The American Health Lawyers Association’s annual Health Care Transactions Conference will take place April 26-28, 2017 in the great city of Nashville, Tennessee! The conference will offer attendees a unique opportunity to learn about the latest commercial developments, strategies, and deal forecasts from noted experts.

As part of its ever-increasing coverage on the topic of health care transactions, AHLA is pleased to offer its business partners the opportunity to profile their expertise on this subject. A number of them have graciously contributed to this Resource Guide, and they have provided AHLA with educational sponsorships to support its development.

This Guide contains valuable analyses and commentaries on significant transaction issues from leading health care experts, all of whom are recognized deal-makers in the health care community. We are pleased to publish this collection of timely, practical, and valuable articles for the benefit of our members and the broader health care community.

AHLA is proud to add this resource to its already impressive array of products and services, and thanks each of our sponsors for making this possible.

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2017 Health Care Transactions Resource Guide

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Transaction Strategies and Long-Term Value Creation: Do Deals Automatically Result in Success for Health Care Organizations?

Mark Reiboldt, Senior Vice President and Co-Leader of Financial Advisory Services Group, Coker Group
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Doing deals isn’t like it used to be, at least not in the context of agreements among health care organizations.

For hospitals, health systems, and other kinds of health care services organizations, deals among entities have been commonplace for many years. Transactions have been a frequently-pursued strategy to expand market value, geographic reach, and growth in the scope of services, all of which ultimately aim to achieve long-term value creation. And, while such strategies have varied considerably in size, scale, and structures, the pursuit of transactions among health care organizations has continued throughout a wide range of evolutionary market dynamics and policy landscape trends.

In many cases involving health care transactions over recent years, getting the deal to “close” was considered the most challenging aspect. Overcoming challenges or differences related to organizational culture, management styles, impact on personnel, and regulatory hurdles were among the common variables that made transactions more difficult. However, once the deal was closed, usually the problematic matters would be more likely to fall into place for the organizations involved. Eventually (and typically), the overarching result of the deal would achieve long-term value.

Fast-forward to today, and it’s safe to say that the equation that links transaction strategies to long-term value creation is not nearly as automatic. Further, in today’s health care marketplace, one cannot just assume that doing a deal—even one that appears to have considerable value on the surface—will automatically have a positive impact on the organization in the future.

Many factors have influenced the current landscape of health care transactions in today’s market dynamic. The financial crisis and economic downturn that the United States and global marketplace continues to work through have played a key role in the new trends faced by the health care industry today. Also, the progression of numerous major policy initiatives impacting health care organizations, such as the Patient Protection and Affordable Care Act and other related policy movements, have proven to be the chief drivers shaping market dynamics and guiding health care industry stakeholders.

But while there is no single culprit in the current health care market paradigm that is changing the deal landscape, it would behoove all parties involved with health care organizations considering transactions as a strategy for long-term value creation and growth to evaluate just how they intend to ensure achievement of value for their deals.

One overarching principle that has increasing validation in today’s marketplace is that the real work towards ensuring that a deal results in long-term value begins after the transaction is complete.

Even though there are still just as many, if not more, challenges in completing a transaction for health care organizations today, just getting a deal done does not mean the largest hurdles are removed. Indeed, the real challenging work is just beginning, and we can rest assured that it will continue for some time. Another aspect to this realization is that the sooner the main parties involved in a transaction start planning for the bulk of difficult tasks to come, the more likely they will be able to take the necessary steps towards the achievement of long-term value.

In the past, the primary questions around a transaction scenario typically related to aspects like valuation (i.e., what are we paying/receiving in this deal?) and financial metrics (e.g., debt retirement and absorption, etc.), as well as softer factors, such as community impact dynamic. And it was common to assume that the appropriate people throughout the combined organization(s)
could work out the kinks related to issues like operations, personnel, revenue cycle management, etc. after the deal closed.

... the sooner the main parties involved start planning for the bulk of the difficult tasks to come, the more likely they will be able to take the necessary steps towards the achievement of long-term value.

When doing health care deals today, however, management teams have to think about all of these factors and much more. If a deal is involving a hospital, one of the biggest issues will be ensuring strength and stability in the physician relations dynamic. Do the hospitals have joint ventures with physician groups? How do the market regions and service offerings compare and mesh? These questions can lead to identifying critical gaps in areas that ultimately can have a significant trickle-down effect on other aspects, including valuation (deal value and long-term value creation). This example is just one of many where leaders in health care organizations have to look before completing or even initiating a deal to (1) validate a deal's true value and viability and (2) identify key risk or gap areas that will be critical to the long-term value equation.

Curiously, as obvious as this might appear, getting ahead of the curve on upcoming or impending challenges is not always something management teams at health care organizations do best. As mentioned, part of this perception is the fact that in many cases in the past, the closing of the deal marked the completion of the difficult portion. As such, management teams just would not be confronted with major issues or questions working against the likelihood of success beyond a transaction’s close.

Pursuing a transaction involving a health care services entity is unlike any other type of acquisition or investment deal process in many ways, even for other health care services organizations and especially for any party that is not already in that business. Just the nature of the parties involved can often result in a process that ends up creeping along at a snail’s pace (or even slower), due to the many stakeholders and range of variables necessary to consider and include in a process involving these types of organizations. In addition, health care deals—especially when not-for-profit health systems and physician entities are involved—entail much greater legal and regulatory scrutiny that all of the parties must address, especially the buyer, to get a deal done.

Another key piece is the valuation metrics in use. These metrics can be different for health care organizations when looking at a transaction’s value versus the “downstream” or “synergistic” value potential for the organization over a longer-term period. The financial drivers involved in a deal between health care provider organizations are unique, regardless of their size. First, the process of determining and negotiating a deal’s valuation and economic terms differs from most deals because of the need to adhere to specific fair market value guidelines. As a result, deals involving such organizations often have limited range of movement in terms of the financial consideration. Guys like me often talk about deal comparables and market multiples; however, the truth is these valuation parameters have a relatively minimum range and often even less movement compared to other markets and industries.

Another key point when considering the financial impact is the value driver that ultimately makes a buyer interested in doing a deal. This aspect is perhaps one of the least-defined pieces of health care merger and acquisition (M&A) deals, and it has been this way over the years and throughout market ups and downs. Most people would think that a health system would be able to tell you relatively quickly the value they hope to achieve from a deal where they’re spending hundreds of millions of dollars. This expectation particularly applies to a not-for-profit system with a role as a major community or market stakeholder.

Unfortunately, this is not always the case, and I would even venture to say that this scenario is most likely more common than the alternative case, where such answers are clearly defined and understood by all of the relevant stakeholders. The truth is, for many hospital deals in the past, they mostly would entail the parties getting together and having an idea that teaming up through a merger or one party selling to the other would result in significant benefits for the organizations, their patients, and their communities as a whole. However, putting any real numbers specifically on where that value would ultimately come about was unlikely. And for some deals, even coming to that general hypothesis of “one good plus one good equaled one great” was a question; in such cases, simple hope essentially was the key driver behind these deals.

Due to the nature of some health care organizations and the particular market dynamics in which they operate, some deals that entailed less than optimal value drivers and other key strategies ultimately turned out okay in the long run. Many of the organizations or partnerships that emerged out of such deal scenarios grew and achieved marked success going forward. For many organizations and during certain periods of growth within the health care industry, value still could be attained, despite the unintended issues that would challenge most consolidation strategies. Whether it was timing and specific market dynamics or the good luck of what turned out to be the right deal at the right time, success that emerged out of some periods of consolidation among health care industries was almost an inevitable result that would benefit most stakeholders, regardless of their shortcomings and poor planning efforts.

However, we know that such luck and inevitable success despite contrarian efforts is not the norm and rarely continues for long periods. In many (or most) cases, the result of the deals among health care organizations was failure and/or significant hardship for the organizations left behind post-transaction. Even in the deal scenarios where great effort was placed on ensuring success, the market dynamics or the lack of adequate planning ultimately resulted in deals that failed to deliver the intended or anticipated long-term value. Many people within the industry
are shocked and surprised that such deals were not as successful as they anticipated or hoped they would be.

In today’s health care marketplace and the current wave of consolidation among all kinds of organizations, regardless of size, scope, or financial investment involved, value is more elusive than ever. Further, achieving value from such deals is only becoming more difficult for all stakeholders involved. Just defining a value target for a deal can be challenging enough for many health care organizations, particularly those larger health systems that tend to grasp tightly to the traditional deal dynamics that were in past cycles. Even if one can peg specific value targets of a deal and the strategic objectives that are tied to defined growth and financial projections post-transaction, setting targets and achieving them in a way that results in long-term growth and value creation for the organization is a different matter.

What then is missing in between setting these targets and seeing them through to reality? Is it the lack of a plan or a “roadmap?” Are the expectations when entering an agreement and driving the value targets unrealistic or improperly influenced and misunderstood? Perhaps there were external market variables that impacted our targets negatively that were not foreseeable, which resulted in missing those targets? Or, were there other unintended consequences on the long-term value justification? The answer is “yes” to all of these questions. All of these variables (or a combination of them) are likely reasons why deals in today’s marketplace fail to deliver long-term value.

So, how can an organization that is pursuing a transaction work to limit the risk of failure or missing its value targets? First, identify the value targets. If the organization is unable to do that, then it should take a step back in the process so that it can address and clearly define the value targets and perhaps other fundamental pieces. Otherwise, how can the organization expect a complex investment or M&A transaction to deliver the value that it envisions if none of the parties, both the buyers and sellers, can articulate these core points?

So, how can an organization that is pursuing a transaction work to limit the risk of failure or missing its value targets?

First, identify the value targets.

Second, there is the planning process. While this may seem like a rather obvious piece, it is the component that is most often ignored or overlooked by organizations engaging in some transaction. Ideally, this planning initiative will produce a “roadmap” that walks your organization(s) from today’s status where the parties are two separate entities, through five or so years down the road (or however long a particular deal will span). The outcome will demonstrate a clear value that has been achieved from the deal strategy and how the organizations continue to build that value model together into the future.

Within this overarching strategic roadmap that spans from the very beginning to years following a deal’s completion, there will also be smaller pieces of the larger map that assist in implementing key segments of the overall process. For instance, there is the deal itself, which is a crucial but still relatively small piece of the overarching picture. Then, there is integration, which again is one of the most critical pieces, but unfortunately, is often missed entirely. The key, however, to the strategic roadmap is ensuring the effective implementation of each of these parts, and just as necessary, ensuring that the management of those parts allows for value to be delivered and transferred in a streamlined, seamless manner throughout the entire process. Think of the roadmap strategy as ultimately guiding the organization to an elusive and well-guarded treasure. However, to eventually arrive at the final “X” that marks the spot, an organization and its leaders first will have to complete a series of distinct tasks and challenges along the way. Only when they reach the top of one hill will they ultimately be able to proceed to the next mountain ahead.

Once a sufficient and comprehensive roadmap plan is in place, the rest is execution.

Though the implementation may seem relatively straightforward on the surface, it entails a lot of uncertainty and potential for confusion. Pitfalls, landmines, and traps are inevitable. The organization must be prepared to negotiate the obstacles, some of which will emerge in the planning process. However, some challenges will arise that are outside an organization’s or team’s range of expertise.

A good time to seek the support of outside advisors is when problems occur. It is important to bring in the necessary technical skills and knowledge of people with experience in specific areas at crucial points or throughout the deal process as a whole. This support typically will come from a combination of deep domain expertise in relevant areas (i.e., health care finance, valuation metrics, quantitative analytics, market research, etc.) and skill in executing such deals that have been successful (and perhaps failures that result in sometimes even more valuable lessons) elsewhere in the marketplace.

This author’s intent here is not to promote consulting services or suggest that success from transactions will only come if an organization hires the right advisor. Using an advisor to help navigate through the deal process is not a requirement or absolute necessity. However, it has been our experience that one of the key characteristics of successful deals is the use of quality outside advisors to help an organization through a process that is highly specialized and nuanced, and in which most management team members do not have specialized experience. Moreover, one of the greatest value components related to using an advisor on a transaction is that depending on an advisor to guide an organization through a deal and the overall value creation strategy process ultimately allows management to focus on their primary job responsibilities. In turn, this freedom contributes to an organization’s overall strategic value, operational efficiency, and growth.
An advisor can help the transaction process in many ways. Investment bankers specializing in M&A advisory are often valuable resources for an M&A transaction; however, their role will typically be limited to the parts that specifically focus on structuring and executing the deal and perhaps arranging financial products, such as credit facilities and other instruments that are implemented in the deal. Bankers are typically restricted to advising on financial or valuation components of a deal, as well as coordinating the various deal process steps. Such high level coordination, however, does not usually involve getting into the details of an organization’s strategic targets, value measurements, and other critical pieces that come into play when trying to achieve long-term value from a specific deal strategy.

A transaction services advisory group can serve as the overall coordinator of the deal process and typically will play a weighty role in the due diligence phase of this process. Due diligence is a critical function, particularly when looking at deals as the buyer. In the health care industry, being the buyer can take shape in different ways; for example, by purchasing an equity stake in a joint venture (JV) enterprise or acquiring another by absorbing debt and/or making capital commitments. Constructing the financial model for such a transaction will entail various inputs for the distinct types of structures. However, the overall process essentially remains the same across all deal efforts. It boils down to one party investing to join another party in a strategy with another entity. Afterward, the newly joined entities or the joined efforts in this particular venture will continue forward under a combined strategy with unique value and growth targets over some defined period.

Other types of advisors that can be of value throughout the transaction process and an organization’s overall strategic effort are those who can get involved in specific pieces of the process. Typically, these advisors will be engaged to provide specific and often technical expertise within a defined component of a deal. Areas can include a valuation advisor who assists an organization on the financial modeling and calculations of a deal or organization’s value. There are also consultants who will provide specialized technical analysis and advice in specific areas of due diligence and/or the integration process. Other specialized consultants may be engaged to provide assistance in key functional areas, such as HR due diligence and payroll consolidation or IT/IS systems and infrastructure integration. Some consultants may be engaged to offer answers on executive compensation or conduct analysis on an organization’s employed physician network and related strategies.

Many different types of advisors are available to provide assistance to an organization throughout the strategic deal process, such as Coker Group, and there are various structures under which consultants can be engaged in this type of scenario. It is critical to understand, however, that no consultant, lawyer, or other “magic bullet” will be able to automatically deliver a result of success by merely engaging them and paying their fees. There is no level of experience and/or domain expertise within a particular technical area that will deliver value from a deal if the efforts are not in conjunction with intentional and proactive strategic planning on behalf of the organization driving the transaction strategy and overall effort.

The real work towards ensuring that a deal yields long-term value begins after the transaction is complete. So how can an organization’s board members, management team, and key stakeholders make certain their deal targets will result in long-term value creation? It is true that even the best plans, roadmaps, outside experts, and financial resources can sometimes miss the projected targets for that deal strategy, but we can learn a lot by looking at some of the trends from various deals that have taken place in the current marketplace and by assessing the significant characteristics that resulted in success versus failure.
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Price, terms, and value are key considerations when entering into transactions such as mergers, acquisitions, divestitures, and joint venture formations. Given the litigious and regulatory-driven nature of the business environment, particularly in the health care setting, it is critical that any management team and board of directors diligently analyze these aspects of a potential transaction, and that analysis may be greatly enhanced by the retention of independent financial advisors. Two advisor tools to consider as part of any transaction diligence are fairness opinions and fair market value (FMV) opinions. Based on the nature and size of a particular transaction, a company’s counsel and board of directors should determine what appropriate measures are to be undertaken and ensure that they enlist the assistance, where appropriate, of qualified and experienced valuation and corporate finance advisors. The table below presents several of the key differences between fairness opinions and FMV opinions, followed by a more detailed discussion of both.

**Fairness Opinions**
A fairness opinion is a written opinion, most typically addressed to a board of directors, stating that specific aspects of a given transaction are fair—from a financial point of view—to a specific constituency of the company. In its most basic form, such as in the sale of a for-profit entity, a fairness opinion might state that the consideration to be received by the common shareholders of the company is fair to those shareholders from a financial point of view. From the other side of an acquisition, the opinion might state that the consideration to be paid by a company is fair to the company (i.e. the buyer) from a financial point of view. Thus, such opinions may sometimes address fairness to the company

<table>
<thead>
<tr>
<th>Fairness Opinion</th>
<th>Fair Market Value Opinion</th>
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<tr>
<td>Prepared for those with a fiduciary duty (e.g., Board of Directors, State AG)</td>
<td>Prepared for the buyer and/or seller</td>
</tr>
<tr>
<td>Actual buyer and seller</td>
<td>Hypothetical buyer and seller</td>
</tr>
<tr>
<td>No mandated Standard of Value—May vary depending upon transaction</td>
<td>Standard of Value defined by IRC 59-60 and further language within Stark Laws</td>
</tr>
<tr>
<td>Conclusion: Fair from a financial point of view</td>
<td>Conclusion: Estimated Fair Market Value range</td>
</tr>
<tr>
<td>Deliverable: Opinion letter and Board of Director presentation</td>
<td>Deliverable: Full valuation report (narrative and exhibits) to the engaging party or parties</td>
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Table 1: Differences Between Fairness Opinions and FMV Opinions
rather than any particular group of stakeholders. This is especially prevalent in the health care context, where so many industry participants are not-for-profit entities and, accordingly, do not need to address the interests of individual shareholders. Instead, these board members have a duty to act as guardians of assets that many state attorneys general view as being in the public trust. In that regard, in many cases state attorneys general may insist that a fairness analysis be prepared and provided to regulators to review in connection with their approval of a transaction.

