

"Health Care and Education Reconciliation Act of 2010", Public Law 111–152, (March 30, 2011); "The Patient Protection and Affordable Care Act Immediately Impacts Providers' Compliance with STARK, the Anti-Kickback Statute, and False Claims Act Enforcement Efforts," By Kathryn R. Gilchrist, Adams and Reese LLP, April 2010, http://arwebserver.arlaw.com/htmlemails/050410healthcare.html (Accessed 1/10/2012);"Section-by-Section Analysis with Changes Made by Title X and Reconciliation included within Titles I-IX," Democratic Policy Committee, http://dpc.senate.gov/healthreformbill/healthbill96.pdf (Accessed 5/24/2010).

Increasing Regulatory Pressures
Fraud and Abuse & Audits

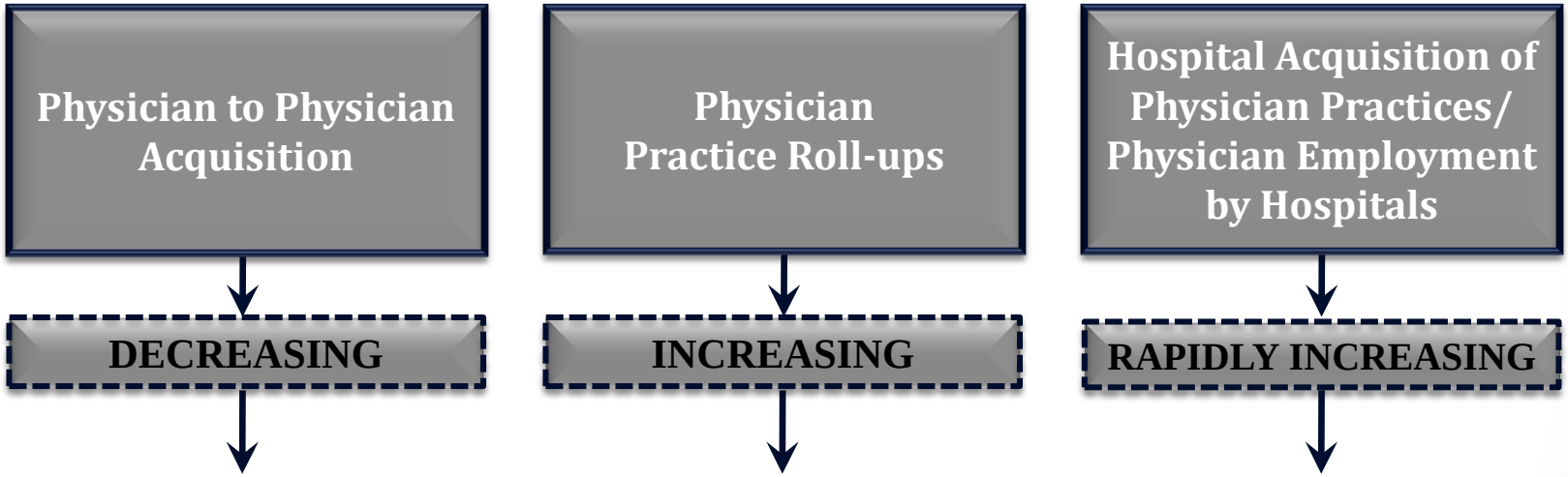
- Increased Agency Scrutiny of Fraud and Abuse
  - Office of Inspector General (OIG) of the (HHS)
  - Department of Justice (DOJ)
  - Internal Revenue Service (IRS)
  - Health Care Fraud Prevention and Enforcement Action Team (HEAT)
- Increased Use of "*Payment Recapture Audits*"
  - Process of identifying improper payments made to contractors or other entities, in which third-party private companies receive a percentage of the improper payments they recover
  - Recovery Audit Contractors (RACs) were created as a result of the Tax Relief and Healthcare Act of 2006 to assist with overhaul of CMS claims payment contractors
  - Other audits
    - Comprehensive Error Rate Testing (CERT)
    - Medicare Administrative Contractor (MAC) / Medicaid Integrity Contractor (MIC) Audits

Increasing Regulatory Pressures
Enforcement of Key Regulations

- **Anti-Kickback Statute (AKS)** – anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony
- **Stark Law** – prohibits referrals from physicians to a provider of Designated Health Services if the referring physician (or a members of his/her immediate family) have a financial relationship with the entity
- **False Claims Act (FCA)** – prohibitions against those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds
- **Fraud Enforcement and Recovery Act (FERA)** – passed in 2009, expands provider liability under the FCA

Changing Competitive Landscape

Emerging Trends in Alignment, Consolidation, & Integration



What is driving these trends?

- Decrease in *reimbursement yield* for several specialties
- Increasing *regulatory scrutiny* of physician ownership of ASTC revenues
- More hospitals are competing for physicians' time
- Increasing *costs* (e.g., advances in technology)
- Change in *lifestyle preference* for younger physicians entering market

Changing Competitive Landscape

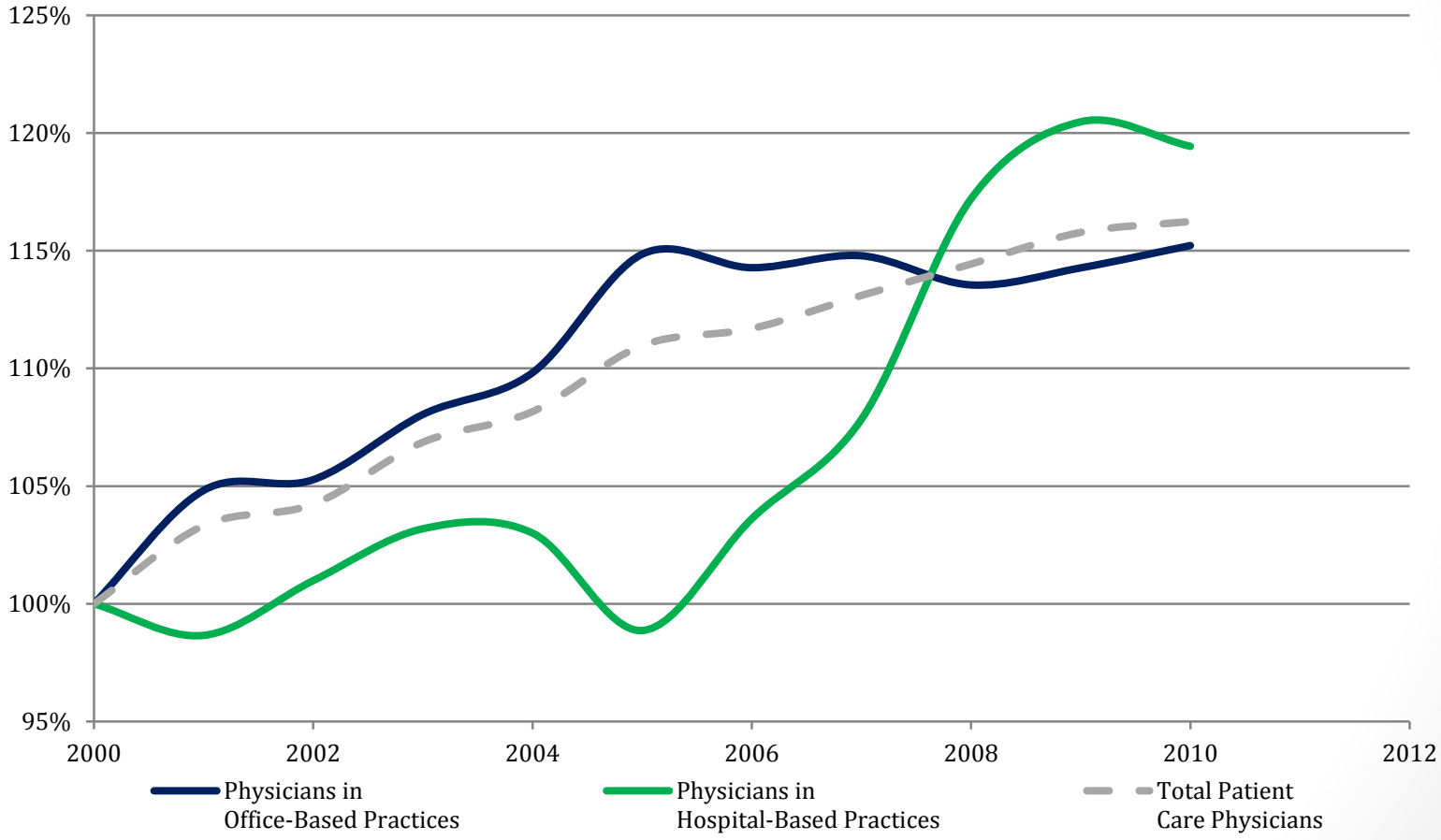
Emerging Trends in Alignment, Consolidation, & Integration