Board members have well-established fiduciary duties to the companies they oversee, including a duty of loyalty and a duty of care. When deciding whether to pursue a material corporate transaction, boards must ensure that proper care is taken in considering the myriad aspects surrounding that transaction, whether financial, regulatory, technological, or human-capital related. However, while every board member brings unique expertise to the table that should be relevant to the overall mission or strategy of any company, they are not expected to be an expert on every topic. Thus, it is reasonable for boards to seek outside advice on matters that do not fall within their area(s) of expertise. Indeed, to carry out their duty of care, it can be argued that many directors should enlist the assistance of expert advisors. Furthermore, state law generally provides that directors are entitled to rely in good faith on third-party experts if those experts have been selected with reasonable care. So long as boards can show that they have fulfilled their primary duties of loyalty and care, courts will generally defer to their decisions (even if those decisions later prove to be wrong) under the business judgement rule. In that regard, fairness opinions are tools that can assist boards in their deliberations surrounding the pursuit and ultimate approval of material corporate transactions. Ultimately, the proper use of a qualified advisor and reliance on that advisor’s fairness opinion can go a long way in demonstrating that the duty of care was fulfilled.

How should a fairness opinion provider be selected? The two most important considerations are qualifications and independence. Qualifications should include deep domain expertise, both in the industry at hand and in providing fairness opinions. With respect to industry experience, the need is especially obvious and especially true in health care, which is a unique animal among all U.S. industries. With respect to fairness opinion experience, while a fairness opinion may be largely based on valuation considerations, the provider must also be expert in analyzing all financial aspects of a given transaction, and the provider firm should have the infrastructure and procedures in place to ensure high-quality, unbiased analyses and conclusions, including peer review processes and a well-functioning committee approval process. In fact, the importance of an opinion approval committee was underscored in 2007 when the Financial Industry Regulatory Authority (FINRA, at the time, the National Association of Securities Dealers) adopted Rule 5150, which provides, in part, that any FINRA member providing a fairness opinion must disclose in the opinion whether or not the fairness opinion was approved or issued by a fairness committee, and further that:

Any member issuing a fairness opinion must have written procedures for approval of a fairness opinion by the member, including:

1. The types of transactions and the circumstances in which the member will use a fairness committee to approve or issue a fairness opinion, and in those transactions in which it uses a fairness committee:
   A. The process for selecting personnel to be on the fairness committee;
   B. The necessary qualifications of persons serving on the fairness committee;
   C. The process to promote a balanced review by the fairness committee, which shall include the review and approval by persons who do not serve on the deal team to the transaction; and

2. The process to determine whether the valuation analyses used in the fairness opinion are appropriate.

While the committee process within a provider firm will guard against bias on the part of individuals performing the fairness analysis, the firm itself should be selected by the board with a careful eye towards institutional independence. The most obvious independence issue arises when an advisor has a financial interest in the transaction itself. For instance, on the sell-side of a transaction in which an investment banker has been used, the simplest route for a board to take may be to request a fairness opinion from that banker. A valid argument can be made that after conducting a credible sale process, speaking to potential buyers, hearing their questions and concerns, and collecting bids, the investment banker on the deal may be in the best position to know the true market value of the subject company. However, if that banker stands to earn a large fee contingent on the successful closing of the deal, then at the very least someone on the outside looking in (i.e. stakeholders and courts) may readily argue that the banker is incentivized to say that the deal at hand is fair in order to close the transaction and collect the fee. While the opinion may be valid and the underlying analysis free of bias, the potential for someone to make this claim is a real issue that should be considered when selecting a fairness opinion provider. Other areas of independence to consider are existing and potential future relationships between the provider and the transaction parties and whether those relationships might influence the outcome of the analysis. This area of potential conflict is important enough that FINRA Rule 5150 requires significant disclosure within the opinion regarding compensation issues and prior or expected future relationships with any transaction parties. It should be noted that FINRA Rule 5150 only applies to opinions issued by FINRA member firms and only in instances where the member knows or has reason to know that the opinion will be provided or described to the recipient company’s
public shareholders. Nonetheless, in the author’s opinion, best practices dictate that all reputable firms follow all provisions of the rule regardless of their membership status or who is expected to receive the opinion.

Of course, once a fairness opinion provider is selected, then the real work must begin. The essence of any fairness analysis consists of weighing the “gives” against the “gets.” As noted, one typical form of opinion might address fairness to the buyer of the consideration to be paid by a company in an acquisition. In that case, the “give” consists of the consideration paid and the “get” consists of the assets/business acquired. If the deal consists of the acquisition of an entire company for cash consideration, then the analysis boils down to the value of the business acquired. The underlying valuation analysis will then generally comprise the methodologies discussed below regarding FMV opinions. However, it is easy to imagine the analysis quickly getting more complicated. The purchase price might include an earn-out that needs to be valued. Or consideration might be paid in the form of the buyer’s stock, necessitating valuation of that stock. On the other side of the ledger, a transaction might not entail purchase of an entire business but rather, certain minority interests or preferred stock, or perhaps even contributions to a joint venture so that everyone’s contributions need to be valued and weighed against the value of the joint venture interest received. In all of these instances, variations on basic valuation methodologies will underlie the analysis, but their application to the proper basket of assets or income streams by the advisor are critical.

While underlying analytical methods may be the same as those employed in any valuation analysis, it is important to note one key difference between a fairness analysis and a FMV opinion. The latter analysis is generally based on a hypothetical willing buyer and willing seller, whereas the former considers the specific deal at hand, including the specific transaction parties. One example of where this might come into play is in the buy-side fairness opinion where the buyer may be willing to pay more than others because of realistically envisioned synergies. In a fairness opinion context, it is not necessarily improper to include at least some portion of the value of those synergies in the analysis. Of course, in the context of health care transactions, any inclusion of synergies must be carefully scrutinized to ensure that the buyer is not paying for referrals (discussed below) or using its tax-exempt status to justify paying a higher price.

Financial advisors should be given adequate time to perform their task, which includes information gathering (both from the company and from public sources), management interviews, preparation of the appropriate analyses and documentation, internal peer reviews, and committee approval. None of this happens overnight, and a solid record of a thoughtful and deliberate process in which an advisor had appropriate lead time will go a long way towards demonstrating that the board fulfilled its duty of care.

That lead time should also include enough time to deliver work product to the board ahead of any meeting at which final transaction approval is sought. That work product will usually consist of two items. First, the opinion itself. The opinion will set out parameters of the fairness determination (i.e., fair to the common stockholders of the company from a financial point of view), describe the transaction at hand, lay out scope of analysis and engagement, and detail the various assumptions and limiting conditions. However, the opinion generally does not contain any detail regarding the underlying analysis leading to the conclusion of fairness. This information should be contained in a separate document. The financial advisors should provide a presentation for the board, and be prepared to walk the board through the materials as a guide to further discussion. The board presentation should contain a summary of the analysis, such as historical and projected financial information and financial and valuation data from comparable public companies and comparable transactions to the extent they are used in the analysis.

Finally, it is important to debunk some misconceptions and point out what a fairness opinion is not. The opinion will state that certain terms (i.e., consideration paid or received) are fair to a particular party or class of parties from a financial point of view. That means that the consideration paid or received falls within a reasonable range of value indicated by the advisor’s analysis. It does not mean that the seller is receiving the highest price or the buyer is paying the lowest price. The opinion only indicates that the price is within (or better than) the range of values determined by the opinion provider. A fairness opinion is also not a recommendation to board members, shareholders, regulators, or anyone else that a transaction should be approved.

There are many additional considerations beyond financial fairness that must guide the decision-making process, such as legal, regulatory, strategic, and corporate culture considerations, to name a few. A fairness opinion only addresses one narrow, albeit critically important, aspect of a transaction and is not a substitute for thorough diligence and debate by a board of directors in making the decision to engage in any corporate transaction.

**Fair Market Value Opinions**

Fair Market Value opinions provide an estimated value range in order to determine the purchase consideration for regulatory compliance purposes. While there are many similarities to fairness opinions in relation to the actual valuation analysis, differences exist, including the overall purpose and deliverables. Also, while fairness opinions are primarily driven by the duties and responsibilities of boards and management, FMV opinions are a function of the regulatory environment within the health care industry. Transactions not consistent with FMV are subject to significant penalties. In fiscal year 2016, the Federal Government won or negotiated over $2.5 billion in health care fraud judgments and settlements, many related to issues with FMV. The following provides a summary of the regulatory framework.

**Regulatory Framework**

Fraud and abuse laws—namely the Physician Self-Referral Law (or more commonly referred to as “Stark Law”) and the federal
Anti-Kickback Statute, as well as tax-exempt regulations—require that certain transactions and arrangements be in compliance or consistent with FMV. Otherwise, civil and criminal penalties may result.

Below presents the definition of FMV as well as relevant regulatory guidance that drives the importance of FMV. A comprehensive regulatory framework overview of federal fraud and abuse laws and tax-exempt laws are beyond the scope of this article. The information related to these laws is provided below as further context regarding FMV.

Fair Market Value is defined within Revenue Ruling 59-60 and Stark Law. Specifically, Revenue Ruling 59-60 states:

“the price at which the property would change hands between a willing buyer and a willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts. Court decisions frequently state in addition that the hypothetical buyer and seller are assumed to be able, as well as willing, to trade and to be well informed about the property and concerning the market for such property.”

Further modified by Stark Law (42 CFR §411.351):

“General market value” means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party…”

“…acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals…”

Stark Law also incorporates the aspect of “commercially reasonable,” specifically:

“An arrangement will be considered ‘commercially reasonable’ in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential DHS [designated health services] referrals.”

Tax-exempt regulations (U.S.C. Section 501(c)(3)) states the following:

Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.

The Anti-Kickback Statute

The federal Anti-Kickback Statute (Anti-Kickback Statute) is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business. See 42 U.S.C. § 1320a-7b. The Anti-Kickback Statute is broadly drafted and establishes penalties for individuals and entities on both sides of the prohibited transaction. Conviction for a single violation under the Anti-Kickback Statute may result in a fine of up to $25,000 and imprisonment for up to five (5) years. See 42 U.S.C. § 1320a-7b(b). In addition, conviction results in mandatory exclusion from participation in federal health care programs. 42 U.S.C. § 1320a-7(a). Absent a conviction, individuals who violate the Anti-Kickback Statute may still face exclusion from federal health care programs at the discretion of the Secretary of Health and Human Services. 42 U.S.C. § 1320a-7(b). The government may also assess civil money penalties, which could result in treble damages plus $50,000 for each violation of the Anti-Kickback Statute. 42 U.S.C § 1320a-7a(a)(7). Although the Anti-Kickback Statute does not afford a private right of action, the False Claims Act provides a vehicle whereby individuals may bring qui tam actions alleging violations of the Anti-Kickback Statute. See 31 U.S.C. §§ 3729–3733. When a private citizen sues on behalf of the Federal government and is successful, they receive a percentage of the ultimate recovery for their “whistleblower” efforts. See id.

In recognition of the broad range of transactions potentially implicated by the Anti-Kickback Statute, certain types of payments are excluded from consideration by statute. 42 U.S.C. § 1320a-7b(b)(3). In addition, the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) has been given authority to adopt “safe harbors” to protect specifically identified business and financial practices from criminal and civil prosecution, provided they fall within parameters defined to minimize the risk for potential corruption. See 42 C.F.R. § 1001.952. Transactions not specifically excluded or granted safe harbor protection are not per se violations of the Anti-Kickback Statute but are evaluated by the OIG on a case-by-case basis. See Office of Public Affairs, Office of Inspector General Department of Health & Human Services, Fact Sheet November 1999, Federal Anti-Kickback Statute.
Table 2: Key Considerations—FMV for Health Care Regulatory Compliance

<table>
<thead>
<tr>
<th>Regulatory guidance</th>
<th>Specific legal aspects driven by Stark Laws, Anti-Kickback Statue, and tax-exempt regulations.</th>
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<tr>
<td>Projections used in Income Approach</td>
<td>Important to be cognizant of certain synergies included in projections used in the Income Approach such that they are consistent with the regulatory framework.</td>
</tr>
<tr>
<td>Normalized base year</td>
<td>May need to include normalizing adjustments to historical financial statements to reflect a hypothetical buyer and/or seller.</td>
</tr>
<tr>
<td>Post-transaction compensation</td>
<td>In transactions where the target’s owner is a physician or physician group to be employed, post-transaction compensation must be carefully considered and included as part of the valuation analysis.</td>
</tr>
<tr>
<td>Capital expenditures and needs assessment</td>
<td>If a business projects future growth, is the existing plant, property and equipment sufficient to support that growth? What is the economic life of existing and new equipment?</td>
</tr>
<tr>
<td>Income taxes</td>
<td>A hypothetical buyer could be either a not-for-profit or for-profit entity; a not-for-profit cannot use its tax-exempt status to justify a higher purchase price, and a for-profit entity cannot offer a higher purchase price to a not-for-profit entity—penalties exist.</td>
</tr>
<tr>
<td>Economic obsolescence</td>
<td>Divergence among practice as to whether intangible and goodwill value may exist absent sufficient cash flow. The selected approach must be thoroughly examined and documented based on the facts and circumstances of a transaction.</td>
</tr>
<tr>
<td>Licenses or Certifications</td>
<td>Do existing licenses provide a competitive advantage? If there are forecasted expansions, are new licenses required?</td>
</tr>
<tr>
<td>Deliverables</td>
<td>Prepared for the parties of the transaction. See below for additional details.</td>
</tr>
</tbody>
</table>

Laws and Regulatory Safe Harbors. Parties who are uncertain whether their arrangements qualify for exclusion or safe harbor protection may request an advisory opinion from the OIG. See id.

Table 3: Approaches to Estimate Value: Income, Market, and Cost

While much of the valuation analysis is similar to that of a fairness opinion, there are critical nuances to know and understand when undertaking the FMV analysis for health care regulatory compliance purposes. A significant contrast with fairness opinions is that the FMV estimate requires the analysis based on a hypothetical buyer and hypothetical seller, rather than an actual buyer and seller within a fairness opinion. This drives many assumptions in the analysis, including but not limited to the type and level of synergies assumed in the Income Approach. Key considerations are summarized in Table 2, presented above.

**Deliverables**

Ultimately, the FMV analysis comprises full valuation report and supporting schedules. It is critical to provide sufficient detail regarding all inputs and assumptions used in the analysis so that any third party has the ability to understand the analysis and conclusions on a stand-alone basis. Statement on Standards for Valuation Services No. 1 (SSVS 1) describes the types of valuation reports a valuation analyst may use to communicate the results of an engagement to estimate value. SSVS No. 1 applies to all AICPA
members who perform valuation services for various purposes (such as transactions, financings, taxation, financial accounting, bankruptcy, management and financial planning, and litigation) as well as for various disciplines in the profession (including consulting, litigation services, personal financial planning, tax, and accounting). Other professional organizations maintain similar requirements (e.g., The Appraisal Foundation mandates the Uniform Standards of Professional Appraisal Practice). Per SSVS 1, a detailed report should include, as applicable, the following sections:

- Letter of transmittal
- Table of contents
- Introduction
- Sources of information
- Analysis of the subject entity and related nonfinancial information
- Financial statement/information analysis
- Valuation approaches and methods considered
- Valuation approaches and methods used
- Valuation adjustments
- Nonoperating assets, nonoperating liabilities, and excess or deficient operating assets (if any)
- Representation of the valuation analyst
- Reconciliation of estimates and conclusion of value
- Qualifications of the valuation analyst
- Appendices and exhibits

SSVS 1 further details each section and information that one should consider including in the report. The level of detail to include in each section is dependent on the type of valuation engagement (e.g., litigation, financial reporting, health care regulatory compliance, etc.). For valuation engagements under health care regulatory compliance, commentary regarding the regulatory framework should also be considered.

The valuation report is restricted to the intended user(s), except if noted otherwise within the report or in the assumptions and limiting conditions. A rigorous and robust valuation process should be put in place to ensure the intended users have a high quality and comprehensive report. Further, the report may be subject to additional scrutiny should it be challenged or brought into litigation. Similar to the fairness opinion process previously discussed, an appropriate FMV analysis includes an independent team and various levels of review. While working as a team and collaborating throughout the analysis, the deliverables should be reviewed internally at various steps. At Duff & Phelps for example, analyst/senior associate work is further reviewed by a vice president/director, then by the managing director and lastly, a concurring review by a second managing director. Finally, the process requires the appropriate quality controls of all deliverables, including an independent calculation check and tie-out by a staff person not involved with the day-to-day engagement.