Direct Employment Model	• Physicians have standard employment agreement with the hospital • Physicians and hospital use separate legal entity to manage the practice
Captive-Group or Equity and Foundation Models	• Physicians are employees of hospital subsidiary • Physicians and hospital use separate legal entity to manage the practice
Hospital-Owned Clinic Staffing Model	• Physicians maintain ownership of practice • Physicians create Professional Services Agreement with the hospital
Co-Management / Joint Ventures	• Hospital enters into agreement with an organization that is either jointly or wholly owned by a physician to provide the daily management services for the inpatient and/or outpatient components of a medical specialty service line
Accountable Care Organizations/ Value Based Models	• Health care organizations in which a set of providers, usually physicians and hospitals, are held accountable for the cost and quality of care delivered to a specific local population

Changing Competitive Landscape

Emerging Trends in Alignment, Consolidation, & Integration

Percent Change by Practice Setting Since 2000



"Physician Characteristics and Distribution in the US" American Medical Association, 2002-2003 edition (p. 329); 2003-2004 edition (p. 320); 2004 edition (p. 322); 2005 edition (p. 311); 2006 edition (p. 311); 2007 edition (p. 311); 2008 edition (p. 403); 2009 edition (p. 406); 2010 edition (p. 438); 2011 edition (p. 436). 2011 edition (p. 436); 2012 edition (p. 440).

Changing Competitive Landscape
Emerging Models of Healthcare

- ***Patient-Centered Medical Home Model***
  - Promotes primary and preventive care services
  - Maximizes efficiency by utilizing manpower resources
  - Reevaluates the role of, and combats overuse of, specialty services
- ***Bundled Payment Model***
  - Used as a means of reducing Medicare costs
  - Reimbursement method that combines institutional and professional charges into a single payment to multiple providers (e.g., both hospitals and physicians) that covers all services involved in a patient's continuum of care
- ***Accountable Care Organization (ACO) Model***
  - Encourages providers to assume accountability for quality and efficiency
  - Bolsters efforts towards payment reform

Technological Change and Clinical Advancements

Clinical Advancements

- The *value of certain services may be reduced for* physicians using outdated techniques and/or lacking sufficient experience in advanced procedures
- Advancements seen in several areas of clinical technology
  - Genetics, Genomics, and Genome Technology
  - Stem Cell Research
  - Diagnostic Technology - Molecular Diagnostics and Personalized Medicine, Imaging Technology
  - Therapeutic Technology – Molecular Pharmacology, Radiation Therapy
  - Robotics and Surgical Technology - Laparoscopic Surgery, Minimally Invasive Surgery, Robotics (The Da Vinci System)
- While contributing to a higher quality of care, advances in pharmaceutical (e.g., Purple Pill), surgical, and management technology (e.g., Electronic Health Records) may drive up healthcare costs

Technological Change and Clinical Advancements

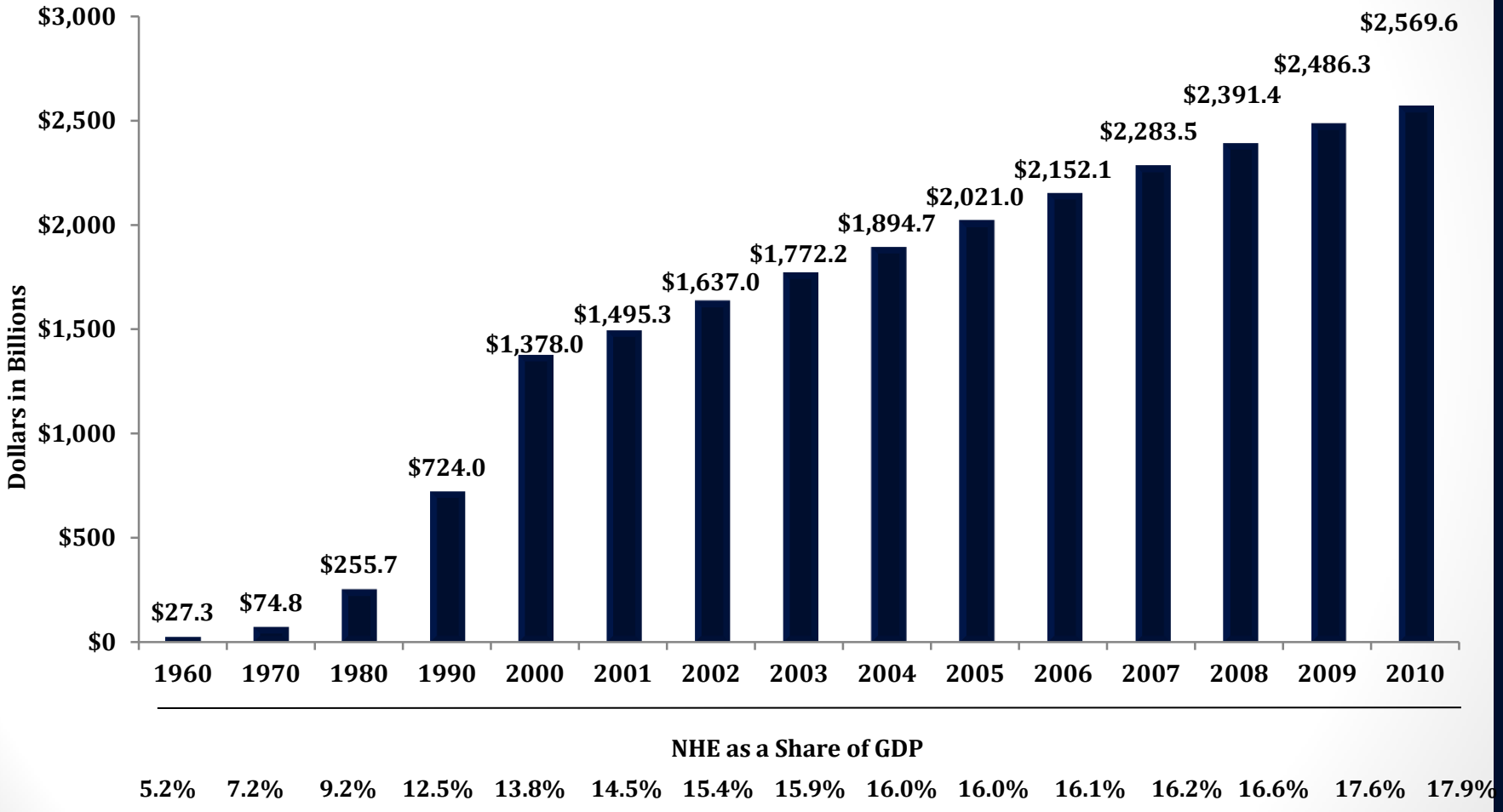
Healthcare Information Technology

- Changes in technology are driven by initiatives toward evidence-based medicine and value-based reimbursement that utilize quality metrics
- Electronic Health Records
  - American Recovery and Reinvestment Act (signed by President Obama February 17, 2009) allots $19.2 billion to ensure every patient has complete, interoperable EHR by 2014
  - Significant investment required for implementation
  - Help eliminate silos and increase continuity of care
  - Must meet "*Meaningful Use*" standards
- Computerized Physician Order Entry (CPOE)
  - Allows electronic ordering of lab, pharmacy, and radiology services, aimed at minimizing ambiguity, inefficiencies, and errors associated with hand written orders
  - Often within clinical decision support (CDS) systems
- The ACA establishes incentive payments for health plans and providers that apply health information technology in the process of improving outcomes

"American Recovery and Reinvestment Act of 2009," Public Law 111-5, February 17, 2009. (Accessed 8/15/2011); Federal Register, Vol. 75, No. 21, Government Printing Office, February 2, 2010, http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/html/2010-2125.htm, (Accessed 8/15/2011), p. 5329-5330; "Patient Protection and Affordable Care Act," Public Law 111–148, March 23, 2010, (Accessed 8/16/2011); "Patient Protection and Affordable Care Act," Public Law 111-148, (March 23, 2011), p. 263-264; "Provider Incentive Programs: An Opportunity for Medicaid to Improve Quality at the Point of Care", By Diane Hasselman, Center for Health Care Strategies, Inc., March 2009, http://www.chcs.org/usr_doc/P4P_Resource_Paper.pdf (Accessed 6/4/2012).

Additional Factors Driving Reform

Rising Healthcare Expenditures



"National Health Expenditure Projections 2010-2020," By Center for Medicare and Medicaid Services, June 29, 2009, https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf (Accessed 10/27/2011).

Additional Factors Driving Reform
Provider Manpower Shortage

- Cap on medical school enrollment
- Graduate Medical Education National Advisory Committee (GMENAC)
  - Aging physicians (one-third of all physicians are 55 and older)
- Younger physicians are less likely to:
  - Take call coverage
  - Work longer hours
  - Undertake the entrepreneurial challenge of opening private practice vs. collecting a salary

"Physician Characteristics and Distribution in the US" American Medical Association, 2010 edition , Chapter 1, https://catalog.ama-ssn.org/MEDIA/ProductCatalog/m1990045/PCDSamplePgs2010.pdf, (Accessed 8/15/2011).

Additional Factors Driving Reform

Changing Patient Demographics

- Growth of aging baby-boomer population
  - Population of people age 65 & older will double to 71 million by 2030
  - People over age 65 utilize twice the amount of medical services of those under 65
  - First baby-boomer entered Medicare program in 2010
- Growth in immigration over several years
  - Increase in the total population requiring healthcare
  - Increase in the overall birth rate and number of newborns
- Increased demand for healthcare services
  - Estimated 46.3 million people in the United States are uninsured
  - Approximately 10 million people buy health coverage through the individual insurance market

"Helping People To Live Long and Productive Lives and Enjoy a Good Quality Of Life," Center for Disease Control and Prevention, http://www.cdc.gov/chronicdisease/resources/publications/AAG/aging.htm, (Accessed 12/16/2011); "Income, Poverty and Health Insurance Coverage in the United States: 2008", U.S. Census Bureau, September 2009, http://www.census.gov/prod/2009pubs/p60-236.pdf, (Accessed 12/16/11), p. 2; "Individual Health Insurance: Fact, Opinion and Policy," Center for Studying Health System Change, October 23, 2002, http://hschange.org/index.cgi?conf=show&what=12, (Accessed 12/16/2011); "Medicare Spending and Financing" Kaiser Family Foundation, Fact Sheet, September 2011, http://www.kff.org/medicare/upload/7305-06.pdf (Accessed 1/1/2012).

VALUATION OF HEALTHCARE ENTERPRISES & ASSETS

Introduction to Healthcare Valuation

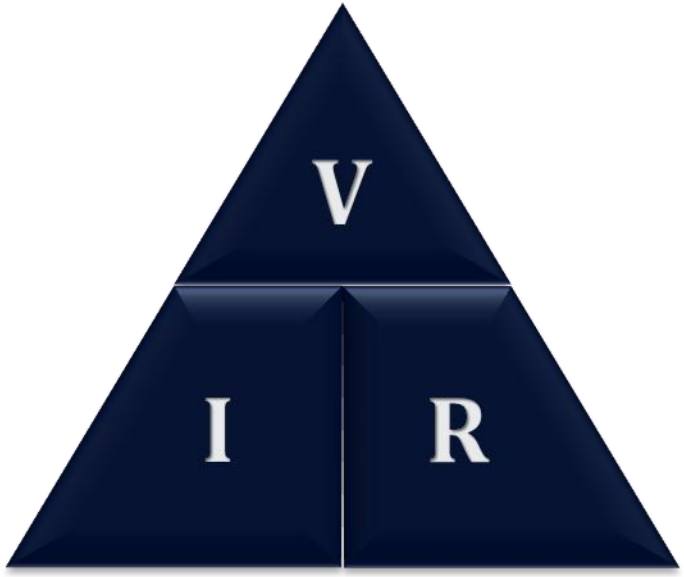
- Many events may set the stage for the valuation (appraisal) of healthcare **Enterprises, Assets, or Services**
- Scope of valuation services
  - Comprehensive, formal written reports with certified opinions
  - Limited, restricted use analyses and/or calculations
  - Valuation consultations or valuation review
- Imperative to establish at the outset of the engagement the specific definition and detailed delineation of the specific elements of the **legal bundle of rights** that describe the property interest(s) to be appraised
- The hypothetical transaction is assumed to be closed with the typical legal protections in place to safeguard the ownership transfer of the legal bundle of rights which define and encompass the transacted property or interest

Economic Principals of Valuation

- ***Substitution***
  - The cost of an *equally desirable substitute*, or one of equal utility, normally sets the ceiling of value
  - Incremental benefit – benefit of "*buying*" rather than "*building*"
- ***Investment Limits***
  - Resources are not normally spent in pursuit of ***diminishing returns*** from property
- ***Anticipation***
  - Economic benefits of rights to control or ownership of property are created from ***expectation of benefits*** or rights to be derived in the *future*
- ***Utility***
  - "*An object can have no value unless it has utility*."
  - However, its ***utility may be derived from its exchange***

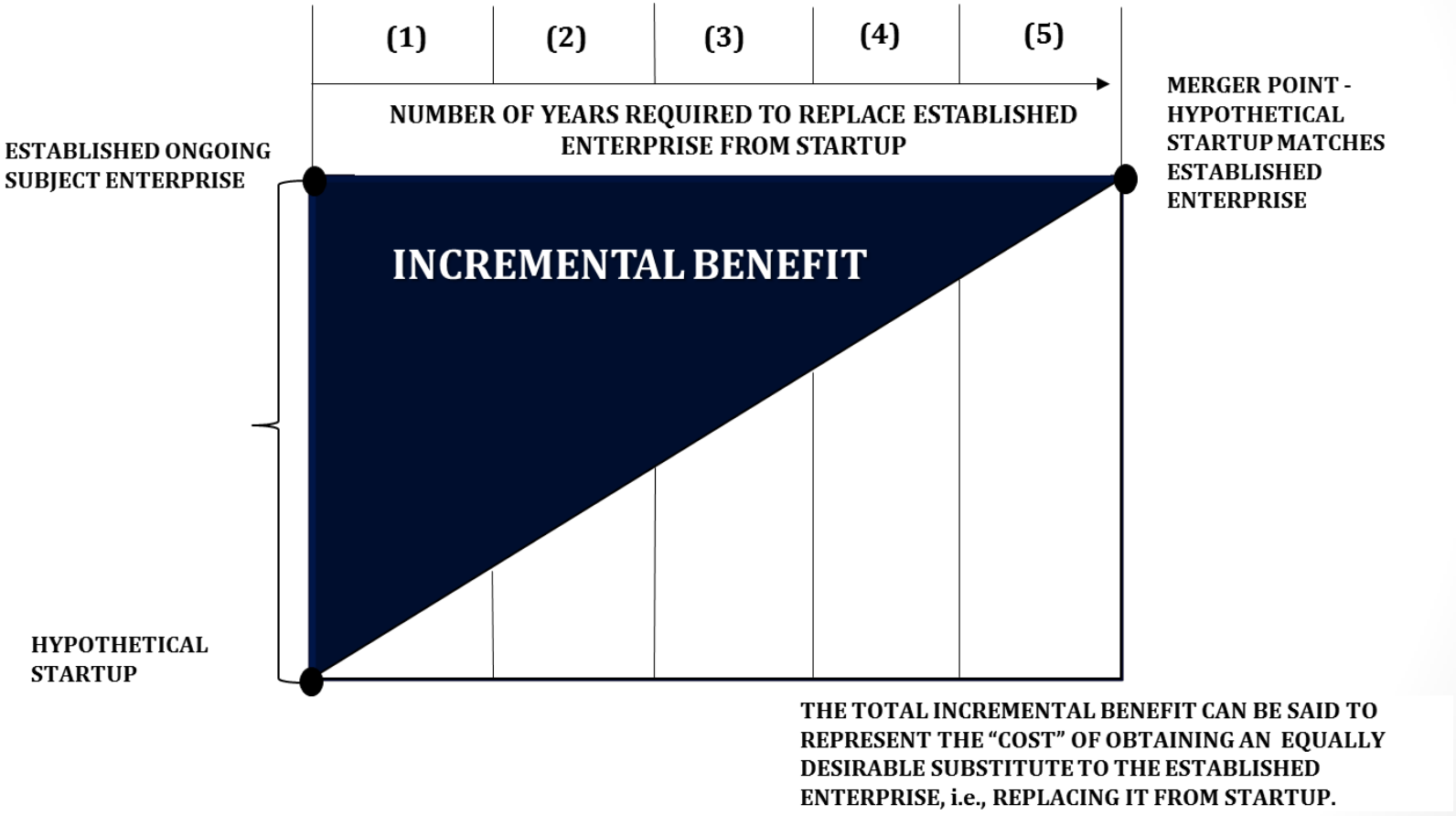
"Appraisal and Valuation: An Interdisciplinary Approach, Volume I", By Richard Rickert, Ph.D. (1987), American Society of Appraisers, International Valuation Sciences Institute, Washington, D.C., Ch. 3, p. 8, 24, 42, 47; "Principles of Economics", By F.W. Taussig, The MacMillan Company, 1918, p. 120.