**Conclusion**

Successful health care transactions face significant challenges from regulatory, operational, and financial risks. Fairness opinions and fair market value opinions provide two tools to mitigate further risk. As discussed in this article, there are many aspects to consider when engaging a party to provide a particular opinion and/or report. Stakeholders in a transaction are best served when they discuss these issues upfront and consider the retention of experienced and independent financial advisors.

**Endnotes**

1. As a primary example, see Delaware General Corporation Law §141(e), which states: “A member of the board of directors, or a member of any committee designated by the board of directors, shall, in the performance of such member’s duties, be fully protected in relying in good faith upon the records of the corporation and upon such information, opinions, reports or statements presented to the corporation by any of the corporation’s officers or employees, or committees of the board of directors, or by any other person as to matters the member reasonably believes are within such other person’s professional or expert competence and who has been selected with reasonable care by or on behalf of the corporation.”


3. Ibid - FINRA Rule 5150(b).

4. The Department of Health and Human Services And The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2016 (January 2017).

5. 42 CFR Parts 411 and 424. “Medicare Program; Physicians’ Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II).”


7. Valuation of a Business, Business Ownership Interest, Security, or Intangible Asset; Issued by the AICPA Consulting Services Executive Committee (June 2007).
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When Purchase Agreements are Read by Accountants: A Look at Post-closing Accounting Treatment

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Not long ago, I sat in a room full of attorneys (five for the client and three for the government). I was to review the break-out of consolidated financial statements, isolating the company in question. Collectively, the attorneys pleaded ignorance, something about being liberal arts majors. To this, I replied, “That’s okay, I don’t understand a word of what is in your documents.” Of course, on some level, the attorneys and I were sandbagging each other, but the point was clear: the worlds of accountants and attorneys came together around the question, “What is the deal, what do the documents say, and where does the accounting treatment fit in GAAP?” When drafting documents for an acquisition and, more particularly, for some form of partnership and joint venture, one must consider the implications on the respective party’s financial reporting. It isn’t enough to wait until after the dust settles for the accountant to apply generally accepted accounting principles or “GAAP” to the deal.

Deals in which one party acquires 100% of the other in the form of cash and assumed liabilities can be pretty straightforward, the biggest challenge being the purchase price allocation. For more complex deals, larger players have the resources of a consistent deal team. The challenge, then, is in the lower middle market and community hospitals or small regional health systems that do a limited number of deals. In these spaces, the deals are few and far between. They also tend to be diverse in nature, e.g., a physician practice, an imaging center, an outlying hospital, and so on.

As health care continues to consolidate, transactions will get done around the various parties’ objectives and interests. How do two not-for-profit hospitals merge? How do for-profit and not-for-profit organizations work together? And how does the accounting get done? Accountants—with the help of both auditors, advisors, and legal counsel—will work through the accounting, but there may be instances where the goal of consolidating or not consolidating financial statements and the structure of the deal are at odds with each other.

What follows is a look at the direct impact on accounting treatment of the purchase agreement, operating agreements, a variety of other contracts and, in some cases, simply the details of executing the deal. This article is not a comprehensive look at all possible issues or alternatives. As we have all learned, every deal has its twist. Rather, the article should point out some common issues that may change the intended accounting treatment.

Acquiring Physician Practices

The most active and common transactions, at least in terms of volume, are deals between the hospital and physicians. Physician practice consolidation has some of the most specific direction within the codification of GAAP. Accordingly, it deserves special attention.

Most often, we see physicians end up being employed by existing physician organizations established by the hospital. These organizations, when set up properly, are generally very straightforward from an accounting standpoint; however, there are exceptions. Various states have prohibitions on the corporate practice of medicine, or the physicians seek to retain the status of their professional corporation for tax planning or other reasons. In these cases, the “buyer” enters into a management contract to effectively control the practice. This model has existed for years and was refined during the time of PhyCor, MedManagement, and others. Most physician management companies that exist...
today continue to use this model. In the model, the ownership might be reduced to one physician who is friendly to the buyer and he or she may "own" multiple Professional Corporations (PCs) or other entities engaged in the practice of medicine in states where the physician holds a license to practice medicine (the nominee shareholder).

The rules regarding the consolidation of these friendly or captive PCs were first spelled out in 1997 when the Financial Accounting Standards Board (FASB) Emerging Issues Task Force (EITF) issued 97-2 concerning physician practice management entities and other contractual management arrangements. EITF No. 97-2 and related language have been superseded. The current guidance is now reflected in the codification of GAAP at Subtopic 810-10-15-22. The guidance considers instances where the physician practice management company (PPMC) cannot own the practice but through contract can control all of the non-clinical aspects of the practice, including distributions of profits. The PPCM will usually employ all non-providers, i.e., those other than physicians, nurse practitioners and physician assistants. The PPCM funds all expenses and provides systems required to operate the practice.

The PPCM will be seen as having a controlling interest in the physician practice if all the following criteria are met:

- Term of 10+ years or the remaining life of the practice.
- Cannot be terminated, except for specific events (e.g. fraud, gross negligence, bankruptcy of PPCM).
- Exclusive decision making over scope of service, contracts, patient acceptance, financing, pricing but not dispensing of medical services (for example, the PPCM can decide to offer MRI but cannot control the ordering of the MRI).
- Total practice compensation of medical professionals, including hiring and firing. This is typically outlined in an employment agreement at the time the practice is acquired and may be amended from time to time.
- The management agreement and its rights are unilaterally saleable or transferable by the PPCM.
- Right to receive income as both ongoing fees and proceeds from the sale in an amount that fluctuates based on performance of the practice. Generally, this covers non-provider expenses and the profit of the practice after the providers have been paid.

To make this work, the PPCM will also have control over the nominee shareholder. The specific definition of a nominee shareholder is spelled out in the glossary of Subtopic 810-10. Generally, the PPCM’s power over the nominee shareholder includes the power to establish or change without cause the nominee shareholder by naming anyone qualified to hold the position.

Having reviewed the control requirements, a full-fledged PPCM will monitor and insist on all six of the requirements being met. It is easy to see, however, on a case by case basis where the ‘buyer’ is a hospital or other local provider that is not focused on the consolidation of revenue how some of the criteria might be negotiated away to appease the physician group. We have noticed, for example, instances where physician groups are consolidated, but when we review the unaudited supplemental data, some practices, designated as PCs, are reported separately from the hospital’s physician organization. Without a review of the facts and circumstances, it is impossible to know if the six criteria have been met. We can envision circumstances where the practice may have retained certain rights, such as the unilateral decision to leave or change the deal down the road. They also may not agree to certain restrictions, terms of the agreement, changes to compensation, hiring and firing, or other managerial decisions. Absence of any of the criteria will result in the practice not being consolidated and the intended buyer will record only the management fee and expenses.

**Not-for-profit Health Care Entities**

This discussion assumes the entities in question are not pre-dominantly supported by contributions but are viable health care organizations.

Not-for-profit health care entities present a unique set of variations. There is specific guidance for health care and not-for-profits. Further, these industry guidelines may direct the user back to the specific GAAP topic. For example, when a not-for-profit entity is dealing with a for-profit entity, the user is directed to Subtopic 810-10 and research and development 810-30 so each of these is consistent with the broader GAAP. Partnerships for not-for-profits should follow need guidance from Accounting Standard Update No. 2015-02, issued in February 2015, which will take effect in 2017 and which will be addressed later in the article. Each of these sections also includes tests of control, some of which we address later in the article as well.

But what about two not-for-profits? Here, the issues become more specific to the not-for-profit status and the various ways in which not-for-profits might come together.

**Mergers**

Under GAAP, a merger occurs when a new entity is formed as the single member of two merging not-for-profits. In this case, the assets and liabilities transfer over at their carrying value based on what is reported on the financial statements or would have been on the financial statements had they been issued on the date of the transaction. That is, there is no mark-up of asset values or goodwill. The only real changes are reflected in consistency in classification and accounting treatment where there can be more than one acceptable answer.

In addition, a merger may trigger a change in a contract or other agreement. Modifications resulting from a merger would be recognized at the time of the merger. For example, to gain assignment of a contract, certain concessions have to be made. Modifications resulting from the renegotiation of the terms other than required by the merger would be reflected in future financial statements.

**Combining entities**

The first course of action is to determine the acquirer. The acquirer is considered to be the entity able to select or dominate the selection of the governing body. If not obvious, the codification provides for factors to consider in determining the
acquirer. Those considerations include how the voting board is organized, how future appointments are made and, in the case of a self-perpetuating board, how the initial appointments are made or any supermajority powers of the respective parties. Another important factor to consider is how the transaction will be recorded on the acquirer’s books:

❯❯ One entity acquires another in a bona fide transaction. Assets and liabilities are measured at fair value with certain exceptions. The exceptions generally relate to value that either should already be at an established current fair value, such as contingencies, or was established through prior election, such as the fair value of the promise to give at some date in the future.

❯❯ Generally, there is a difference in the consideration given and the fair value of the net assets acquired:

– If the consideration given is greater than the fair value of the net assets, it is recorded as goodwill.
– If the fair value of the net assets is greater than the consideration given, the difference is treated as a contribution and recorded on the date of acquisition classified based on the nature of any donor-related restrictions. This differs from a for-profit bargain purchase where the difference would be treated as a gain.

❯❯ Special situations where assets may not be transferred directly to the acquirer but will benefit the acquirer. Assets for the ultimate benefit of the acquirer but retained by the ‘seller’ or transferred to a third party are recorded on the acquirer’s books.

– For example, the acquired entity had $10 million allocated for the construction of a new cancer center. At the time of the transaction, the funds are transferred to a third-party foundation to be paid over to the acquirer as the new cancer center is built. The acquirer will still record the $10 million as restricted assets even though it does not hold the funds because it will be the sole beneficiary of the funds in the future, so long as it builds the new cancer center.

Controlling an Entity Through Operating Agreements, Contracts, or Other Form

Typically, we think of entities as one party having a majority of ownership. Public companies or other for-profit entities focused on growing revenue are very conscious about meeting the criteria for consolidation in joint ventures and partnerships. The not-for-profit, on the other hand, often straddles the fence between maintaining control and broadening community reach and integration. It becomes important to the controlling interest to make sure nothing in the governance of the joint venture entity or contract impedes the consolidation. It is equally important to the non-controlling interest that their objectives are met and that they have a level of control as it relates to those objectives. For a tax-exempt hospital, this might include decisions regarding charity care. (The issue of consolidating a physician or other professional practice is addressed previously in the article.)

Partnerships or joint ventures typically fall into two groups: Variable Interest Entities (VIEs) and the more traditional voting interest entities. In the case of a VIE, an entity that has effective control and is the primary beneficiary will be required to consolidate the investee entity. The rules regarding determination of a VIE are complex and were developed at least in part out of the Enron scandal, requiring entities to be consolidated because financial consequences (positive or negative) need to be reflected in the financial statements of the primary beneficiary. Historically, one of the more common VIEs was the case in which the owner of a private business owned the real estate integral to the core business separately for a variety of reasons. This was a common theme in the long term care industry where the operations and real estate are in different entities but have common or overlapping ownership. One cannot operate the facility without real estate, and the real estate is not worth as much without the operations.

Not-for-profit entities are not subject to the requirements of VIEs

Health care organizations are frequently involved in voting interest entities, LLCs, partnerships, etc. The issue of who consolidates arises when the powers of the majority shareholder are restricted by certain approval or veto requirements. Non-controlling shareholders, members or partners can come into play through supermajority powers found in some agreements, particularly between not-for-profit and for-profit identities. Recent updates to Subtopic 810 were outlined in Accounting Standard Update No. 2015-02, issued in February 2015, which provide more specific language on the issue, including improved definitions of certain key terms. Key rights to consider in determining control include Kick-Out Rights, Participating Rights, and Protective Rights:

❯❯ Kick-Out Rights typically allow a limited partner or other party to dissolve the entity or remove the general partner or other entity generally seen as controlling the ordinary course of business.

❯❯ Participating Rights allow non-controlling parties to block and/or participate in significant financial and operating decisions occurring in the ordinary course of business. Participating Rights do not necessarily allow the non-controlling party to initiate an action, just to participate in the action.

❯❯ Protective Rights provide for protection of the non-controlling party. The approval or veto rights might include increases in debt, purchase of high dollar equipment or other capital commitments, or removal of the manager in the case of bankruptcy or breach of duties.

Despite all of the definitions, the ultimate evaluation requires judgements based on the facts and circumstances. In the simplest form, the evaluation requires consideration of questions such as: Does the non-majority owner party have control or protection? Can the non-controlling party effectively block certain decisions that occur in the ordinary course of business? Or is the control largely to protect the non-majority owner party?

Let’s assume that in an LLC with a Catholic health care entity (non-majority owner) and another health care entity (majority owner), the Catholic health care entity has the power to block a service or other issue contrary to Catholic Health Directives, but
otherwise all business decisions are made by the majority owner entity. In this case, the power is only protecting the Catholic entity and the majority owner entity consolidates.

If, however, the non-majority owner entity had a series of rights when viewed on aggregate (e.g., veto power of key operating issues, staffing, budgeting, or the right to remove the controlling entity from management), the non-majority owner entity might overcome the majority voting interest. In such a case, the non-majority owner will consolidate. Such a scenario will likely garner much discussion by both parties to the agreement and the level of actual control.

**Contractual Control**

Even without a legal transfer of assets or merger, an entity may be required to consolidate financials. One entity may agree to provide support and management if it is given sufficient control over the process. For example, Hospital A agrees to guarantee the debt or obligation to make significant capital improvements (Economic interest) if Hospital B will enter into a management contract giving Hospital A substantial control over the ordinary course of business at Hospital B (Control). Hospital A would likely consolidate Hospital B, again subject to a thorough review of facts and circumstances.

In other circumstances, the controlling entity does not have a majority of board votes but has contracted with the other entity as a sponsor or other relationship whereby it controls all of the financial funding and, indirectly, the decision making. The controlling entity would likely consolidate the other entity.

**Governmental Entities**

GAAP for governmental entities is governed by the Governmental Accounting Standards Board (GASB). In thinking about GAAP for governmental entities, many fundamentals are the same, as is the goal of reliable reporting. There are differences in the terminology, concepts, and the focus on issues common to governmental entities. A government will certainly be judged on its fiscal soundness, but it will also be judged on how it fulfills its role in the community served. In some cases, GAAP promulgated by GASB may be substantially different from GAAP promulgated by FASB. Governmental health care entities in the form of hospital districts, hospital authorities, or county- or municipal-operated facilities compete with for-profit and not-for-profit hospitals. In fact, many governmental hospitals have dual status as a governmental entity and a 501(c)(3) organization. Accordingly, there is a tendency to want to look and act like the competitors. Nevertheless, the financial statements must be prepared in accordance with GAAP for governmental entities, and references in the documents to GAAP may want to specify “as promulgated by GASB.”

**Recording Transactions**

In an acquisition by a governmental hospital, the excess of consideration given over the net position acquired is reported as a deferred outflow of resources. (If we were describing a non-governmental transaction, the excess of the total purchase price over the value of net assets would be reported as goodwill.) The deferred outflow of resources is attributed (amortized) to future periods in a systematic and rational manner, generally based on factors that most closely relate to the goodwill. Guidance for Governmental Combinations can be found in the GASB Codification Co10, which includes four illustrative examples; unfortunately, none of these examples are health care specific. Generally, the question is, “Over what period of time would a hospital expect to realize the goodwill?” This period might vary based on short and long term plans for the facility, demands for new capital, and shifting demographics that may affect the service delivery. For example, a rural hospital transitioning to more outpatient services likely has limited goodwill, but to the extent it does, it may be very short lived. In general, selection of the amortization period is given more discretion than in non-governmental GAAP.

If consideration given is less than net position achieved, the acquisition value assigned to non-current assets is reduced, unless the conditions of the acquisition indicate that the seller intended to provide a reduced price as economic aid to the acquirer—for example, where the purchase price is less than acquisition value by $5 million with the understanding that the acquirer must subsidize operations or invest some amount of money to ensure that the hospital continues to operate in the community. Some portion of the $5 million would likely be reported as contribution revenue (considered a gain in a for-profit transaction; a contribution in a not-for-profit transaction).

**Conclusion**

In a direct sale of stock, interest, or assets, the issues around consolidation are generally straightforward. When one of the large growing health care companies (for-profit or not-for-profit) does a deal, they have the team and the experience to sort out the issues related to consolidation. However, as the health care industry continues its consolidation, particularly in the form of joint ventures or affiliations, the controls, options, and protections afforded the parties will raise questions over who, if anyone, should consolidate. While more likely to occur in one-off deals or where parties are focused on working together, controlling party complexity can slip into any agreement when the party with majority ownership interest seeks to assure the non-majority ownership party.

The parties to any agreement should make certain that their respective accounting experts, be they CFOs, controllers, auditors, or other consultants, have a good understanding of the key components related to control and the financial reporting consequences.