The Value Pyramid

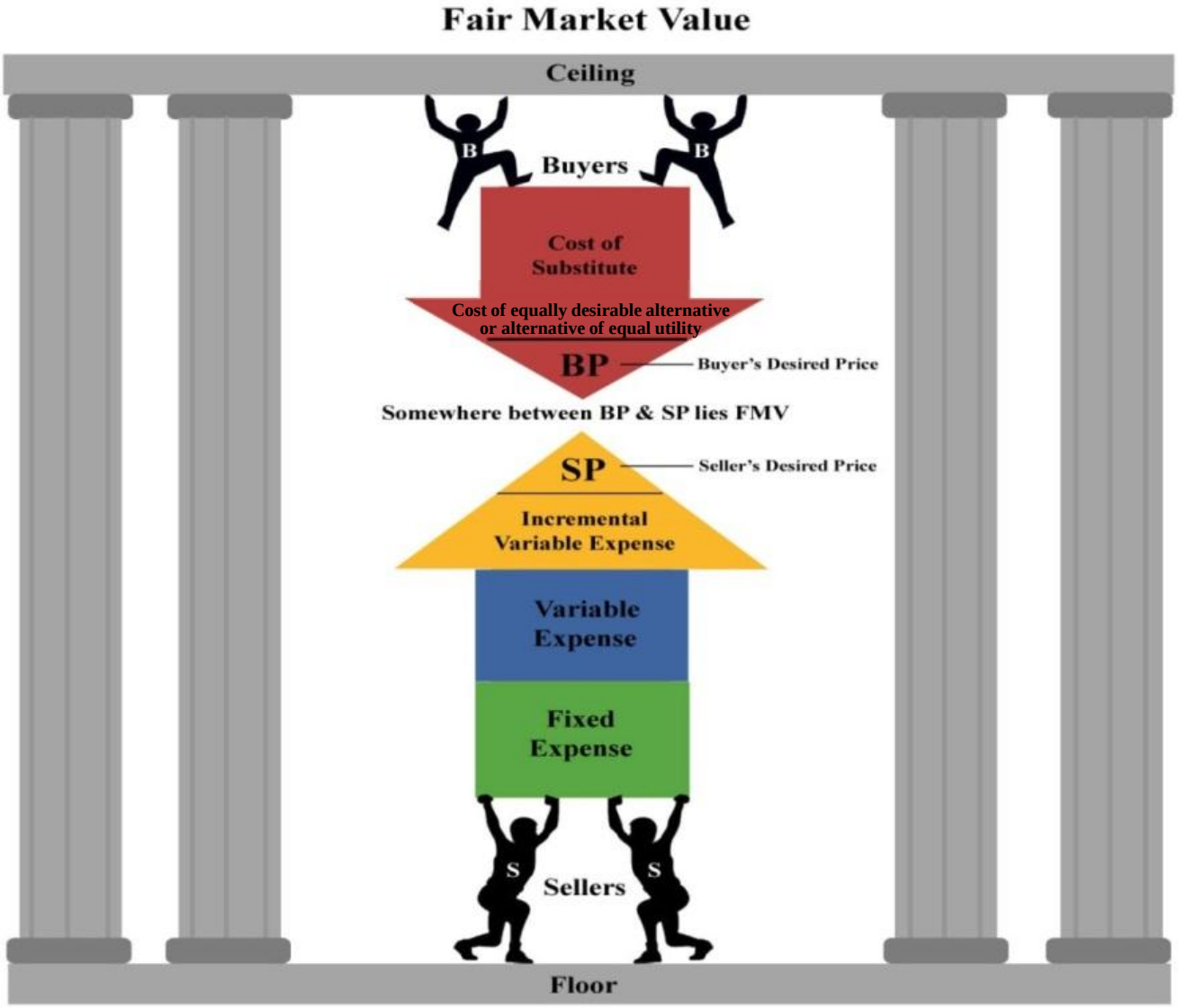


- "V" – Economic Value of the Enterprise, Asset, or Service
- "I" – Economic Benefit Stream, e.g., Income, Earnings, and Cash Flow as defined by appraiser and appropriate to assignment
- "R" – Risk Adjusted Required Rate of Return applicable to selected benefit stream, e.g., Discount Rate, Cap Rate, and Multiple Valuation

Buy or Build – Value as an "*Incremental Benefit*"



Willing Seller – Willing Buyer



Standard of Value

"Value to Whom?"

- Outlines the type of value to be determined
- Standards of Value include:
  - Fair Market Value (FMV)
  - Fair Value
  - Investment (Strategic) Value
  - Market Value
  - Book Value
  - Taxable Value
  - Loan Value

Premise of Value

"Value Under What Further Defining Circumstances?"

- Further defines the Standard of Value to be used and under which a valuation is conducted
- Defines the hypothetical terms of the sale
  - Value in ***Use***
  - Value in ***Exchange***
    - Value as a mass assemblage of assets in place
    - Value as an orderly disposition
    - Value as a forced liquidation

Various Standards of Value in Healthcare Transactions

- The *standard of value* definition includes the following additional assumptions:

(1) The hypothetical transaction considered contemplates a universe of typical potential purchasers for the subject property and not a specific purchaser or specific class of purchaser

(2) Buyer and seller are typically motivated

(3) Both parties are well informed and acting in their respective rational economic self-interests

(4) Both parties are professionally advised and the hypothetical transaction is assumed to be closed with the typical legal protections in place to safeguard the transfer of ownership of the legal bundle of rights which define and encompass the transacted property or interest

(5) A sufficiently reasonable amount of time is allowed for exposure in the open market

(6) A reasonable availability of transactional capital in the marketplace

(7) Payment is made in cash or its equivalent

Various Standards of Value in Healthcare Transactions

Fair Market Value (FMV)
Stark Law Definition

- *"The value in arm's-length transactions, consistent with the General Market Value."*
  - *"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…"* [emphasis added]
  - *"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...where the price…has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals."* [emphasis added]

42 CFR 411.351.

Various Standards of Value in Healthcare Transactions

Fair Market Value (FMV)
Internal Revenue Service (IRS)

- 501(c)(3) enterprises must avoid "***excess benefit***" transactions
- **Valuation standard (as per IRS Regs.)** is ***Fair Market Value***
  - *"…price at which property or the right to use property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy, sell, or transfer property or the right to use property, and both having reasonable knowledge of relevant facts."*

"Excess Benefit Transaction", 26 CFR § 53.4958-4 (January 23, 2002).

Distinctions Between the Various Premises of Value

- *Premise of Value a*nswers the question:
  - *Value under what further defining circumstances?*
- Defines the hypothetical terms of the sale
  - Value in *Use*
  - Value in *Exchange*
- Further defines the *Standard of Value* to be used and under which a valuation is conducted
- Should be appropriately defined and agreed to by all parties at the outset of each valuation engagement

"Appraisal and Valuation: An Interdisciplinary Approach", By Richard Rickert, Ph.D. (1987), American Society of Appraisers, International Valuation Sciences Institute, Washington, D.C., Ch. 3, p. 6-7.

Distinctions Between the Various Premises of Value

Value in Use

- **<u>Value in Use as a going concern</u>** - "*value in continued use, as a mass assemblage of income-producing assets, and as a going-concern business enterprise.*"
- "*Assumes that the assets will continue to be used as part of an ongoing business enterprise, producing an economic benefit of ownership of a going concern.*"
- *"…require[s] a reasonable likelihood that the subject enterprise would generate, in the reasonably foreseeable future, sufficient net margin to generate the requisite economic cash flow to support the value of the capital investment required to generate the revenue stream of the provider enterprise."*

-Pratt

"Valuing a Business", By Shannon Pratt, Fifth Edition, 2008, p. 47; "The Adviser's Guide to Healthcare – Consulting with Professional Practices", By Robert James Cimasi, American Institute of Certified Public Accountants, New York, NY, 2011, p. 165.

Distinctions Between the Various Premises of Value

Value in Use

- The basis of all *economic values* derive from some form of *economic usefulness*, also termed *utility*
- The benefits and/or satisfaction derived from:
  - Use of properties & services
  - Use & consumption of goods
  - Use of intangibles
  - Use of money derived from exchanging the property
- **All "*economic values*" are variations of "*Value in Use*"**

"Appraisal and Valuation: An Interdisciplinary Approach, Volume I", By Richard Rickert, Ph.D. (1987), American Society of Appraisers, International Valuation Sciences Institute, Washington, D.C., Ch. 3, p. 6-7.

Highest and Best Use

"That use among possible alternatives which is legally permissible, socially acceptable, physically possible, and financially feasible, resulting in the highest economic return."

- *"The selection of the appropriate premise of value is an important step in defining the appraisal assignment. Typically, in a controlling interest valuation, the selection of the appropriate premise of value is a function of the highest and best use of the collective assets of the subject business enterprise."*
- *"Each of these alternative premises of value may apply under the same standard, or definition, of value. For example, the fair market value standard calls for a 'willing buyer' and a 'willing seller.' Yet, these willing buyers and sellers have to make an informed economic decision as to how they will transact with each other with regard to the subject business."*
- *"In other words,* ***is the subject business worth more to the buyer and the seller as a going concern*** *that will continue to operate as such,* ***or as a collection of individual assets****...In either case, the buyer and seller are still 'willing.' And, in both cases, they have concluded a set of transactional circumstances that will maximize the value of the collective assets of the subject business enterprise."* [emphasis added]

- Pratt

"Appraisal and Valuation: An Interdisciplinary Approach", By Richard Rickert, Ph.D. (1987), American Society of Appraisers, International Valuation Sciences Institute, Washington, D.C., Ch. 3, p. 55; "Valuing a Business: The Analysis and Appraisal of Closely Held Companies", By Pratt, Shannon P., Niculita, Alina V., Fifth Edition, McGraw Hill, New York, NY,(2008), p. 47-48.

Highest and Best Use

"That use among possible alternatives which is legally permissible, socially acceptable, physically possible, and financially feasible, resulting in the highest economic return."

- A business enterprise that fails to produce sufficient evidence to indicate a reasonable likelihood that it would, as a going concern enterprise, in the reasonably foreseeable future, be able to generate sufficient economic benefit to support the invested capital utilized to generate the revenue stream of the enterprise, cannot support a valuation premise of *Value-in-Use as a Going Concern*
- In that event, the adoption of the *"Value-in-Exchange"* premise of value is indicated

"Appraisal and Valuation: An Interdisciplinary Approach", By Richard Rickert, Ph.D. (1987), American Society of Appraisers, International Valuation Sciences Institute, Washington, D.C., Ch. 3, p. 55.

Distinctions Between the Various Premises of Value

Three levels of *Value in Exchange*:

(1) "***Value as an assemblage of assets*** – *Value in place, as part of a mass assemblage of assets, but not in current use in the production of income, and not as a going-concern business enterprise.*" [emphasis added]

(2) "***Value as an orderly disposition*** – *Value in exchange, on a piecemeal basis (not part of a mass assemblage of assets), as part of an orderly disposition; this premise contemplates that all of the assets of the business enterprise will be sold individually, and that they will enjoy normal exposure to their appropriate secondary market.*" [emphasis added]

(3) "***Value as a forced liquidation*** – *Value in exchange, on a piecemeal basis (not part of a mass assemblage of assets), as part of a forced liquidation; this premise contemplates that the assets of the business enterprise will be sold individually and that they will experience less than normal exposure to their appropriate secondary market.*" [emphasis added]

"Valuing a Business, Chapter 2: Defining the Assignment", By Shannon Pratt, Fifth Edition, 2008, p . 47-48.

Distinctions Between the Various Premises of Value

Valuation Approaches and Methods

Income Approach

- Discounted Cash Flow
- Single Period Capitalization
- Discounted Future Benefit

Market Approach

- Merger and Acquisition
- Guideline Publicly Traded Company
- Prior Subject Entity (Practice) Transactions

Asset/Cost Approach

- Adjusted Book Value
- Liquidation Value
- Excess Earnings

Distinctions Between the Various Premises of Value

Income Approach

- Measures the present value of anticipated future economic benefits that will accrue to the owner of the property interest to be appraised
- Economic benefit of ownership has several potential measures, including:
  - Net operating income
  - Net income
  - Cash flow
  - Dividend payouts
- A risk-adjusted required rate of return, matched to the level of economic benefit employed (e.g., pre-tax/after-tax), by which the benefits are discounted, must be developed

Distinctions Between the Various Premises of Value

Market Approach

- Premised upon the concept that actual transactions of comparable property provide guidance about indications of value
- Comparables selected must exhibit –
  "homogenous badges of comparability"
  - Market Service Area with Geographic Variations
  - Payor Mix
  - Provider (Specialty and Subspecialty) Mix/Case Mix
  - Revenue Size and Profitability
  - Asset Size and Capital Structure
  - Investment Time Horizon
  - Market Entrance Barriers, e.g. Certificate of Need

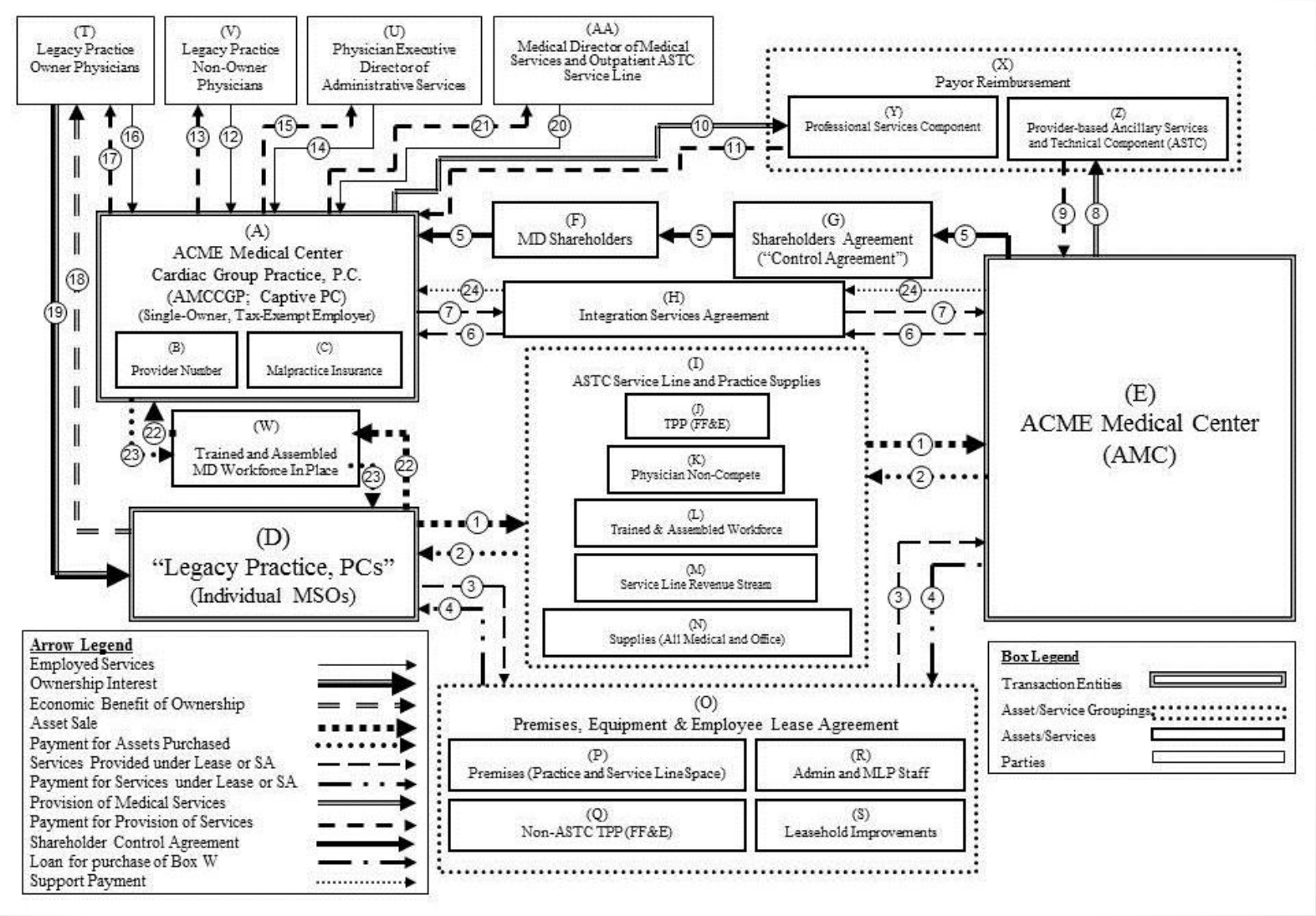
Distinctions Between the Various Premises of Value