**Endnotes**

1. Given the complexity of VIEs, the authors have not attempted to address the full standards on VIEs in this article.
2. Recent changes allow private businesses to elect not to consolidate essential leased property with common control. Each instance should be reviewed based on facts and circumstances.
3. Prior to the sale of a governmental hospital, it may be important to look at the differences in GAAP and the impact of those differences on the Income Statement and Balance Sheet so that any prospective acquirer can make an apples-to-apples comparison.
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Maritime Disasters and Distressed Hospitals: What Every Board Should Know About Assessing Risk

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On September 30, 2015, the cargo ship El Faro left port in Jacksonville, Florida, bound for Puerto Rico and aware of Tropical Storm Joaquin and its projected path. The ship’s captain, an experienced seaman, had charted a course that would allow El Faro to reach San Juan while maintaining a safe distance from Joaquin’s destruction. With El Faro’s owner approving that course, the ship and crew left port despite forecasts from the National Hurricane Center that Joaquin would develop into a hurricane the next day.

Twenty-six hours after setting sail, battered by the winds and seas created by Category 3 Hurricane Joaquin, El Faro sank off the coast of a Bahamian Island, losing her entire 33-person crew. As the ship’s recorded bridge audio and other intelligence would later determine, a confluence of events—some within the captain’s control and some beyond it—ultimately contributed to making this voyage one of the worst disasters in the modern history for the U.S. Merchant Marine. With the benefit of advanced weather forecasts, satellite imagery, and modern communications, it’s easy to ask: how did a disaster like the El Faro happen?

With the swells increasing in size and frequency, El Faro’s Captain was asked about altering course. “No, no, no. We’re not gonna turn around.”

–El Faro Bridge Audio Recording

Across the United States, hospital management teams and governing boards are facing their own gathering storm. Since 2010, approximately 190 hospitals across the country have closed. Similarly, and by these authors’ count, approximately 85 hospitals have sought the protection of the U.S. bankruptcy courts since 2011. While the number of hospital closures and bankruptcies may seem small compared to the 4,862 community hospitals in the United States, the hospital industry has experienced fundamental structural changes that make closure or bankruptcy a risk that is now visible on the horizon for many hospitals.

Table 1: Hospital Closures in the U.S.

<table>
<thead>
<tr>
<th>Year</th>
<th>Closures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>15</td>
</tr>
<tr>
<td>2011</td>
<td>18</td>
</tr>
<tr>
<td>2012</td>
<td>23</td>
</tr>
<tr>
<td>2013</td>
<td>26</td>
</tr>
<tr>
<td>2014</td>
<td>41</td>
</tr>
<tr>
<td>2015</td>
<td>37</td>
</tr>
<tr>
<td>2016</td>
<td>27</td>
</tr>
</tbody>
</table>

Like the captain and crew of El Faro, many hospital management teams and governing boards are increasingly struggling just to keep their ships afloat, let alone make it safely to port. With hindsight, we can ask of a hospital that has closed, “Why didn’t it change course, away from the threat, when it had time?” The speed of most cargo vessels and approaching storms provides ample time to gather new data, react, and change course. Yet the Captain and owners of the El Faro did not take steps to keep the ship and crew out of harm’s way. Likewise, in most instances, hospitals that close or go bankrupt struggle for many years with deteriorating market position, poor operating results, and eroding balance sheets. We scratch our heads and ask, how could El Faro sail into harm’s way without changing course? In a similar light, it’s not difficult to ask of a now-defunct hospital, how did it progress from being a stable institution to a stressed, and
eventually distressed entity without altering its doomed trajectory as years passed? Captains and hospital governing boards, by tradition and law, are responsible for the safety of personnel and assets under their watch. Yet the most common regret we hear from board members after we complete an assessment of strategic options is “I wish we had this conversation two years ago.”

Intuitively, we know that the sooner a new course is plotted, the greater the benefit to sailors and hospital stakeholders alike. By acting earlier, the magnitude of the course correction is lessened and developing risks are mitigated before they become acute. The disruption, risk, and cost of a massive change in course are avoided. Why, then, do hospital boards defer action until the hospital’s options have narrowed to the equivalent of 1) staying with a sinking ship that has lost propulsion and is being battered by huge waves, strong winds, and shifting cargo or 2) abandoning ship into a Category 3 hurricane with estimated 140 mph winds and 50-foot waves? In hindsight, it is clear that a chance to preserve options and reduce operating risk was missed, but what can we glean from the El Faro disaster and recent health care industry trends regarding hospital closures and bankruptcies?

Whether regarding the El Faro or distressed hospitals, hindsight makes clear that decision makers have not accurately assessed a changing set of environmental risk factors. As objective advisors to hospital boards and leadership teams, attorneys are often placed in positions where they can see the early warning signs of organizational stress. Correctly identifying these early warning signs, proactively engaging a board in these fraught conversations, and applying the proper solutions at the appropriate level of intensity can steer health care organizations back on course and avoid calamity. Lessons from the El Faro provide fitting analogs for those leading or advising hospitals and health systems in various levels of financial and operational stress.

**What Are the Warning Signs of Increasing Organizational Risk?**

Academic literature addressing hospital bankruptcies consistently, and not surprisingly, has found similarities among hospitals that file for bankruptcy. These hospitals lose money in the years prior to closure, operate in aging facilities, experience declining equity positions, and struggle to meet current obligations. Among most business enterprises, however, a negative trajectory in any of these metrics would typically trigger course correction strategies. Based on our experience, most hospital boards do not evaluate available information from a strategic perspective on a regular basis. Instead, financial results and operating statistics are often compared to budget and prior year results. As a result, key trends in performance and operating risk can be missed.

The failure to compare the organization’s performance beyond its budget forecast and prior year performance unnecessarily escalates operating risk and reduces available course correction options. For example, many boards are only provided with an overview of the organization’s financial performance in the context of a 30-minute session to review and approve audited financial statements. These sessions often fail to address longer term, fundamental, strategic or operating trends occurring over several years. A variance to budget is explained by a mild flu season or the departure of a key physician, while longer-term financial, operating, and strategic trends are not monitored and go unheeded.

One of the most important ways to provide boards with a sound assessment of organizational strength is to ensure that the board and management examine long term trends for clinical, operating, market, and financial indicators at least annually. A review of key risk indicators should capture a longer-term trend line that provides an assessment of the organization’s strategic position and identifies areas of risk. Importantly, an objective review of these key risk indicators provides both board members and management with a distance from the daily management and operations of the organization that may otherwise cloud the ability to see more subtle and steady signs of performance erosion (e.g., an aging ship, a strengthening storm, an aging medical staff or gradual shifts in patient migration patterns for key services). These signs of performance erosion can be missed when the focus is about maintaining shipping schedules or performance to current year budget.

“What’s concerning me is that the umm—is that—the information we’re getting from other sources is so much different from this.” —El Faro’s Third Mate after reviewing new weather advisories and questioning whether to change the current course.

A sample of key risk indicators that should be monitored and reported annually with a five-year trend analysis is provided below in Table 2.

**Table 2: Key Risk Indicators**

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>• Operating Revenue Trend</td>
</tr>
<tr>
<td>Indicators</td>
<td>• Operating Cash Flow &amp; Cash Flow Margin Trends</td>
</tr>
<tr>
<td></td>
<td>• Days in A/R Trend</td>
</tr>
<tr>
<td></td>
<td>• Debt Service Coverage Trend</td>
</tr>
<tr>
<td></td>
<td>• Operating Margin Trend</td>
</tr>
<tr>
<td></td>
<td>• Days Cash on Hand Trend</td>
</tr>
<tr>
<td>Operating</td>
<td>• FTEs per AOB Trend</td>
</tr>
<tr>
<td>Indicators</td>
<td>• Case Mix Index Trend</td>
</tr>
<tr>
<td></td>
<td>• Payer Mix Trend</td>
</tr>
<tr>
<td></td>
<td>• Key Volume Trends (O/P and I/P)</td>
</tr>
<tr>
<td></td>
<td>• Practice Operations, Production and Losses Trend</td>
</tr>
<tr>
<td>Value</td>
<td>• Medicare Cost Position Trend</td>
</tr>
<tr>
<td>Indicators</td>
<td>• Attributed Covered Lives Trend</td>
</tr>
<tr>
<td></td>
<td>• Quality Scores Trend</td>
</tr>
<tr>
<td>Market Position</td>
<td>• Market Share Trend</td>
</tr>
<tr>
<td></td>
<td>• Provider Alignment, Recruitment and Retention</td>
</tr>
<tr>
<td></td>
<td>versus Documented Need, Turnover, Productivity</td>
</tr>
</tbody>
</table>
How Can We Avoid Disaster?

Every hospital board should examine its five-year trend line for the above metrics on an annual basis. This conversation should involve management and a robust and pragmatic discussion of underlying trends. Specifically, the board and management should review trends with a focus on the competitive landscape and the hospital’s available resources and capabilities to address adverse operating, financial, clinical, and competitive factors. While undertaking expense reductions is a vital tool for many hospital turnarounds, “the process used to determine which services or facilities are eliminated” serves as an “important distinction that separates successful and unsuccessful turnarounds.” For boards weighing the effectiveness of a proposed turnaround plan, it is important to differentiate between short-term, one-time gains that can be achieved through “across-the-board” cost reductions and more thoughtful cost reductions that address specific programs, services, or facilities that systemically contribute to the organization’s poor financial performance. Based on our experience working with hospitals with varying levels of stress or distress, the spectrum below (Table 3) serves as a signpost that can provide hospital boards, management teams, and their advisors with some perspective of the warning signs indicative of organizational stress or distress.

A successful hospital turnaround plan places significant demands upon a hospital’s board and its management team. Developing a successful turnaround plan requires that the organization fully assess and harness its available human, facility, and financial resources; address gaps in organizational capabilities; identify the hospital’s niche segment within the area’s overall health care competitive landscape; and then execute on that plan. Boards and management often benefit by having outside experts involved in formulating and monitoring performance against the turnaround plan. This is true whether existing management remains in place or whether the board elects to bring in new management.

“Mariners must be cautioned never to leave themselves with only a single navigation option when attempting to avoid a hurricane … early decisions to leave restricted maneuver areas are [often] the most sensible choice.” – Marine Safety: Assessing Options, National Oceanic and Atmospheric Administration

In our experience, most hospitals experiencing the early warning signs of stress miss these indicators of increasing distress. For those who do see the signs, it is almost always management that will act. Given the board’s delegation of management of the hospital to the management team, this is not surprising. These organizations frequently have sufficient internal resources and capabilities to develop and effectuate a performance improvement plan.

The board’s delegation of responsibility to management to develop and implement a performance improvement plan should include board oversight and review of the adequacy of management’s plan and tracking of the organization’s progress toward targeted results. As the chart on pages 26-27 (Table 4) provides,
external assistance may be retained to provide the board with objective advice and aid in the development of a performance improvement plan that fully inventories the hospital’s internal resources and capabilities and positions the organization to maximize its return on these internal assets. If available resources or management’s plan prove inadequate to mitigate growing risks, then more drastic intervention is required.

“Sometimes circumstances overwhelm you. You can do all the planning you want.”
—Steven Werse, Ship Captain & Secretary-Treasurer of the Master Mates and Pilots Union.

If management’s performance improvement plan does not achieve the desired results or events overwhelm the plan, then the Board should be prepared to act before bond covenants are violated or other thresholds are crossed. Timely intervention can greatly reduce the operating, clinical, financial, and market risks associated with executing the hospital’s strategic plan.

For some boards, a variety of factors may require the use of external advisors to develop and execute a turnaround plan (e.g., the present management team’s is unable to effectively execute an established plan, competitive or market forces overwhelm organizational resources, and/or the attention or participation by secured creditors or bondholders in the development of the hospital’s turnaround plan). In such circumstances, it is critical that external advisors secure “early wins” for the organization that result in quick improvements to the hospital’s bottom line performance and signal to other stakeholders that lasting organizational improvement is underway.

Among hospitals that are highly stressed and distressed, a lack of internal resources often means that core business office functions or standard managerial activities have either gone dormant or have atrophied severely. Specific opportunities for organizational performance improvement can usually be found in a number of areas, including but not limited to: (1) efficient staffing practices, (2) improved employed-provider practice operations, (3) revenue cycle operations improvement, (4) review of non-core assets and operations, and (5) rigorous supply chain management.

In hospital organizations experiencing higher levels of stress or distress, a successful turnaround plan typically requires some change in key management positions. Depending on the severity of the organization’s stress or distress, external advisors may report to the board either through the existing chief executive officer of the organization or directly to the board itself. Developing these clear reporting and accountability channels early in the turnaround process serves as best practice and avoids ambiguity and shirked responsibilities among those involved.

Regardless of whether a hospital’s existing management team, interim executive leadership, or external advisors are tasked with implementing a turnaround plan, the responsibility lies with the board to take timely action to correct course. Initiating the necessary board discussions that focus on improving operating results and assess strategic options before all favorable options are eliminated is both prudent and necessary. Taking timely action to correct course is essential to avoid circumstances where the only options are to go down with the ship or to abandon ship into 140 mph winds and 50-foot seas. The responsibility for avoiding such tragic outcomes is one of the most critical responsibilities of any ship’s captain or hospital’s board.

### Table 4: Indicators, Warning Signs, and Navigation Options

<table>
<thead>
<tr>
<th>Stable / Stressed / Distressed</th>
<th>Indicators &amp; Warning Signs</th>
<th>Navigation Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stable Level 1</strong></td>
<td>• Consistent margins</td>
<td>➢ Shape organization culture to match organization’s objectives&lt;br&gt;➢ Engage in intermediate and long-term strategic planning&lt;br&gt;➢ Develop capital planning and use strategy</td>
</tr>
<tr>
<td></td>
<td>• Growing top line revenue</td>
<td></td>
</tr>
<tr>
<td><strong>Stable Level 2</strong></td>
<td>• Adequate reinvestment in asset base&lt;br&gt;• Organizational growth no longer presumed</td>
<td>➢ Accelerate organization cultural alignment initiatives&lt;br&gt;➢ Analyze strategic options available to organization&lt;br&gt;➢ Develop a performance improvement plan and develop organization’s personnel to execute on plan</td>
</tr>
<tr>
<td><strong>Stressed Level 1</strong></td>
<td>• Modest deterioration in market position&lt;br&gt;• Operating, financial and strategic indicators trending negative</td>
<td>➢ Undertake a strategic options analysis&lt;br&gt;➢ Development of a performance improvement plan; recruit key personnel to execute on plan&lt;br&gt;➢ Task management with effectively executing on performance improvement plan with objective milestones and key performance indicators of success</td>
</tr>
</tbody>
</table>
Correcting Course in Advance of a Coming Storm

While not all hospital bankruptcies and closures can be avoided, hospital boards can take timely action before risk factors escalate and remaining options fade away. For a hospital board, charting a low-risk course as an early action is essential to prevent damaging delays and avoid organizational tragedy. Our experience tells us that many boards wait two years or more in the face of mounting danger before they take action. An annual report assessing financial, operational, value, and market risk factors and trends—as well as a robust yearly conversation about organizational resources and capabilities and the competitive landscape—are essential activities of every hospital board.

“Look at the red sky over there. Red in the morning, sailors take warning.” –El Faro’s Captain on the morning of El Faro’s last voyage.

Unfortunately, the industry risk factors buffeting hospitals and health systems have only grown more acute and more dynamic in recent years. Hospital and health system boards need to appreciate both the organization-specific and industry-wide sources of risk confronting their organizations. Failing to recognize risk factor trends can greatly diminish strategic options, placing the organization in grave danger.

ENDNOTES

1 See Landy PhD, Amy Yarbrough and Robert J. Landry III, JD “Factors Associated with Hospital Bankruptcies: A Political and Economic Framework,” 54 Journal of Healthcare Management 4 (July/August 2009) 252-72 (citing, among other studies, a qualitative analysis of hospitals that filed for bankruptcy).
2 See Langabeer II EdD, James “Hospital Turnaround Strategies,” 86 Hospital Top- ics: Research and Perspectives on Healthcare 2 (Spring 2008) 3-10 at 4 (finding that a “severely depressed hospital has endured on average 2-6 years of continu- ous operating, and sometimes net, losses”).
3 Landy at 254 (stating “a proactive approach that identifies organizations with the potential for future problems in advance of poor financial statements requires the examination of nonfinancial factors in addition to financial ratios and balance sheets”).
4 See Langabeer at 7-8 (offering a conceptual framework for assessing contraction and expansion strategies in successful hospital turnarounds).
5 Id. at 7.

<table>
<thead>
<tr>
<th>Stable / Stressed / Distressed</th>
<th>Indicators &amp; Warning Signs</th>
<th>Navigation Options</th>
</tr>
</thead>
</table>
| Stressed Level 2 | • 2+ years of declining margins  
• 2+ years of flat top line revenue  
• Reserves adequate to fund 5 or fewer years of worsening losses | ➢ Commission a strategic options analysis developed by an outside party  
➢ Seek out and realize improvements in revenue cycle management  
➢ Consider placement of a Chief Implementation Officer |
| Distressed Level 1 | • Inadequate resources to alter trajectory  
• Cost cutting measures yield only marginal benefit  
• Significant turnover in key management positions  
• Accelerated deterioration in market position | ➢ Commission a strategic options analysis, including analysis of liquidity position and creditor analysis  
➢ Seek out and realize improvements in revenue cycle management to improve cash position  
➢ Consider placement of a Chief Restructuring Officer tasked with realizing performance improvement opportunities  
➢ Consider undertaking an affiliation process for a new owner/operator |
| Distressed Level 2 | • 3+ years of declining/negative margins  
• 3+ years of flat or decreasing top line revenue  
• Investments are below rate of depreciation for 3+ years  
• Cost cutting measures impact core programs and functions  
• Reserves sufficient for less than 3 years of worsening losses | ➢ Execute on strategic options that preserve value of the organization and best ensure long-term viability  
➢ Retain a Chief Restructuring Officer  
➢ Evaluate effectiveness of negotiating with creditors via out-of-court channels or the bankruptcy court  
➢ Undertake an expedited affiliation process |
SullivanCotter is the leading independent consulting firm in the assessment and development of performance-based total rewards programs and workforce solutions for the health care industry and not-for-profit sector. For 25 years, the firm has provided unbiased advice to executives and boards to help attract, retain and motivate executives, physicians, advanced practice clinicians and employees at all levels. Through the Center for Information, Analytics and Insights, SullivanCotter has developed the most widely recognized compensation surveys in the United States. Combining data-driven intelligence with national insights, we act with integrity to help organizations fulfill their missions, business objectives and regulatory requirements.
In today’s rapidly changing environment, health care organizations must understand how to effectively integrate and optimize advanced practice clinicians (APCs)\(^1\) to support the achievement of the “quadruple aim”\(^2\)—higher quality, lower costs, improved population health, and better work life of health care providers. A successful strategy includes implementing care delivery models that maximize the capabilities of each team member within the framework of federal and state laws, regulations, and accreditation standards. Coordination with a knowledgeable compliance team can inform the integration strategy and mitigate risk.

This article addresses the growing demand for APCs as well as three regulatory requirements that pose challenges that are essential to a successful APC integration strategy:

❯❯ Evaluation of APC competency standards
❯❯ Third-party payer policies related to billing for services provided by APCs
❯❯ Appropriate attribution of APC productivity in production-based physician compensation plans

This article is not intended as a comprehensive review of all the risks associated with APC integration; rather, it focuses on three elements that may represent unique challenges.

Growing Demand for APCs

According to an IHS Inc. (currently dba IHS Markit) report released by the Association of American Medical Colleges (AAMC), a projected physician shortage is expected by 2025 (see Figure 1).\(^3\) Concurrently, the U.S. Bureau of Labor Statistics projects the number of APCs to grow significantly between 2014 and 2024 (see Figure 2).\(^4\) While Figure 2 provides data for nurse anesthetists, nurse midwives, and nurse practitioners, a review of data from the U.S. Bureau of Labor Statistics reveals nearly identical growth within the physician assistant profession.

According to the IHS Markit report, physician demand will significantly outpace supply due to such factors as:\(^5\)

❯❯ Shifting population demographics relative to age
❯❯ Increased access to medical insurance under the Affordable Care Act
❯❯ A decline in the average hours worked per week by younger physicians in contrast to their predecessors

Sullivan Cotter’s research shows that this pressure has resulted in new hiring patterns. Seventy-two percent of participating health care organizations have hired APCs in the past year, and 62 percent plan to add more in the upcoming year.\(^6\) Some organizations employ more than 1,000 APCs in at least fifty different specialties, yet some are still in the early stages of integration. As a result, APC roles are changing rapidly and vary by specialty in different models of care. As such, assessing competency is an important first step in optimizing utilization.

Figure 1: Total Projected Physician Shortfall Range, 2014–2025\(^3\)
Providing safe, high-quality care is at the core of every health care organization’s mission, making it essential to ensure the competency of every provider. While having an effective competency assessment program is important to providing high quality patient care, it is also necessary to meet the regulatory and accreditation requirements set forth by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission. Across the country, the maturity and effectiveness of APC competency assessment programs varies significantly. Organizations that carefully structure their programs are positioned to improve provider performance and identify and manage provider competency issues. This ensures compliance with CMS requirements, which state “the organization’s governing body must ensure that all patient care is provided by practitioners who have been evaluated by the medical staff and are practicing within the scope of their privileges.”7, 8 Additionally, CMS requires the medical staff conduct periodic appraisals of its members.9

The Joint Commission bolsters the CMS requirements with standards defined in the Focused Professional Practice Evaluation (FPPE)10 and Ongoing Professional Practice Evaluation (OPPE).11 The OPPE/FPPE process standards, which function as an assessment protocol, apply to all privileged providers, including APCs providing a medical level of care. These standards also mandate that competency assessment data must be collected and reviewed more frequently than once a year.

Despite requirements coming from both CMS and Joint Commission, organizations find challenges in implementing competency assessment programs. Data from the 2016 findings from The Center for Advancing Provider Practices (CAP2™) indicate that only 81 percent of respondents have a uniform medical staff competency evaluation process for APCs and physicians,12 and only 59 percent report they assess APC competency more than once a year,13 both of which are Joint Commission requirements.

During a Joint Commission visit, surveyors will review a hospital’s OPPE/FPPE policies to ensure the inclusion of APCs. They will also review APC files for privileges granted and evidence that the OPPE/FPPE assessments are tied to those privileges. Sample Joint Commission findings related to APCs include

- Underdeveloped or lack of OPPE/FPPE process for APCs
- Lack of definition of data to be reviewed for APCs or use of generic measures despite specialization
- Inability to collect data due to attribution of activity to the physician
- Use of subjective evaluation only by supervising/collaborating physician
- No FPPE criteria have been developed when a focused review was required for an identified issue of competence


Improving APC Competency Assessment Programs

The first step in operationalizing an APC competency assessment process is to identify the necessary data to collect and review. To inform that decision, organizations should consider starting with the criteria used to assess physicians. The type of data to be collected is determined by individual departments and then approved by the medical staff. Organizations may also want to consider a common set of data for all APCs, such as the number of patient contacts, volume of procedures, and patient satisfaction data. Including APCs in the development of the competency program and allowing experienced APCs to assess the competencies of new APCs should also be considered. Multiple other approaches to assess APC competency are shown in Figure 3.

Processes for each approach should be clearly defined. For example, if chart reviews are to be completed, the process should state how many charts should be reviewed and the criteria to be assessed. This could include such elements as history and physical, medication reconciliation upon discharge, and a complete discharge summary. A paper or automated checklist can be

![Figure 2: Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners Percent Change in Employment, projected 2014–2024](image)
developed to capture the correct elements and drive consistency throughout the organization.

As the APC workforce has grown, organizations have started adding APC representation to their Medical Staff Credentialing Committee. CAP2™ data show 36 percent of organizations have an APC representative on the credentialing committee, and 55 percent of those have the right to vote. APC representatives work closely with the medical staff office to help coordinate the credentialing, privileging, and competency assessment processes for APCs. APC representatives also provide expertise about state and federal laws and regulations as well as the APC education, certification, and licensure requirements.

Many organizations have developed a separate APC Committee to address important APC issues, including credentialing, privileging, competency assessment, and so on. CAP2™ data indicate that 46 percent of organizations utilize such a committee. Figure 4 provides an overview as to the scope of responsibility of these committees.

Figure 4: APC Committee Scope of Responsibility

Ensuring the effectiveness of an APC competency assessment process is dependent upon a thoughtful approach and an appropriate allocation of time and resources from the medical staff office, IT, and quality departments for support.

Third-party Payer Policies and APC Billing

The operational challenges of a growing APC workforce are compounded by the complexities of billing and third-party payer policies related to APCs. Because the rules vary by payer (government or commercial) as well as the setting, health care organizations must ascertain the policies for each payer with whom they contract, including policies for every setting in which they provide services and every practitioner type providing those services.

Claims instructions, enrollment procedures, and reimbursement rates vary widely. While claims for services provided by physicians are always submitted under the physician’s National Provider Identifier (NPI) and reimbursed at 100 percent of the fee schedule, claims instructions for services provided by APCs vary by payer and setting, with reimbursement ranging from 60 to 100 percent of the physician fee schedule. Identification of these requirements serves as a starting point to mitigate billing risk and avoid allegations of fraud and abuse.

Medicare

Professional services provided by PAs, NPs, CRNAs, CNMs, and CNSs are covered under Medicare Part B. The aforementioned APCs must be enrolled in the Medicare program. Reimbursement is at 85 percent of the physician rate when claims are submitted under the APC’s NPI. Some provisions, known as “incident to” and shared/split visit billing, allow for claims to be submitted under the physician’s NPI for 100 percent reimbursement; however, strict requirements must be met. As an example, a hospital may not bill APC work effort as “incident to” in a facility setting. Failure to satisfy the requirements means that claims must be submitted under the APC’s NPI.

State Medicaid

Each state Medicaid program promulgates its own rules, and these vary widely by practitioner type. While every state Medicaid program pays for services provided by PAs and NPs and enrolls PAs and NPs as ordering/referring providers, the claims’ methodologies are often different. Enrollment applications for APCs are not uniform, nor are policies for services covered or reimbursement rates. Additionally, many states have managed Medicaid products that are essentially commercial payers who also may promulgate their own rules.

Commercial Payers

Commercial reimbursement rates for APC services vary widely. Many commercial payers do not enroll the APCs into their systems for billing purposes, and APC services are billed under the physician’s NPI. On occasion, coverage for certain services may not be covered when provided by APCs. As organizations negotiate with commercial payers, they must ascertain policies for each payer with whom they contract. Organizations implement operational business decisions in an effort to maximize reimbursement; however, these may actually negate their intended purpose. Examples of such decisions include requiring that new patients only be seen by a physician, or that the physician must also see every patient seen by an APC. Such redundancies, when not necessary, can actually increase costs and decrease patient access.

Improving APC Billing Practices

In recent years, there has been increased scrutiny of APC billing practices by the Office of Inspector General of HHS and the U.S. Department of Justice (DOJ).

In 2016 alone, the DOJ settled with three organizations related to APC billing claims for a total in excess of $6M. In today’s environment of heightened scrutiny, the emergent settlements bring to mind this Arabian idiom: “If the camel once gets his nose in the tent, his body will soon follow.”

If concerns over potential audits or the avoidance of allegations of fraud and abuse that may span beyond mere billing
are not compelling enough, it is still worth a closer look from a business perspective to make sure providers are actually providing the services they are authorized to provide and are able to perform and receive payment for the services rendered.

The complicated rules and regulations set at the federal, state, and payer contract level suggest that provider education, assessment, and feedback are needed. The following considerations provide approaches for APC billing compliance:

1. Conduct an evaluation of current APC billing practices within the organization. The following provide a series of questions to assist in navigating the evaluation:
   a. Has each APC provider been enrolled in the Medicare, Medicaid, and commercial payer systems as applicable?
   b. How has the organization ensured compliance with government payers’ billing and reimbursement policies?
   c. Has the organization ascertained the payment policy for each commercial payer with whom they contract?
   d. Is the organization billing for services rendered by APCs? If so, how are the associated work relative value units (wRVUs) being attributed?
   e. Is the organization billing the Medicare program under the “incident to” and/or shared/split visit provisions for work provided by APCs? If so, how does the organization ensure that the physician participation requirements for those provisions have been met? What is the process for claims adjudication when a physician has participated (e.g., signed a note) but has not met these requirements?

2. Provide initial and ongoing education to key stakeholders to improve adequate documentation and coding of APC work effort.
   a. Key stakeholders should include both physicians and APCs as well as clinical operations managers and billing and coding staff.
   b. Training should be specific to specialty and practice setting.
   c. Training should also include education on regulations and guidelines, including a review of specialty-specific case studies for common and unique situations.
   d. Audits should be conducted and feedback delivered to providers regularly.
   e. An organizational resource should be identified to address questions and concerns.

The implementation of a compliance program focusing on billing practices is a key strategy for risk mitigation. Training and ongoing feedback to improve documentation and billing can improve compliance with the regulations, capture proper revenue for services provided, and mitigate the risk of improper claims.

**APC Productivity Attribution and Physician Compensation**

As health care organizations expand their APC workforce, they may look to maximize the reimbursement associated with services provided by APCs (e.g., Medicare’s “incident to” and shared visit billing).22 Technical billing requirements aside, submitting bills to Medicare under the physician’s NPI for work performed by APCs, either in part or in total, presents potential

### Key Questions for Consideration Relative to APC Billing:

- Who is providing the service?
- Who is documenting services? How has the service been documented?
- By whom is the APC employed?
- In what setting is the APC providing the service?
- By which payer is the patient covered?

risks specific to physician compensation arrangements. Such risks are related to ensuring these compensation arrangements are fair market value and commercially reasonable, as required by numerous exceptions within the physician self-referral law (hereinafter referred to as Stark).23

### Improving Awareness of the Risks in Production Models under the Bona Fide Employment Exception

Many health care organizations that enter into direct employment relationships with physicians avail themselves of the bona fide employment exception within Stark. To satisfy that exception,24 an employed physician's financial arrangement must satisfy the following conditions:

- Employment is for identifiable services.
- Amount of the remuneration under the employment is directly or indirectly the volume or value of any referrals by the referring physician.
- Remuneration is provided under an arrangement that would be commercially reasonable, even if no referrals were made to the employer.

The exception permits a productivity bonus based on services personally performed by the physician (or an immediate family member of the physician). While there is a shift underway in physician compensation design to integrate value-based metrics, physicians continue to be compensated under production-based models. According to a recent annual survey of physician compensation,25 physicians' personally performed wRVUs or professional collections comprise a significant portion of their total cash compensation. Approximately three-quarters of respondents use productivity-based metrics for their primary care, medical, and surgical physicians. Overall, productivity-based compensation can often comprise 50–65 percent of the total cash compensation.

The prevalence of production-based plans coupled with growing APC utilization leads to inevitable tension: Who should receive the productivity credit when certain types of services are provided, the physician or the APC? This inherent tension cannot be overlooked with regard to the regulatory compliance risk it may create relative to physician cash compensation in an employed, production-based compensation model.

A hypothetical case study sheds light on the potential risks associated with the productivity attributions in production-based plans.

Returning to the statutory exception for bona fide employment under Stark, although legal opinions in the market may be
Case Study: A Production-based Plan for an Employed Primary Care Physician

A family medicine physician has built a busy practice that has two dedicated APCs. To the extent all applicable payer requirements are satisfied, the practice bills APC work as “incident to” for Medicare patients and under the physician’s NPI for commercial payers (as required and/or accepted by the payer).

The family practitioner is on a productivity-based compensation plan whereby she receives a market median rate per wRVU for all personally performed services. Her total cash compensation approximates the 90th percentile, which is consistent with the productivity billed under her NPI. The wRVU productivity levels for the three providers are as follows:

- Physician: 8,000 wRVUs
- APC A: 1,500 wRVUs
- APC B: 1,000 wRVUs

Upon review, it is apparent that the APCs have low wRVU productivity because the majority of services were billed under the physician’s NPI. The physician’s overall level of productivity and, correspondingly, her total cash compensation are being driven, at least in part, by the work effort of the APCs. Based on these figures, it is conceivable that the physician’s wRVUs could be overstated by about 3,500 wRVUs (assuming the APCs produce at or around the market median of approximately 3,000 wRVUs). In addition, the physician does not have any financial accountability for the APCs in her practice, as the costs are covered by the employer.

To the extent that the legal analysis determines that “incident to” and shared visit production does not meet the “personally performed” requirements, implement the following processes:

- Conduct a legal analysis on the application of the “personally performed” provision within the bona fide employment exception relative to production-based models
- Review existing production-based compensation plans to determine how “incident to” and shared visit services are being billed and how the work effort is being attributed
- Educate physicians and APCs, as well as staff responsible for managing the compensation plan, as to the implications of “incident to” and shared visit billing

Regardless of the ultimate legal position on the “personally performed” provision of the exception, organizations should be aware of the need to exclude “incident to” and/or shared visit productivity when assessing physician cash compensation for fair market value. Most physician compensation surveys, at least by definition, exclude wRVUs attributed to APCs from the physician productivity and payout rates that they publish. As organizations conduct internal or external fair market value analyses, they should exclude “incident to” and/or APCs’ allocation of shared visit production when assessing the competitive position of effective payout rates relative to the market to ensure an “apples to apples” comparison.

Improving Awareness of the Risks to Consider in Production Models within an Employed Group Practice

Physician groups that meet the qualifications of a group practice under Stark are not subject to the same limitations relative to “personally performed” productivity, as evidenced in the following description of permissible productivity bonuses:

A physician in the group practice may be paid a productivity bonus based on services that he or she has personally performed, or services “incident to” such personally performed services, or both, provided that the bonus is not determined in any manner that is directly related to the volume or value of referrals of DHS by the physician (except that the bonus may directly relate to the volume or value of DHS referrals by the physician if the referrals are for services “incident to” the physician’s personally performed services).

In contrast to the bona fide employment exception, Stark’s definition of a group practice expressly allows an organization the ability to credit physicians with “incident to” and shared visit wRVUs. The ability to provide such credit in the context of a production-based compensation plan in a hospital-owned medical group raises potential risks that often go unnoticed.