Asset Approach

- Under the *Principle of Substitution*, the FMV purchaser would likely pay no more, and the seller could likely accept no less, than the cost of producing *an equally desirable substitute or a substitute of the same utility*
- *Cost based methods* ***are*** often utilized (as are *market* and *income* based methods) under the *Asset Approach*
- Utilizing the *cost based methods* of the *Asset Approach*, value is determined by establishing the current cost of reproducing or replacing an asset, less applicable elements of depreciation
  - Economic obsolescence
  - Functional obsolescence
  - Technical obsolescence
  - Physical deterioration

Valuation of Healthcare Enterprises

Illustrative Summary of Healthcare Transaction



Identification and Classification of Assets

"These perplexing questions as to the nature of the thing to be valued might seem to be of no concern to the student of valuation, however…[h]ow one shall define property in a given case is bound up with the question how one shall find value in that same case.

The two problems must be treated together by persons who understand their interrelationship."

- James C. Bonbright

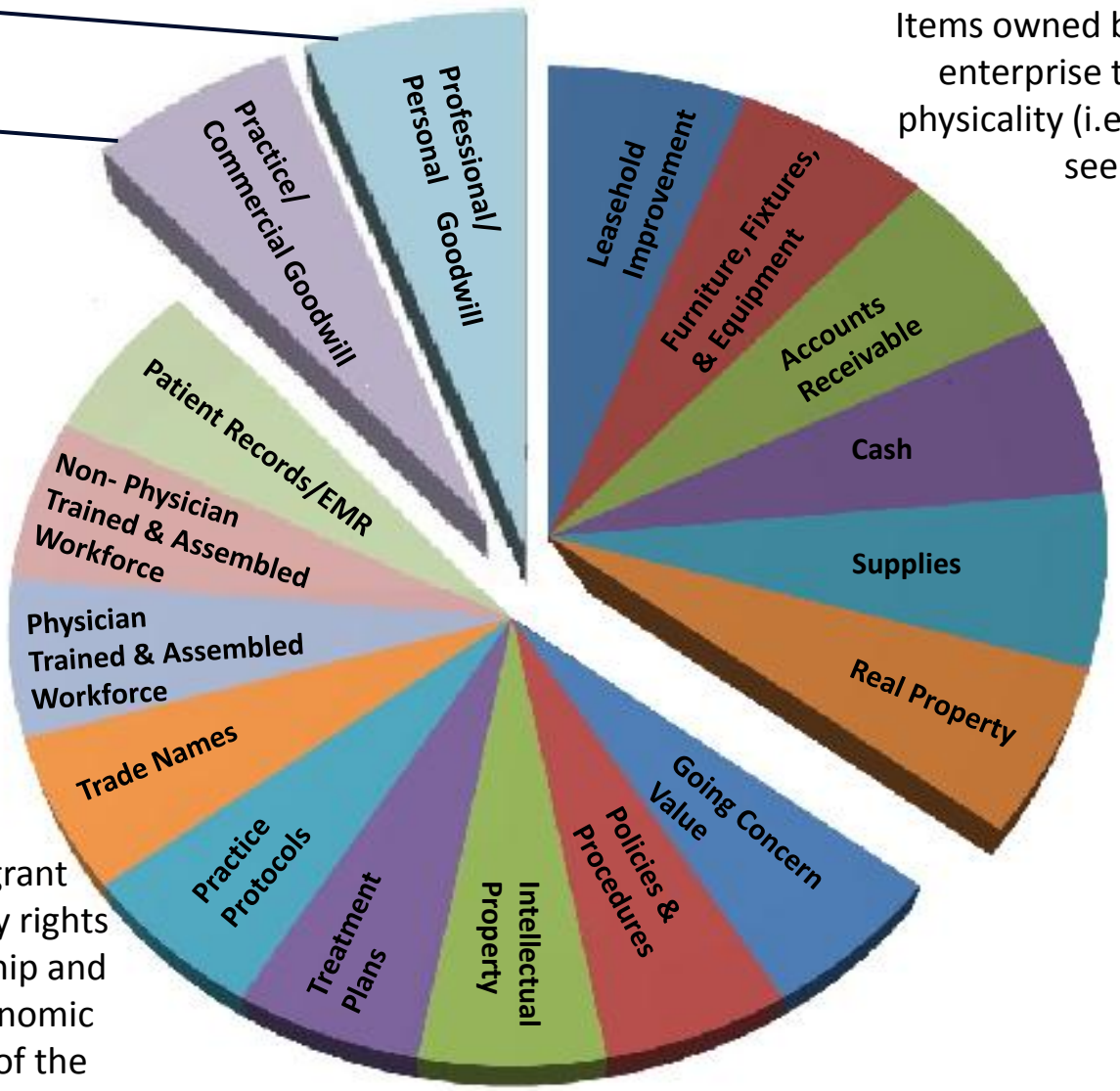
"The Valuation of Property: A Treatise on the Appraisal of Property for Different Legal Purposes", By James C. Bonbright, New York, NY: McGraw-Hill, 1937, p. 99.

Valuation of Healthcare Assets

Propensity of patients to return to a specific practice

Knowledge, skill, and reputation of practitioner. Cannot be sold, therefore no economic value

Tangible Assets
Items owned by the subject enterprise that possess a physicality (i.e., they can be seen or touched)



Intangible Assets
Non-physical items that grant certain specified property rights and privileges of ownership and that have or promise economic benefits to the owner(s) of the subject enterprise

Valuing Intangible Assets

Classifying Intangible Assets

- Payor/Client
- Goodwill
- Human Capital
- Intellectual Property
- Locations and Operations
- Governance or Legal Structure
- Marketing and Business Development
- Regulatory or Legal
- Financial or Revenue Stream
- Technology

"The Adviser's Guide to Healthcare – Consulting with Professional Practices," By Robert James Cimasi, American Institute of Certified Public Accountants, Inc. New York, NY, 2011.

Valuing Tangible Assets
Furniture, Fixtures, and Equipment (FF&E)

- *Fair Market Value* standard of value often used
- Assumptions
  - Debt-free cash sale
  - "*As is, where is*"
  - Continued utilization
  - Sufficient revenue stream to justify use
- Highest and best use - "*[T]he most probable and legal use of a property, which is physically possible, appropriately supported, financially feasible, and that results in the highest value*."

"Valuing Machinery and Equipment: The Fundamentals of Appraising Machinery & Technical Assets," Third Edition, Machinery and Technical Specialties Committee of the American Society of Appraisers, 2011, p.531.

Valuing Tangible Assets
Furniture, Fixtures, and Equipment (FF&E)

- Assets can be depicted through a depreciation expense report
  - May include asset descriptions, dates of acquisition, acquisition costs, accumulated depreciation, deprecation methods, and taxable lives for the FF&E
- Replacement cost new (index price)
  - Determined by multiplying appropriate asset inflation factors to historical cost
- Economic value of the assets
  - Calculated by applying a devalue percentage to the index price
- The devalue percentage
  - Calculated as the age of the asset (in years) divided by the economic useful life of the asset
- Other considerations in analysis of FF&E assets include
  - Functional obsolescence
  - Economic obsolescence

"Valuing Machinery and Equipment: The Fundamentals of Appraising Machinery & Technical Assets," Third Edition, Machinery and Technical Specialties Committee of the American Society of Appraisers, 2011, p.504.