Take, for example, an office-based primary care practice in which a family medicine physician is paid on a simple wRVU-based model. The physician currently works with one APC. Because the employed group satisfies the group practice definition, the physician is credited with all of the “incident to” productivity generated by the APC. At present, the hospital subsidizes the family medicine physician’s practice on the basis of his professional revenue and practice expenses at approximately $100,000 annually.

The physician is currently in such high demand that he is booking three months out. In an effort to reduce the wait time for new appointments and improve access for established
patients, the practice hires another experienced APC. The employer maintains responsibility for the costs associated with hiring that APC; in other words, the physician bears no economic risk related to the expense of the APC. The following illustration provides an overview of the potential challenge with the addition of this new APC.

Based on the assumptions in the illustration above, the physician has the opportunity to earn approximately $76,000 more in cash compensation just by adding the APC to his practice.

![Additional APC Cost Projections](image)

Before any consideration of indirect expenses and/or projected professional revenue attributable to the APC, additional compensation cost is projected at $210,283.

This scenario presents two challenges.

- **First**, the increase in cash compensation attributable to the work effort of the APC is rather significant at $76,000. As noted in the prior hypothetical, the fair market value analysis of the physician’s cash compensation requires that he be able to support his total cash compensation based on his own productivity, exclusive of any wRVUs attributed to him by virtue of the APCs.

- **Second**, the hospital was already subsidizing this physician’s professional practice at approximately $100,000 per year. To the extent that the professional revenue attributable to all of the new APC’s work effort is insufficient to cover the full cost of that APC and the additional cash compensation paid to the physician, it stands to reason that the hospital's support of the physician's practice will increase beyond $100,000.

A cursory look at current regulatory trends highlights the underlying concerns with this example. For some time, government regulators have been increasingly focused on the practice loss argument as one approach to arguing that a physician’s financial arrangement is not commercially reasonable. This argument finds support from Judge Gregg Costa of the Southern District of Texas in his opinion on the motion to dismiss the plaintiff’s False Claims Act allegations against Citizens Medical Center of Victoria, Texas. Judge Costa noted the following:

Court notes Relators’ allegations that the cardiologists’ income more than doubled after they joined Citizens, even while their own practices were costing Citizens between $400,000 and $1,000,000 per year in net losses. Even if the cardiologists were making less than the national median salary for their profession, the allegations that they began making substantially more money once they were employed by Citizens is sufficient to allow an inference that they were receiving improper remuneration. This inference is particularly strong given that it would make little apparent economic sense for Citizens to employ the cardiologists at a loss unless it were doing so for some ulterior motive—a motive Relators identify as a desire to (sic) induce referrals.27

The practice loss theory is not intended to suggest that losing money on a physician practice is necessarily unreasonable; rather, it effectively mandates that organizations document the business justification for the financial arrangements they enter into with their physicians. It also encourages careful consideration in the development of physician and APC cash compensation plans.

Organizations in a similar fact pattern to the example above should consider the following. First, by reviewing and documenting goals for integrating APCs into clinical practice, an organization can focus on proposed outcomes, such as improving access, quality, cost efficiency, and patient experience. Second, organizations must understand the financial implications of integrating additional APCs. The question to answer is whether the totality of the arrangement, including the physician compensation arrangement, the cost of adding the APC, and the projected professional revenue exceeds anticipated expenses. At this point, the organization can properly weigh benefits against costs and document a persuasive business justification to support their strategic decisions regarding enhanced APC integration. Stated slightly differently, if the addition of an APC simply serves to increase the compensation of the physicians while increasing the employer's costs, then the employer's practice loss just increased, potentially implicating concerns regarding the commercial reasonableness of that staffing change and the corresponding physician compensation.

**Conclusion**

Amidst the unending changes in today’s health care market, one thing is certain: if the physician shortage projections are accurate, organizations must begin developing alternative staffing strategies to meet escalating demand for professional services. Strategies for success include implementing mindful care delivery models that maximize the capabilities of each member of the team within the framework of federal and state laws, regulations, and accreditation standards. Coordination with an established compliance team can inform the integration strategy and mitigate risk.

As organizations embark on the journey toward the future of integrated staffing models, the following considerations can provide a sound foundation for better compliance:

- Develop a process for assessing the competency of APCs that
mirrors the process used for physicians, and ensure the assessment frequency is more than once per year.

Ensure compliance with, awareness of, and education on the complexities of billing and third-party payer policy, to include the following:

- An understanding of current requirements with government and commercial payers, and
- An ongoing education series aimed at both providers and nonproviders focused on documentation and appropriate coding.

Closely monitor the attribution of APC work effort in the context of physician compensation plans and ensure physician compensation arrangements are fair market value, commercially reasonable and financially sustainable. Additionally, develop a consistent process for assessing and documenting the business rationale for adding additional APCs to a physician practice.

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1 For purposes of this article, the term APC includes Physician Assistant (PA), Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM).
2 Thomas Bodenheimer, MD, and Christine Sinsky, MD, “From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider,” Annals of Family Medicine, 12, No. 6 (November/December 2014): 573-576, http://www.annfammed.org/content/12/6/573.full.
5 IHS Inc., “The Complexities of Physician Supply and Demand”.
9 Medicare Condition of Participation: 42CFR § 482.22(a)(1).
10 Joint Commission Comprehensive Accreditation Manual for Hospitals Medical Staff Standard MS.08.01.01.
11 Joint Commission Hospital Accreditation Manual, Medical Staff Standard MS.08.01.03.
12 CAP2™ is a comprehensive database that has helped 300 health care organizations nationwide assess, manage, and optimize the use of APRNs and PAs on their care provider teams. CAP2™ data and findings help these health care organizations in 31 states, representing over 25,000 APRNs and PAs in 50 specialty areas.
13 CAP2™
14 CAP2™
15 CAP2™
16 CAP2™
17 CAP2™
18 Services provided by PAs are covered under Part B: Section 1861(s)(2)(K)(i) of the Social Security Act and 42 CFR § 410.74. Nurse Practitioner: Section 1861(s)(2)(K)(i) of the Social Security Act and 42 CFR § 410.75 nurse practitioners as covered Part B services.
19 CMS, “Medicare Enrollment Guidelines for Ordering/Referring Providers,”

VMG Health is recognized as a leader in healthcare valuation based on our extensive experience with valuing all types of healthcare facilities, organizations and compensation arrangements. Our unique combination of industry experience, regulatory knowledge and valuation expertise makes VMG Health the preferred choice for healthcare providers and their advisors who require high-quality, independent advice in a timely manner.

Fair Market Value Opinions
Business Valuations
Physician Compensation Arrangements
Capital Asset Valuations

Real Estate Valuations
Dispute Resolution & Litigation Advisory
Fairness Opinions

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Health care M&A activity continued its half-decade long growth trend in 2016. Though the dollar value of total deals decreased relative to 2015 due to a spike in managed care megadeals in 2015, when excluding 2015, the dollar value of deals has continued to increase annually since 2012. The increase in both volume and value of health care M&A activity is driven by changing technology, an aging population, an increase in the number of insured people through the Patient Protection and Affordable Care Act (ACA), and the implementation of value-based payments and alternative payment models. Taken together, these factors have driven providers to consolidate in an effort to take advantage of the economies of scale necessary to meet the goals of the “triple aim,” namely, increase service offerings and access to care, decrease cost, and improve the quality of care.

Leveraging VMG’s expertise as a leading provider of transaction health care valuation services, this article examines 2016 trends and 2017 expectations across seven prominent health care verticals. An overarching factor shaping the near-term future of health care M&A activity will be the effect of any changes to the ACA in 2017. While buyers tend to proceed cautiously in the face of uncertainty, large regulatory changes affecting health care providers has historically been accompanied by an increase in M&A activity.

Ambulatory Surgery Centers
The total number of Medicare-certified ambulatory surgery centers (ASCs) in the United States grew at a compound annual growth rate of 1.1%, increasing from 5,135 ASCs in 2010 to 5,496 ASCs in 2016.1 The ASC industry continues to remain highly fragmented with approximately 72% of freestanding ASCs being independently owned and operated. The remaining 28% of the ASC industry is controlled by large players, including United Surgical Partners, Inc., AmSurg Corp., Surgical Care Affiliates, Inc., HCA Holdings, Inc., Surgery Partners, and other multi-site operators.

In 2016, VMG observed a decrease in valuation multiples with median total invested capital (TIC) to trailing twelve month (TTM) earnings before interest, taxes, depreciation, and amortization (EBITDA) (TIC/TTM EBITDA) declining from 6.7x in 2015 to 6.5x in 2016. Despite the decline in median multiples, over the same period, we observed a wider dispersion in TIC/EBITDA multiples with the top transaction multiples (i.e., those in the 75th percentile and above) increasing from greater than 7.2x in 2015 to greater than 7.8x in 2016.

Table 1: VMG Observed ASC Multiples

<table>
<thead>
<tr>
<th>TIC / EBITDA</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>25th Percentile</td>
<td>5.9x</td>
<td>5.7x</td>
<td>5.0x</td>
</tr>
<tr>
<td>Median</td>
<td>7.0x</td>
<td>6.7x</td>
<td>6.5x</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>9.1x</td>
<td>7.2x</td>
<td>7.8x</td>
</tr>
</tbody>
</table>

On November 1, 2016, the Centers for Medicare and Medicaid Services (CMS) released the 2017 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center payment system policy changes and payment rates final rule. Based on the final rule, ASC payment rates will increase by 1.65% in 2017. Beginning January 1, 2017, CMS began implementing its site neutral policy. The goal of the policy is to stop paying hospital off-campus facilities the same reimbursement rates as hospital outpatient departments (HOPD). For ASCs which are billed as HOPDs, the change could cut reimbursement rates by up to 50.0%. Facilities affected under this policy include facilities located more than 250 yards from a hospital’s campus that began serving patients after November 1, 2015 and were previously billing Medicare as an HOPD.

The trend of consolidation and mega-transactions continued in 2016, following the 2015 merger of Tenet Healthcare Corporation and United Surgical Partners, Inc. Two of the three publicly-traded ASC companies were involved in megadeals in 2016.
Envision Healthcare Holdings, Inc. merged with AmSurg Corp. on December 2, 2016 in an all-stock deal that valued the combined entity at an implied total enterprise value (TEV) to TTM EBITDA multiple of 10.0x. Additionally, Optum (a subsidiary of UnitedHealth Group) announced the acquisition of Surgical Care Affiliates, Inc. (SCA) on January 9, 2017 for approximately $2.35 billion consideration paid to shareholders. The acquisition is expected to close in the first half of 2017.

VMG expects the consolidation trends to continue in 2017 as ASCs seek to guard themselves from increasing reimbursement, regulatory, and competitive risk and as health systems and insurers aim to defend market share and diversify operations. Driving these factors is the health care industry’s continued push to provide services in lower cost outpatient settings. We expect hospitals and health systems to continue direct participation in the ASC industry through either outright acquisitions or indirect participation via a joint venture (JV) arrangement with ASC management companies and/or local physicians. VMG expects ASC multiples to trend neutral to favorable in 2017 due to continued high demand and favorable economic variables for ASCs.

### Diagnostic Imaging Centers

The diagnostic imaging market is highly fragmented with the top twenty operators accounting for approximately 13.5% of the total centers. RadNet, Inc. is the largest single operator, controlling 306 of the approximately 6,816 total diagnostic imaging centers (IMCs). In 2016, VMG observed a decrease in median TIC/TTM EBITDA multiples from 4.7x in 2015 to 4.6x in 2016.

<table>
<thead>
<tr>
<th>Table 2: VMG Observed IMC Multiples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TIC / EBITDA</strong></td>
</tr>
<tr>
<td>25th Percentile</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>75th Percentile</td>
</tr>
</tbody>
</table>

Physician alignment with hospitals has impacted referral volume to unaffiliated and independent IMCs. Many hospitals are now pursuing transactions of IMCs after having already acquired and aligned with the referring physician groups (for example, large orthopedic groups). The IMCs are often secondary targets and might be acquired several months later, after referral patterns have shifted. The continued physician alignment trend has tempered actual and anticipated volume growth in unaffiliated IMCs and has impacted valuation multiples. Subsequently, operators are increasingly pursuing health system JV relationships in an effort to reduce competition with the health systems.

Since the passage of the Deficit Reduction Act of 2005, there have been significant reimbursement cuts for IMCs. The reimbursement cuts have targeted perceived over-utilization and cuts have been structured to incentivize upgrading equipment by providing lower reimbursement to older, technologically outdated scanners. For example, in 2017, IMCs not meeting computed tomography (CT) scanner standards will have technical reimbursement reduced by approximately 15%. Estimates range from $20,000 to $150,000 to upgrade older CT equipment and up to $500,000 to replace CT equipment. Similar cuts are proposed for x-ray machines providing analog (i.e., film-based) or computed (i.e., cassette-based) imaging. The cumulative result is a dampening of cash flow returns to IMC investors as both operating expense and capital expense, as a percentage of revenue, increase.

CMS provided the 2017 OPPS final rule which increased reimbursement slightly for most modalities with the exception of magnetic resonance imaging (MRI). Reimbursement declines for MRI were primarily due to the restructuring of imaging ambulatory payment classifications payable under the OPPS. IMCs that are structured as HOPDs (and which remain HOPDs after the implementation of the site neutral policies discussed in the Physician Services section) will experience a rate increase of 1.65%. Additionally, as discussed in the Physician Services section, the CMS site neutral policies could reduce reimbursement by up to 50% for HOPDs located more than 250 yards from a hospital’s campus that began serving patients after November 1, 2015 and which currently bill Medicare as an HOPD.

In March 2016, Fujian Thai Hot Investment Co. completed its $102.5 million acquisition of a 51.5% stake in Alliance HealthCare Services, Inc. (consideration paid to shareholders). The transaction resulted in implied TEV/TTM Revenue and TEV/TTM EBITDA multiples of 1.7x and 6.5x, respectively. VMG expects another slow year in IMC M&A volume as operators opt to pursue strategic partnerships and JV relationships with health systems in lieu of outright acquisitions. We expect transaction multiples to trend neutral in 2017 on lower total volume.

### Physician Services

The annual volume of physician services (PS) transactions has been impacted by large regulatory changes (i.e., the passage of the ACA in 2010 and the passage of MACRA in 2015). Physicians are increasingly opting to align into larger groups, adopt the accountable care organization (ACO) model, or align with health systems rather than face the burden and expense of increased regulatory and data reporting requirements alone.

On April 14, 2015, the Senate passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which permanently removed the sustainable growth rate (SGR) formula from the determination of the conversion factor under the Medicare Physician Fee Schedule (MPFS). The SGR formula has been replaced with fixed 0.5% annual increases through 2019. Therefore, under MACRA, the conversion factor will increase 0.5% annually from 2015 to 2019. After 2019, physician payments under the MPFS will remain flat through 2025. During this time period, individual physicians can achieve payment increases through participation in either the Merit-based Incentive Payment System (MIPS), which will be developed by the Secretary of Health and Human Services, or an alternative payment model (APM).

The MIPS supersedes three legacy CMS programs: Meaningful Use, the Physician Quality Reporting System, and the Value-Based Payment Modifier. Depending on the provider’s
participation level, payment adjustments in the first year will range from negative 4.0% to positive 4.0%. The range will increase annually to approximately negative 9.0% to positive 9.0% by 2022. Providers opting the Advanced APM route will have the potential for a lump sum incentive payment of 5% annually from 2019 to 2024. The following models are approved as Advanced APMs by CMS for 2017:

❯ Next Generation ACO Model
❯ Comprehensive Primary Care Plus Model
❯ Medicare Shared Savings Program Tracks 2 and 3
❯ Comprehensive End-Stage Renal Disease Care Model (Large dialysis organizations and non-large dialysis organizations two-sided risk arrangements)
❯ New participation models have been planned for 2018

VMG expects another year of high transaction activity as physicians and physician groups seek alignment in order to avoid penalties from MACRA’s data reporting requirements. We expect the move to value-based reimbursement and alternative payment models to drive transaction activity higher in 2017. Additionally, any major regulatory changes to the ACA in 2017 will likely drive increased M&A activity, as regulatory changes have historically driven the physician services market.

### Acute Care Hospitals

As of 2016, there were approximately 4,725 general acute care hospitals (ACHs) in the United States excluding specialty hospitals. The total number of hospitals has remained relatively flat over the past 13 years, increasing slightly from 4,567 in 2003 to 4,725 in 2016. In 2015, spending on hospital services accounted for the largest percentage of total personal health expenditures. During 2015, total expenditures on hospital services were approximately $1.036 trillion or approximately 32.3% of total national personal health care expenditures. Total hospital spending has increased 4.7% compounded annually from $902.7 billion in 2012 to $1.036 trillion in 2015. The growth in hospital spending has accounted for a significant portion of growth in total national health care expenditures in recent years.

The VMG ACH Index consists of Community Health Systems, Inc. (CHS), HCA Holdings, Inc. (HCA), LifePoint Health, Inc. (LPNT), and Tenet Healthcare Corporation (THC). The VMG ACH Index ended 2016 with a TEV/TTM EBITDA multiple of 7.6x. Individually, CHS ended 2016 at 8.4x; HCA ended 2016 at 7.4x; LPNT ended 2016 at 7.7x; and THC ended 2016 at 7.6x. Quorum Health Corporation (QHC) is not included in the VMG ACH Index as the company did not start trading on the New York Stock Exchange until April 2016.

Several public for-profit health systems have been divesting a sizable amount of hospital assets in order to reduce debt. In April 2016, CHS completed its spin-off of 38 hospitals into a new public company, QHC, for approximately $1.2 billion in net proceeds. In March 2016, THC closed its sale of five Atlanta hospitals to nonprofit WellStar Health System, Inc. resulting in an enterprise value of $661 million. In October 2016, HCA announced it was selling Oklahoma University Medical Center to University Hospitals for $750 million; the deal had an implied TEV/TTM Revenue multiple of 0.8x and TEV/TTM EBITDA multiple of 7.2x. Finally, in November 2016, CHS announced it was selling Spokane Washington Hospital Company, LLC to nonprofit MultiCare Health System, Inc. for $425 million.

The divesting trend for ACHs isn’t over yet. Trevor Fetter, the CEO of THC, has publicly stated plans to reduce portfolio risk by divesting non-core facilities. CHS announced plans to divest 25 hospitals in its 4th Quarter 2016 earnings call on February 21, 2017, and has publicly stated that CHS is focused on trying to receive around 10x TEV/TTM EBITDA on the facilities they are divesting. As mentioned above, CHS divested close to 40 hospitals in 2016 alone.

There was significant consolidation activity in 2016 as well. In October 2016, Dignity Health and Catholic Health Initiatives announced they are in merger talks. If completed, the merger would create the nation’s largest not-for-profit hospital company. In May, Capella Healthcare, Inc. and RegionalCare Hospital Partners Inc. completed a merger of the two companies. The combined entity has 16 health systems in 12 states with approximately $1.7 billion in revenue. In October, Ardent Health Services and LHP Hospital Group, Inc. announced plans for a merger that would create one of the largest privately owned for-profit hospital operators in the United States.

On August 2, 2016, CMS released the FY 2017 Inpatient Prospective Payment System (IPPS) policy changes and payment rates final rule. Based on the final rule, IPPS payment rates will increase by 0.95% in 2017. CMS also removed the Two-Midnight Rule’s negative (0.2%) reimbursement adjustment for 2017 after years of opposition by ACHs. Additionally, total Disproportionate Share Hospital Payments, which are payments made by state Medicaid programs to qualifying hospitals who serve a large number of uninsured and Medicaid individuals, will decrease by approximately $400 million in 2017.

For 2017, VMG expects a continued high level of ACH M&A activity as well as other strategic alignments, including JV’s and joint operating agreements, as hospitals and health systems emphasize providing coordinated, cost-effective care. VMG expects multiples to trend neutral as large operators continue to divest non-core entities and mid-size operators continue to consolidate.

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### Table 3: VMG Index of Acute Care Hospitals

<table>
<thead>
<tr>
<th>Source: S&amp;P Capital IQ</th>
<th>TEV/TTM EBITDA</th>
</tr>
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<tr>
<td>01/2016</td>
<td>7.00x</td>
</tr>
<tr>
<td>04/2016</td>
<td>7.50x</td>
</tr>
<tr>
<td>07/2016</td>
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</tr>
<tr>
<td>10/2016</td>
<td>8.50x</td>
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<tr>
<td>01/2017</td>
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The divesting trend for ACHs isn’t over yet. Trevor Fetter, the CEO of THC, has publicly stated plans to reduce portfolio risk by divesting non-core facilities. CHS announced plans to divest 25 hospitals in its 4th Quarter 2016 earnings call on February 21, 2017, and has publicly stated that CHS is focused on trying to receive around 10x TEV/TTM EBITDA on the facilities they are divesting. As mentioned above, CHS divested close to 40 hospitals in 2016 alone.

There was significant consolidation activity in 2016 as well. In October 2016, Dignity Health and Catholic Health Initiatives announced they are in merger talks. If completed, the merger would create the nation’s largest not-for-profit hospital company. In May, Capella Healthcare, Inc. and RegionalCare Hospital Partners Inc. completed a merger of the two companies. The combined entity has 16 health systems in 12 states with approximately $1.7 billion in revenue. In October, Ardent Health Services and LHP Hospital Group, Inc. announced plans for a merger that would create one of the largest privately owned for-profit hospital operators in the United States.

On August 2, 2016, CMS released the FY 2017 Inpatient Prospective Payment System (IPPS) policy changes and payment rates final rule. Based on the final rule, IPPS payment rates will increase by 0.95% in 2017. CMS also removed the Two-Midnight Rule’s negative (0.2%) reimbursement adjustment for 2017 after years of opposition by ACHs. Additionally, total Disproportionate Share Hospital Payments, which are payments made by state Medicaid programs to qualifying hospitals who serve a large number of uninsured and Medicaid individuals, will decrease by approximately $400 million in 2017.

For 2017, VMG expects a continued high level of ACH M&A activity as well as other strategic alignments, including JV’s and joint operating agreements, as hospitals and health systems emphasize providing coordinated, cost-effective care. VMG expects multiples to trend neutral as large operators continue to divest non-core entities and mid-size operators continue to consolidate.
Urgent Care Centers

The urgent care industry has witnessed a surge of strategic and financial ownership in recent years. Since 2010, the percentage of urgent care centers (UCCs) owned by strategic and financial investors increased from 14% of total center ownership in 2010 to 39% of total center ownership in 2015. During the same time period, UCCs owned by physicians and hospitals decreased from 78% of total center ownership to 41% of total center ownership.6 Data for 2016 is not available at the writing of this article, but we expect 2016 to report similar trends as observed for 2015.

Table 4: Ownership of Urgent Care Centers

![Graph showing ownership of Urgent Care Centers]

Source: Urgent Care Association of America

Driving the strategic and financial interest in UCCs is the perceived potential for positive cash flow generation through expansion of an existing platform and/or operational changes. Thriving UCCs are generally able to provide cash flow returns to strategic and financial investors due to either 1) high levels of volume in underserved markets or 2) leverage of mid-level providers relative to physician providers. Many financial investors are acquiring physician-owned and operated UCCs and implementing a staffing model more heavily reliant on lower cost mid-level providers. State laws regulate the amount of physician oversight required in individual UCCs.

There were several large UCC transactions in 2015. In March 2015, post-acute provider Select Medical Corp. and private equity firm Welsh, Carson, Anderson & Stowe (WCAS) announced they were entering into a JV, acquiring Concentra Inc. and its 300 UCCs from Humana Inc. for a purchase price of $1.055 billion and an implied TEV/TTM Revenue multiple of 1.1x.3 In April 2015, UnitedHealth Group’s subsidiary, Optum, announced it was acquiring MedExpress and its 141 UCCs from private equity firms General Atlantic, Sequoia Capital, and Highmark Capital for $1.5 billion.2 In May 2015, private equity firm ABRY Partners, LLC announced it was acquiring FastMed and its 87 UCCs from private equity firm Comvest Partners.

Following the M&A boom of 2015, transaction activity slowed in 2016 due to buyers’ need to digest recent UCC purchases. However, strategic and financial buyers remained relatively active. In January 2016, United Surgical Partners International, a JV between Tenet Healthcare Corporation and WCAS, announced it was acquiring CareSpot Express and its 35 urgent care centers from WCAS. In August 2016, private equity firm Revelstoke Capital Partners, LLC announced it was acquiring Fast Pace Urgent Care and its 36 urgent care centers from private equity group Shore Capital Partners.

Urgent care centers are reimbursed by Medicare according to the MPFS. On November 2, 2016, CMS released the FY 2017 MPFS payment and policy changes final rule and increased the MPFS conversion factor by approximately 0.24% in 2017.

VMG expects continued expansion in the UCC industry in 2017 driven by the health care industry’s continued push to lower-cost outpatient settings and increased consumer demand for cheap, convenient access to care. We expect an increase in volume of UCC patients due to the ACA creating newly insured patients every year, many without a primary care provider. Despite the growth in the UCC industry, M&A transaction volume is expected to stay below 2015 levels as buyers continue to digest acquisitions and expand on previously acquired platforms. VMG expects UCC multiples to trend neutral to favorable in 2017 due to high demand and low supply of mature entities.

Freestanding Emergency Departments

The two classifications of freestanding emergency departments (FSEDs) are hospital-based off-campus emergency departments (Hospital-Based ED) and independent freestanding emergency departments (Independent ED). Hospital-Based EDs are hospital-run and must be located within 35 miles of the affiliated hospital, integrated with the affiliated hospital, attend to Medicare Conditions of Participation, be licensed by the state, meet the requirements of 24-hour per day operations, and must comply with the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA requires all who come to an emergency room to be treated regardless of insurance status or ability to pay. Independent EDs, on the other hand, do not have an affiliation to a hospital, are not recognized by CMS as emergency departments, are not reimbursed by Medicare, and therefore have no obligation to comply with EMTALA.7

Independent ED operators have been leading the growth in FSEDs by rapidly opening Independent EDs primarily in states with no Certificate of Need (CON) requirements and where FSEDs are permissible. For example, as of 2010, the state of Texas had no Independent EDs. As of 2015, Texas had 156 Independent EDs, approximately 90% of the 172 Independent EDs in the U.S., with the majority of the remaining 10% located in fellow non-CON states Arizona and Colorado.4

Regulatory scrutiny of FSEDs has increased recently with the growth of the industry. The Medicare Payment Advisory Commission (MedPAC) has recommended adding modifiers flagging FSEDs’ claims, asserting that FSEDs benefit from an exemption to the site-neutral payment law. There has been criticism
claiming patients mistake FSEDs for urgent care centers and can end up with a bill as much as ten times higher than the same service performed in an urgent care setting. Additionally, there have been claims that Independent ED operators benefit from the EMTALA exemption, as well as claims that Independent EDs purposely place facilities in ZIP codes where it is less likely to serve uninsured patients.

Adeptus Health Inc. (Adeptus), the largest U.S. operator of FSEDs, grew from one FSED in 2002 to 97 FSEDs in Q3 2016. The inability of Independent EDs to accept Medicare, Medicaid, or Tricare has proven to be an issue for operators such as Adeptus, who is witnessing significant commercial volume declines in the company’s Independent ED markets. In order to gain access to government payer volumes, in 2016 Adeptus built several micro-hospitals to convert their Independent EDs into Hospital-Based EDs. In another strategy to convert Independent EDs into Hospital-Based EDs, Adeptus entered into multiple JV agreements with health systems. These strategies have led to a heavy drain on Adeptus’ capital resources. As a result, Adeptus’ stock price decreased from a high of $120.88 on August 4, 2015 to $7.64 on December 30, 2016.

Table 5: Growth in Adeptus’ Freestanding EDs

<table>
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<tr>
<th>Year</th>
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<td>2016</td>
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Post-Acute Care

Post-acute care facility types include skilled nursing facilities (SNF), long-term acute care hospitals (LTACH), inpatient rehabilitation facilities (IRF), home health agencies (HHA) and hospice agencies (HSPA). The number of Medicare certified post-acute facilities in the United States is published by MedPAC annually. The 2017 MedPAC report has not been released yet. As such, we are relying on the 2016 MedPAC report, which is based on 2014 data.

The number of Medicare certified IRFs decreased from 1,221 in 2004 to 1,177 in 2014. The decline during this time period is attributable to the reimplemention of the 75% rule in 2004. The 75% rule required that 75% of patients admitted to an IRF have a primary diagnosis that falls within 13 distinct high acuity diagnostic categories. Even though the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) lowered the 75% threshold to 60%, the effects of the rule still resulted in a large decrease in IRF volume, particularly by limiting the number of hip and knee replacement patients who could be treated at an IRF. It should be noted that the number of Medicare certified IRFs increased 1.4% from 1,161 in 2013 to 1,177 in 2014.

The number of Medicare certified LTACHs increased 8.6% compounded annually from 100 in 1990 to 373 in 2006, which resulted in a significant increase in Medicare spending. As a result, Congress passed the MMSEA, which imposed a moratorium on new LTACHs from 2007 to 2010. The moratorium was extended by the ACA to December 2012, but included exemptions for LTACHs that were given Certificates of Need. The moratorium on LTACHs was reinstated by the SGR Reform Act for a three-year period from April 1, 2014 to September 30, 2017.

The number of Medicare certified HHAs increased 4.5% compounded annually from 7,528 in 2000 to 11,453 in 2010. CMS imposed a moratorium on new HHA enrollment on the Chicago, Dallas, Detroit, Houston, Miami-Dade, and Fort Lauderdale areas effective July 2013, determining these areas to have a high risk of fraud. The moratorium has since been expanded to include all of Florida, Illinois, Michigan, and Texas. As a result, the growth in the number of HHAs has slowed, increasing just 2.1% compounded annually from 12,199 in 2011 to 12,461 in 2014.

The number of HSPAs increased 1.7% compounded annually from 3,250 in 2000 to 4,092 in 2014. During the same time period, the number of Medicare hospice beneficiaries increased 6.7% compounded annually to approximately 1.3 million beneficiaries in 2014.

With the capital costs and regulatory pressure on LTACHs and IRFs, as well as the continued shift toward lower cost outpatient settings, M&A volume for HHAs and HSPAs has increased. This trend can be seen in the portfolios of public post-acute providers Kindred Healthcare (KND), HealthSouth (HS), Select Medical Corp. (SMC), LHC Group (LHC), and Amedisys, Inc. (AMED). Of facilities owned by these companies from 2013 to 2016, the total number of LTACHs has decreased (11.8%), the total number of IRFs has increased (30.9%), the total number of...
HHAs has increased (52.8%), and the total number of HSPAs has increased (130.4%).

### Table 6: Public Post-Acute Providers

<table>
<thead>
<tr>
<th>Year</th>
<th>HHAs</th>
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<th>LTACHs</th>
<th>IRFs</th>
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<td>1,274</td>
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Kindred acquired 74 HHAs and seven HSPAs from the Arkansas Department of Health in June 2016 for $39 million and an implied TEV/TTM Revenue multiple of 0.7x. Kindred also acquired several more HHAs and HSPAs throughout the year. In February 2016, Amedisys acquired Associated Home Care and its eight HHAs for $38.1 million, of which $10.1 million is contingent on 5-year EBITDA thresholds, and an implied TEV/TTM Revenue multiple of 0.95x. Amedisys acquired three other HHAs in 2016. In March 2016, Compassus, Inc. acquired the majority of Genesis Healthcare, Inc’s HHA and HSPA operations for $84 million, with an implied TEV/TTM EBITDA multiple of 9.3x. Finally, in January 2017, Almost Family Inc. completed its acquisition of an 80% interest in CHS’ 74 home health and 15 hospice locations for $128 million and an implied TEV/TTM EBITDA multiple of approximately 6.5x (including full run-rate synergies).

Private equity buyers were active as well with Blue Wolf Capital Partners LLC acquiring National Home Health Care Corp. in March 2016 for $103 million and acquiring Great Lakes Caring Home Health and Hospice in November 2016. Bain Capital Private Equity virtually built a home health platform overnight, acquiring Epic Health Services, Inc. in December 2016 for $950 million and Pediatric Services of America, Inc. in January 2017.

Through 2016, CMS released the final Prospective Payment System (PPS) payment and policy changes for each of the post-acute verticals. CMS increased the LTACH PPS standard federal payment rate by 1.75%, increased the IRF base reimbursement rate by 1.49%, increased the HHA payment rate by 2.5%, and increased the HSPA payment rate by 2.1% for 2017.

Given the capital requirements and regulatory pressure on LTACHs and IRFs, VMG expects M&A volume in post-acute to continue to focus on HHAs and HSPAs. The fragmented status of both the HHA and HSPA industries has left plenty of room for continued consolidation. Value-based payment and alternative payment models will continue to pressure health systems to reduce hospital readmissions and direct patients to more cost-effective settings across the post-acute vertical.

### Conclusion

Driven by regulatory changes, VMG expects the health care industry as a whole to continue the push towards increasing service offerings, decreasing cost while improving quality, and taking advantage of economies of scale. The decision by health care entities to enter into transactions of any size will be one that is heavily scrutinized by regulators and stakeholders. Federal and state statutes generally provide that pricing in health care transactions should consider the Fair Market Value (FMV) of the transferred business or asset. Along with hiring an experienced health care transaction attorney, securing an experienced health care financial advisor to perform a fair market value analysis can be a critical part of the due diligence process for any transaction.

### Sources
1. Center for Medicare and Medicaid Services
2. Envision Healthcare Corporation’s Presentation at 35th Annual JP Morgan Healthcare Conference
3. S&P Capital IQ
4. Medicare Payment Advisory Commission
6. Urgent Care Association of America, 2016 Benchmarking Report
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The topic of goodwill in a physician practice acquisition continues to be hotly debated. There are very different viewpoints on how to value physician practices and whether hospitals can pay for goodwill in an acquisition. It is not uncommon to hear those in the health industry say "Hospitals can't pay for goodwill" or "Our system has a rule that we don't pay for goodwill in physician practice acquisitions." However, there is no legal or financial reason why goodwill cannot be considered in a physician practice acquisition. In fact, paying for goodwill upfront can often be financially beneficial for the hospital rather than paying increased compensation over a longer period of time.