Valuing Tangible Assets

FF&E Illustration

A	B	C	D	E	F	G	H	I	J	K	L
Type	Desc.	#	Econ. Life	Asset Condition	Year Acquired	Acquis. Price	Indexed Price	Replacement Cost New	Devaluage %	Condition Factor	Restated Value
M	Deluxe Ultrasound Table	1	15	5	1990	$3,629.73	$5,915.70		85.00%	80.00%	$709.88
M	Philips Ie33 Echo System	1	5	3	2007			$65,000.00	48.83%	100.00%	$33,258.33
M	Midmark TEE Procedure Treatment Cart	1	10	4	1991	$2,354.00	$3,731.31		85.00%	90.00%	$503.73
M	Tilt Table	1	15	2				$3,500.00	18.11%	110.00%	$3,152.72
M	Patient Step Stools	3	15	3	2001	$255.00	$339.67		54.28%	100.00%	$155.30
M	Exam Chairs	3	15	3	2000	$900.00	$1,221.56		58.94%	100.00%	$501.52
Historical Price						$7,138.73					
Restated Value							$11,208.24				
Fair Market Value of FF&E per Cost Approach											$38,281.48

A: Classified as Medical (M) or Office (O) Equipment
B/C: Description of equipment and quantity
D: Economic useful life (3, 4, 5, 7, 10, 15, 20, 25, 30, 40 years)
E: Condition Factor Weight
F: Acquisition date, per review of data
G: Acquisition price, per review of data
H: Current index for type (M) or (O) divided by index at acquisition times ACQ. PRICE. Source: "Valuation Quarterly", Marshall & Swift

I: Replacement cost new estimate, if applicable
J: Devaluage percentage based on economic life
K: Condition factor
L: Restated Value, indexed price*(1-Devaluation Percentage)*Condition Factor = Valuation

"The Adviser's Guide to Healthcare – Consulting with Professional Practices," By Robert James Cimasi, American Institute of Certified Public Accountants, Inc. New York, NY, 2011.

Valuing Tangible Assets
Accounts Receivable

- The accounts receivable should also be restated to reflect an actual expected collections rather than the book value
- Reflecting the FMV Accounts Receivable will typically include some adjustment(s) to:
  - Historical collection rate
  - Cost of collection
  - Present value adjustment to the book value of gross allocated charges

"Valuing Machinery and Equipment: The Fundamentals of Appraising Machinery & Technical Assets", Third Edition, Machinery and Technical Specialties Committee of the American Society of Appraisers, 2011, p.504.

Valuing Intangible Assets

- Intangible assets are ubiquitous in healthcare and may create economic value
  - ***Patents*** **–** protect new drugs, devices, etc.
  - ***Copyrights*** **–** protect software and teaching documentation
  - ***Trademarks*** **–** protect brand/reputation
  - ***Trade secrets*** **–** protect proprietary therapies
- More challenging to value
  - Must determine existence
  - Must be capable of quantifying
  - Usually riskier and require higher rate of return

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Valuing Intangible Assets
Goodwill and Patient Related Assets

- Amount of intangible asset "***residual***" value related to an enterprise which has not been separately and discretely identified
- ***Custodial Rights to Medical Charts and Records***
  - Either analog/hard copy electronic medical records
  - May be separately identified and quantified aside from goodwill
  - Often considered as part of goodwill as they create the background that supports the propensity for the continued patient-provider relationship
- ***Professional/Personal Goodwill***
  - Results from the charisma, education, knowledge, skill, board certification, and reputation of a specific physician practitioner
  - Since these attributes "*go to the grave*" with that specific individual physician and therefore cannot be sold, they have no economic value
- ***Practice/Commercial Goodwill***
  - The unidentified, unspecified, residual attributes of the practice as an operating enterprise, that contribute to the probability of the continuity of the revenue of the practice (in part due to the perception of propensity of patients to return to the practice in the future)
  - Frequently transferred

Valuing Intangible Assets
Human Capital

- ***Staff/employee and provider employment agreements***
  - Provides certain assurances under which the employee/provider fulfills the role as a representative
- ***Trained and assembled workforce in place***
  - Value of recruiting, hiring, assembling, the training, and experience employees
  - Significant investment due to the high-tech nature of managing and operating practices and the complexity involved in entity development
- ***Policies and procedures***
  - Usually developed and refined over extended time period, at a cost to owner(s)
  - Policies and procedures lend to the efficiencies and productivity and ultimately the likelihood of achieving savings
- ***Depth-of-management***
  - Success may significantly depend upon the leadership
  - Qualifications and experience brought to the organization by management personnel may provide value to the entity

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Valuing Intangible Assets
Trained and Assembled Workforce

- Identification as distinguishable and subject to appraisal as a distinct and separate intangible asset which is discrete and quantifiable
- The existence and the *FMV* attributable to a TAWF, as a discrete intangible asset, separate and distinct from other intangibles, and possessing economic utility by virtue of the right to control employees as the means of production, even in insolvent, non-operating companies is illustrated in bankruptcy law
  - It should be noted that the value related to TAWF, under the valuation premise of *value-in-exchange,* is conditioned upon both an *assemblage* and the probability of *retention* of the workforce, as well as, the existence of an agreement specific to a transaction of the TAWF
- Must be consistent with prohibition against consideration of referrals, which lends to utilizations of the asset/cost approach method to valuation, in contrast to income approach methods

Glosband v. Watts Detective Agency, Inc., 21 B.R. 936 (D.C. Mass. 1981), affirmed by Robinson v. Watts Detective Agency, Inc., 685 F. 2d 728 (1st Cir. 1982).

Valuing Intangible Assets
Intellectual Property

- ***Practice Protocols***
  - Standardized steps and agreed upon process to diagnose and manage a patient throughout the continuum of care
  - Developed over time based upon patient outcome data used as evidence of a higher quality/more cost-effective delivery of services
  - May bring value to the organization in the form of shared savings payments treatment plans/care mapping
- ***Procedure Manuals and Laboratory Notebooks***
  - Outlines the steps necessary to perform the various tasks required for the operation of the organization
  - Can assure the continuous productivity and consistency of performance of staff
- ***Technical and Specialty Research/ Patents and Applications***
  - The "*work-in-progress*" of patents, copyrights or other intangible assets
  - Patents may include specialized equipment and instruments that lead to increased care and beneficial quality outcomes for the patient population

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Valuing Intangible Assets
Intellectual Property

- ***Copyrights***
  - Proprietary software that can generate schedules and track patient care across multiples providers in the network
  - Software may produce utilization and outcome reports based upon the treatment provided, which is necessary for benchmarking and budgeting
  - Software may increase productivity, patient care outcomes, and shared savings payments
  - Also includes books, patient information brochures, web sites and similar communication-related assets
- ***Trade Names & Trade Secrets***
  - Can bring recognition and "*brand loyalty*" to the organization
  - Examples include: Kaiser, Mayo, etc.
- ***Royalty Agreements***
  - Usually related to copyrights or patents owned
  - Can provide a continuing revenue stream

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Valuing Intangible Assets
Locations and Operations

- ***Computerized Management Information Systems***
  - Used for reports regarding financial operating and patient outcome performance
  - Can aid in future management, decision-making and strategic planning
- ***Favorable Leases and Leasehold Interests***
- ***Historical Documents***
  - Examples include: financial statements, patient charts, and productivity reports
  - Create a historical record for which future records can be compared for the purpose of management, decision-making and future strategic planning
- ***Supplier Contracts***
  - Can provide pricing and service assurances
  - Can provide increased accuracy and reliability for budgeting of operations and a cost advantage for producing and providing its services

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Valuing Intangible Assets
Governance/Legal Structure

- ***Organizational Documents***
  - Examples include: corporate by-laws, operating agreements and shareholders agreements
  - Written record of the "*rules*" by which the organization operates and provides certain privileges and protections to the owner(s)/shareholder(s) on an individual, as well as, a collective, basis
- ***Income Distribution Plans***
  - Agreed upon formula(s) by which the owner(s)/shareholder(s), as well as, other providers are compensated and receive shared savings
- ***Covenants Not-to-Compete***
  - May provide some competitive protection to the organization from employees or colleagues who may, at their departure to a competitor, put the organization at risk of losing patients and/or referrals

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Valuing Intangible Assets
Marketing and Business Development

- ***Advertising***
  - Examples include: web-site, social and print media, billboards, and phone numbers
  - Acts much like trade names in creating a desired image of the organization in an effort to create "*brand loyalty*"
- ***Franchise/License Agreements***
  - Enable the organization to access markets (either geographical or service) not previously feasible
- ***Joint Ventures and Alliances***
  - May enable organization to gain access to additional revenue streams