In negotiations, physicians receive value either through the upfront purchase price or through ongoing compensation, with hospitals often putting more value into the latter. However, goodwill and other intangible assets such as workforce-in-place, patient visits, systems, etc. drive practice earnings.

Payment for goodwill that was built over time is very different than payment that might be construed as paying for current or future referrals to a hospital. In addition, paying for goodwill in the purchase price can have cash flow and tax benefits for both the buyer and seller.

**Historical Trends in Physician Practices and Acquisitions**

To better frame up the discussion over goodwill, it’s important to understand the trends in physician practice transactions and how we arrived at our current state.

Prior to the 1980s, the number of physicians numbered around 150 per 10,000 people. They could simply “hang up a shingle” thanks to overwhelming demand and a limited supply of physicians. "Acquiring" a physician practice was not a common event because practices were not up for sale.

By 1985, the number of physicians grew to more than 240 per 10,000. In fact, the physician population grew three and a half times faster than the general population from 1960 to 1988. As the supply of physicians increased, it generated a greater interest in acquiring practices—and the practice's goodwill—instead of starting from scratch because of the lower costs associated with acquisition. In fact, many physicians today very likely paid for a practice's goodwill when they initially acquired the practice.

In 1990, concern over increasing health care costs grew, as did discussions regarding health care regulation. Physician practice organizations (PPOs) and health maintenance organizations (HMOs) developed rapidly, and the acquisition of physician practices increased along with their price tags. As the demand for acquisition grew, so did their fair market value.

In the early 2000s, utilization and health care costs grew rapidly. Questions arose about whether the acquisition of physician practices were at least partly responsible for rising costs. In addition, regulators called into question whether payment for goodwill was actually payment for current and/or future referrals, so health systems and their legal counsel began scrutinizing the dollar amount attached to the purchase of goodwill in acquisition transactions. However, this concern was discounted by many appraisers and legal counsel due to the low correlation between purchase price and referrals. No regulations were implemented indicating goodwill could not be paid when acquiring a physician practice.

The concept that goodwill cannot be paid for when acquiring a physician practice is still discussed and debated today. Acquisition demand remains high, physicians’ expectations about the value of their practices has not gone down, and buyers are increasingly using other ways to structure acquisitions. To get a deal done, more value is being placed on the physicians by way of compensation rather than the purchase price attached to the acquisition of the business. While such an arrangement does not often change the overall amount of cash going to the physician, it does change how and when the physician is paid. Further, the payment is no longer called “goodwill,” even though the payment is likely based on or related to the “goodwill” a physician has developed for the practice, her recurring patient base, the practice's systems and workforce in place, and the overall success of the practice.
Regulations and the Effect on Physician Practice Transactions

Much of how goodwill is viewed or perceived in the context of physician practice transactions relates to the Stark and Anti-Kickback regulations, as well as interpretations of what is considered payment for referrals in acquisitions.

The federal physician self-referral law, or Stark Law 1, was passed in 1989. It prohibits physician referrals for designated health services for Medicare and Medicaid patients if a physician has a financial relationship with the entity, unless the payment is at fair market value and compensation is established in advance, not determined based on volume or value of referrals.

Stark specifically prohibits hospitals from directly compensating physicians for labs or other procedures performed at the hospital. However, if a physician is employed by the hospital and her compensation is not directly based on the volume of labs, the physician is not in violation of the Stark Law. If a physician refers business to a hospital and the hospital later acquires the physician, the purchase price is not tied to income related to those referrals and thus the value would not be in violation of the Stark Law. The Stark Law does not state that goodwill cannot be paid for in a physician practice acquisition, and if the purchase price is not tied to referrals or revenue generated at the hospital, acquisition of the practice and its goodwill would not be in violation of the Stark Law.

The Anti-Kickback Statute, which is often referenced when determining the fair market value of an acquisition, prohibits the knowing and willful offer, payment, solicitation, or receipt of remuneration to induce or reward referrals of services reimbursable by a federal health care program such as Medicare or Medicaid. The Statute does not state that a hospital cannot pay for goodwill. In fact, goodwill is often part of the fair market value for both health care and non-health care-related businesses. However, if payment for services or payment for the acquisition is above fair market value, the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services may assume the payment was made to induce referrals and could be considered to be a violation of the Anti-Kickback Statute.

Arrangements between hospitals and physician practices must also be commercially reasonable, an element of key compensation exceptions to the Stark Law that differs from the concept of fair market value. An agreement is considered commercially reasonable if:

- It makes good business sense (i.e., the agreement is a sensible, prudent business agreement from the perspective of the parties),
- Any entity would be willing to enter into the same agreement absent potential referrals,
- The purchase price is set at fair market value, and
- The acquisition is one that a prudent investor would make, understanding the investment options of purchasing a practice or building the practice from scratch.

The commercially reasonable concept is a market-based concept that should consider historical trends in transactions between other buyers and sellers, without factoring in referrals. In looking at historical trends for physician practices that were not purchased by hospitals, the commercially reasonable concept would not preclude a hospital from paying for goodwill when acquiring a physician practice.

These federal regulations were implemented in large part due to growing concern over the rapidly increasing costs and utilization of health care, with the main question that was often at the forefront being: did these acquisitions by hospitals of physician practices create incentives to increase the volume of services being performed (lab, X-ray, etc.), thereby increasing the price of those services?

It is the author’s opinion that paying for goodwill upfront, not tied to any specific hospital service, has less correlation to referrals and the volume of services rendered than compensating a physician based on her work relative value units (RVUs). Based on recent Stark violations, the OIG agrees.

Since 2010, Stark violations relating to physicians’ compensation have become more prevalent. In fiscal 2016 alone, three health systems paid a total of over $450 million to settle claims involving illegal compensation construed as payment for referrals.

With the increased scrutiny being placed on compensation, health systems need to carefully look at physician compensation arrangements to ensure they are set at fair market value and cannot be construed as payment for referrals. If physicians of a practice are generating compensation above fair market value, the purchase price offered by the hospital would likely need to be higher to compensate the physicians for the lower expected future annual compensation in order to stay within fair market value parameters for both the compensation and purchase price.

The concept of making less in compensation as an employee than as an owner of a practice is commercially reasonable and consistent with nonregulated transactions and independent practices. Oftentimes, business owners understand their compensation will be lower after they sell, but they also understand that the purchase price paid to them will factor in this compensation reduction. Hospitals may need to look at different ways of structuring a Stark-compliant transaction that takes into consideration value for goodwill if they want to increase their service capabilities by growing through acquisitions. Structuring transactions by putting more value into the purchase price versus increasing future compensation may be more enticing for certain physicians.

Other buyers entering the market now include private equity firms, practice consolidators, and insurance companies, which are in a unique position to understand the concept of goodwill and therefore more likely to offer attractive deals to physicians interested in selling their business. To compete with these other buyers, hospitals will need to treat goodwill as a potential part of any physician practice acquisition.

Fair Market Value (FMV): Breaking It Down

As we look to support a price between a hospital and a physician that reflects fair market value, it is important to understand what it is. Fair Market Value, as defined by the Internal Revenue Service (IRS) is:

“The price at which the property would change hands between a willing buyer and a willing seller when the former
is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of relevant facts." --Revenue Ruling 59-60 The definition of FMV is very similar under Stark, but the concept of “compulsion” is replaced with the concept of “referrals” or the ability to “generate business for the acquiring party.”

In most business situations, FMV is arrived at by a buyer and a seller negotiating a reasonable price that meets both parties’ expectations. Normally, the seller wants to sell at the highest price possible, and the buyer wants to pay the lowest price possible. As they negotiate, they arrive at a price that is agreeable to both of them—this price is what would be considered “fair market value.” For healthcare transactions, appraisers often get involved in setting the price to ensure referrals are not factored into the purchase price. An appraiser’s FMV determination should still be the same as what the buyer and seller would otherwise negotiate, without factoring in referrals.

To arrive at the FMV, appraisers will use the cost, income, and market approaches to value. However, many appraisers have very different ideas on which methods are most appropriate for calculating FMV, and these approaches may yield very different results. It is the appraiser’s job to put herself in the buyer’s shoes, as well as that of the seller’s, and arrive at a value that is agreeable to both parties, without compulsion to buy or sell and without consideration for value or volume of referrals. To do so, consideration should be given to 1) the price that is paid between willing buyers and willing sellers who do not refer business and 2) the economics of the deal to both the buyer and the seller.

Part of the consideration buyers look at is how much it would cost to buy versus build a practice to generate the same cash flow. These considerations can be reviewed with the market and cost approaches to value. The income approach is important as well, but may consider the income with and without the practice without factoring referrals into the equation. In the cost approach, it may be difficult to consider all the costs it would take to start a practice. However, a key value of a practice is the workforce in place, including the physicians, mid-level employees, and non-providers. The workforce in place is represented by a calculated value based on the time it would take each existing employee to interview, train, and ramp up to his or her current productivity. This could also be calculated by estimating the net loss a provider generates as the provider ramps up to full productivity—a loss that a buyer would not have to incur when buying a practice that is already productive.

Value for workforce in place supports the value for goodwill because assigning value for workforce in place is treated as goodwill for financial reporting purposes under the Generally Accepted Accounting Principles (GAAP) fair value standards.

By performing the three approaches, it is the author’s opinion as an experienced appraiser of healthcare practices and one who has prepared many valuations of physician practices using the methods above that paying for goodwill and intangible assets in a physician practice acquisition is supportable as fair market value and is commercially reasonable.

Goodwill in Physician Practices

That other small businesses pay for goodwill further supports the notion that paying for goodwill when acquiring a physician practice should not be construed as payment for referrals. Following are some key points that support this position:

- In small businesses of similar size to a physician practice generating comparable income to the owner, goodwill is often paid (even though all of the compensation goes to the owner) as it does in a physician practice. Interestingly, of the 259 asset purchase transactions recorded in the online database Pratt’s Stats, with $1 million to $5 million in sales and discretionary earnings of less than $200,000, over 80% had intangible assets and goodwill in the purchase price. (Pratt’s Stats Database, Business Valuation Resources, www.bvresources.com/products/pratts-stats)
- Health care practices that are not being purchased by hospitals and are not concerned with Stark and Anti-Kickback regulations—specialty practices such as dental, optometry, therapy, and chiropractic which continue to have many transactions between practitioners—continue to receive payment for goodwill.
- Prior to hospitals getting involved in physician acquisitions, payment for goodwill in a physician practice in the 1990s was very common, as evidenced by the transactions recorded in the Goodwill Registry, a publication by Health Care Group, Inc. The Goodwill Registry includes information on the prices and goodwill paid to acquire physician practices, and contains over 10,000 transactions, with more than 5,000 involving primary and secondary physician practices as well as dental, therapy, and ambulatory surgery center transactions. (Goodwill Registry published by The Health Care Group)

Paying for Goodwill is a Smart Move

Goodwill can be supported through reviewing past transactions of physician practices not involving hospitals, small business transactions, and practice transactions in which referrals are not applicable.

While a number of Stark legal cases involving health care facilities and fair market value exist, the large majority do not relate to the purchase price or goodwill but rather, are related to the physician’s annual compensation. Tying compensation to production has historically created more scrutiny by regulators than payment for goodwill in the acquisition price (i.e., paying for what was built in the practice, not referrals). Less concern should therefore be focused on goodwill in the purchase price.

Paying for goodwill when acquiring a physician practice, if structured under FMV standards, is not paying for referrals. Physician practice buyers will agree that the true value of a practice lies not in the tangible assets (desks, exam tables, supplies), but in the intangible assets—patient relationships, a trained workforce, the patient base, systems in place, location, and having an established practice—because these are what drive income. Value should therefore be placed on the assets that create the most value to the buyer.

Paying for goodwill also may cost the buyer less in the long run. Following are examples of how paying for goodwill can
save a hospital money over time. The examples compare the total cash flow after 10 years when a buyer paid goodwill in a purchase price (paid $300,000 versus $150,000) versus when the buyer paid for the value in the form of compensation (year one compensation of $275,000 versus $230,000):

**Example 1: Payment for Goodwill vs. Payment through Compensation**

<table>
<thead>
<tr>
<th>Scenario A (No goodwill):</th>
<th>Scenario B (Pay goodwill):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase price: $150,000</td>
<td>Purchase price: $300,000</td>
</tr>
<tr>
<td>Compensation year one: $275,000</td>
<td>Compensation year one: $230,000</td>
</tr>
<tr>
<td>Total payments after 10 years: $2,900,000</td>
<td>Total payments after 10 years: $2,600,000</td>
</tr>
</tbody>
</table>

With the example above, the hospital buyer ends up paying $300,000 less in cash by paying more upfront and less in the ongoing compensation. In addition, setting compensation at a level that is higher than compensation for other physicians in a comparable field often can create future issues should other physicians expect to be compensated at the same level, which could make for a much greater difference in the total cash outlay.

Paying for goodwill upfront can ultimately save money for the hospital buyer by decreasing overall physician compensation, which tends to increase over time and sets the expectation for other physicians’ compensation. This obvious cost savings is the reason many buyers should seriously consider paying for goodwill and other valuable intangible assets upfront versus paying for goodwill through ongoing compensations to the physicians.

**Positive Tax Implications if Goodwill is Part of the Transaction**

Future compensation and tax paid on the sale are also considerations for buyers and sellers. Even if the pretax proceeds are the same, the tax paid over 10 years can be very different, which can factor into the decision to buy or sell. Tax implications are so important to buyers and sellers that these implications can derail a transaction if not structured in a reasonable way. There are positive tax implications for the seller if a transaction includes an allocation to goodwill. Any gain or loss allocated to goodwill is taxed at capital gains rates, and compensation would be taxed at ordinary income rates. Ordinary income rates can be twice as much as capital gains rates.

Following are the highest individual federal tax rates applicable to different categories of purchase price:

- Ordinary income (W2 compensation): 39.6% for married filing jointly
- Capital gains (goodwill): 20%

Following is an example of how structuring a transaction can affect the overall net cash received by a seller:

**Example 2: Tax Implications**

**Scenario 1:**

<table>
<thead>
<tr>
<th>Practice purchase</th>
<th>Scenario 1</th>
<th>Estimated Tax rate</th>
<th>Estimated Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangible Assets</td>
<td>150,000</td>
<td>39.60%</td>
<td>59,400</td>
</tr>
<tr>
<td>Goodwill intangibles</td>
<td>-</td>
<td>20%</td>
<td>-</td>
</tr>
<tr>
<td>Total Purchase price</td>
<td>150,000</td>
<td></td>
<td>59,400</td>
</tr>
<tr>
<td>Annual compensation</td>
<td>275,000</td>
<td>39.6%</td>
<td>108,900</td>
</tr>
<tr>
<td>10 Years</td>
<td>2,750,000</td>
<td></td>
<td>1,089,000</td>
</tr>
<tr>
<td>Total</td>
<td>2,900,000</td>
<td></td>
<td>1,148,400</td>
</tr>
<tr>
<td>Net Total Proceeds</td>
<td>1,751,600</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scenario 2:**

<table>
<thead>
<tr>
<th>Practice purchase</th>
<th>Scenario 1</th>
<th>Estimated Tax rate</th>
<th>Estimated Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangible Assets</td>
<td>150,000</td>
<td>39.60%</td>
<td>59,400</td>
</tr>
<tr>
<td>Goodwill intangibles</td>
<td>150,000</td>
<td>20%</td>
<td>30,000</td>
</tr>
<tr>
<td>Total Purchase price</td>
<td>300,000</td>
<td></td>
<td>89,400</td>
</tr>
<tr>
<td>Annual compensation</td>
<td>260,000</td>
<td>39.6%</td>
<td>102,960</td>
</tr>
<tr>
<td>10 Years</td>
<td>2,600,000</td>
<td></td>
<td>1,029,600</td>
</tr>
<tr>
<td>Total</td>
<td>2,900,000</td>
<td></td>
<td>1,089,000</td>
</tr>
<tr>
<td>Net Total Proceeds</td>
<td>1,721,600</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Scenario 2, although the pretax receipts were the same at $2.9 million, the tax paid in Scenario 1 was $30,000 more than in Scenario 2. For physicians, $30,000 can make a significant difference in their decision to sell or not sell.

**Goodwill Should Not Be a Dirty Word**

Paying for and characterizing goodwill in a transaction is legal and can be beneficial to both parties. While not all acquisitions warrant value for goodwill, goodwill should be considered as part of the transaction if the practice’s characteristics justify it. The same considerations that are factored into any small business under FMV standards should be factored into the valuation of a physician practice being acquired by a health system. By assigning value for goodwill in a transaction, physicians receive value for something they’ve built, and health systems may pay less overall in the long run.

*If you would like to discuss this article, visit me at the Wipfli Exhibit Table at AHLA’s 2017 Health Care Transactions Conference.*
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