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Valuing Intangible Assets
Regulatory and Legal

- ***Facility Licenses, Medical Licenses, Permits***
  - May be a barrier to entry or a competitive advantage
- ***Litigation Awards***
  - Tangible benefits (e.g., cash) or intangible benefits (e.g., upholding a non-compete dispute)

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Valuing Intangible Assets
Financial/Revenue Stream

- ***Office Share Arrangements***
- ***Management Services Agreements (MSAs)***
  - Define the terms under which an outside organization provides certain management services (e.g., accounting, billing, contracting)
  - If a specific MSA provides a competitive financial advantage, it may hold economic value to the owner(s)
- ***Financing Agreements***
  - May have value if the organization is able to obtain favorable terms (e.g., amount of credit, interest rate, amortization of loan) that may lead to organizational growth, through additional working capital, capital purchases, acquisitions, etc.
- ***Budgets/ Forecasts/ Projections***
  - Serve as a "*road-map*" of the future financial performance
  - Necessary for management to make strategic decisions, such as equipment purchases and provider recruiting, which enhances the probability of future net economic benefit to the owner(s)

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Valuing Intangible Assets
Technology

- ***Computer Software/Network Integration***
  - Contributes to efficient operations and productivity
- ***Technical/Software Documentation***
  - Written record of intangible assets in use
- ***Maintenance/Support Agreements***
  - Helps ensure consistent technology performance
- **Creates Economic Benefit and Value Only If Working Effectively**
  - Track patient data and medical history
  - Increase productivity
  - Readily accessible health information
  - Reduce costly errors
  - Forecast healthcare expenditures

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Valuation of Healthcare Assets

Generally Accepted Benchmarking Data

LIKELIHOOD OF EXISTENCE OF SPECIFIC ASSETS OF PHYSICIAN ORGANIZATIONS 1. Almost always 2. Often 3. Sometimes 4. Almost never, minimal	**Solo**	**Office Based Group**	**Academic**	**Hospital Based Group**	**IPA**	**GPWW**	**MSO**	**PPMC**	**Hospital-ist**
Tangible									
1) Accounts Receivable	1	1	3	1	4	4	4	2	2
2) Cash, Investments	3	2	4	2	4	4	3	2	2
3) Furniture, Fixtures, and Equipment	1	1	4	4	4	4	1	2	4
4) Leasehold Improvements	3	1	4	4	4	4	3	2	4
5) Real Property	3	3	4	4	4	4	3	3	4
6) Supplies	1	1	3	4	4	4	3	2	4
7) Medical Library	4	2	2	3	4	4	4	4	4
Intangible									
1) Payor/Customer-Related									
a) Managed-Care Agreements	1	1	1	1	1	3	4	2	1
b) Provider Service Agreements/Medical Directorships	3	2	1	1	4	3	4	3	1
c) Direct Contracting Customer Lists	3	2	3	4	2	4	4	3	3
d) HMO Enrollment Lists	4	3	3	4	2	4	4	2	4
2) Goodwill and Patient-Related									
a) Custody of Medical Charts and Records	1	1	3	4	4	4	4	3	4
b) Personal/Professional Goodwill	1	1	1	2	4	4	4	3	2
c) Practice/Commercial Goodwill	3	2	3	3	3	3	3	3	3
d) Patient Lists/Recall Lists	2	2	3	4	4	4	4	3	4
3) Human Capital-Related									
a) Employment/Provider Contracts	4	1	1	1	3	4	3	2	1
b) Trained and Assembled Workforce	2	1	4	3	3	4	2	2	4
c) Policies and Procedures	3	2	3	2	2	3	2	2	3
d) Depth of Management	4	2	3	4	3	3	2	2	4

Valuation of Healthcare Assets

Generally Accepted Benchmarking Data

LIKELIHOOD OF EXISTENCE OF SPECIFIC ASSETS OF PHYSICIAN ORGANIZATIONS 1. Almost always 2. Often 3. Sometimes 4. Almost never, minimal	**Solo**	**Office Based Group**	**Academic**	**Hospital Based Group**	**IPA**	**GPWW**	**MSO**	**PPMC**	**Hospital-ist**
Intangible									
4) Intellectual Property-Related									
a) Practice Protocols	4	2	2	2	3	3	4	3	2
b) Treatment Plans/Care Mapping	3	2	2	2	3	3	4	3	2
c) Procedural Manuals/Laboratory Notebooks	4	2	2	3	4	4	3	2	3
d) Technical and Specialty Research	4	3	2	4	4	4	3	3	3
e) Patents and Patent Applications	4	3	2	3	4	4	4	4	4
f) Copyrights	4	3	3	4	4	4	4	4	4
g) Trade Names	3	2	4	4	3	3	3	1	4
h) Trade Secrets	4	3	3	4	3	3	4	3	4
i) Royalty Agreements	4	4	3	4	3	3	3	3	4
5) Locations and Operations-Related									
a) Management Information / Executive Decision Systems	4	2	3	3	2	3	2	1	4
b) Favorable Leases-Leasehold interests	2	3	3	4	4	4	3	3	4
c) Going Concern Value	3	2	3	4	3	4	2	2	4
d) Asset Assemblage Factors	3	2	4	4	4	4	2	2	4
e) Historical Documents/Charts/RVU Studies	2	2	2	3	3	4	3	3	4
f) Supplier Contracts, e.g. Group Purchasing Orgs.	3	2	2	4	4	3	2	2	4
6) Governance/Legal Structure-Related									
a) Organizational Documents	4	1	2	1	3	2	1	1	4
b) Income Distribution Plans	4	1	1	1	4	1	1	1	4

Valuation of Healthcare Assets

Generally Accepted Benchmarking Data

LIKELIHOOD OF EXISTENCE OF SPECIFIC ASSETS OF PHYSICIAN ORGANIZATIONS 1. Almost always 2. Often 3. Sometimes 4. Almost never, minimal	**Solo**	**Office Based Group**	**Academic**	**Hospital Based Group**	**IPA**	**GPWW**	**MSO**	**PPMC**	**Hospital-ist**
Intangible									
7) Marketing and Business Development-Related									
a) Print Ads, Telephone #s, Billboards, etc.	2	2	3	4	4	3	2	3	4
b) Franchise/License Agreements	3	3	4	4	4	4	3	3	4
c) Joint Ventures/Alliances, e.g. "Call-a-nurse"	3	2	2	4	4	3	3	2	4
d) Market Entrance Barriers/Factors	3	2	2	2	3	3	3	3	3
8) Regulatory/Legal-Related									
a) Facility Licenses	4	3	4	4	4	3	3	3	4
b) Medical Licenses	1	1	1	1	4	4	4	4	1
c) Permits – Real Estate Special Use	3	3	4	4	4	3	3	3	4
d) Litigation Awards and Liquidated Damages	4	3	4	3	3	3	3	3	4
e) Certificates of Need	4	3	4	4	4	3	3	3	4
f) Medicare Certification/UPIN	1	1	1	1	4	4	4	3	1
g) Certifications-e.g. NCQA, AAAHC, JCAHO	3	3	3	3	3	4	4	3	1
9) Financial/Revenue Stream-Related									
a) Office Share	3	3	4	4	4	2	2	3	4
b) Management Services Contracts	4	3	4	4	4	2	1	1	1
c) Financing Agreements	4	3	4	4	4	3	3	3	4
d) Underwriting/Private Placement Memoranda	4	3	4	4	4	3	2	1	4
e) Budgets/Forecasts/Projections	4	2	3	3	2	3	2	1	4
10) Technology-Related									
a) Computer Software/Network Integration	4	2	4	4	2	3	2	1	4
b) Technical/Software Documentation	4	3	4	4	2	3	2	1	4
c) Maintenance/Support Relationships	2	1	4	4	1	2	1	1	4

CONCLUDING REMARKS

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- Healthcare reform's impact on the rapidly changing reimbursement, regulatory, competitive, and technological environment is accelerating the pace of healthcare transactional activity and driving changes in both the operational and financial aspects – and, consequently, the value – of enterprises, assets, and services

- Given the severity of regulatory penalties for entering into legally impermissible arrangements, it is reasonable to conclude that a certified opinion of value as to the FMV and commercial reasonableness of a given transaction by a qualified, credentialed appraisal is helpful in withstanding regulatory scrutiny

"*Love Everyone, Trust No One, and Paddle Your Own Canoe*"