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Up Front
4  The President’s Perspective
5  Executive View
6  Comments from Capitol Hill

Feature
8  Physician-Owned Hospitals Continued Financial Viability
12  Do Mandated Growth Restrictions Destroy Physician Owned Hospital Value?

In Depth
16  Beyond Ownership – Improving Your Bottom Line Through Internal Enhancement
20  Group Purchasing Organizations Will Help Your Bottom Line

PHA Profiles
22  Physician Profile: Robert Sewell, MD, FACS
26  Hospital Profile: The NeuroMedical Center Surgical Hospital, Baton Rouge, La.
30  Clinical Profile: Oh No, OSHA!!
33  Corporate Profile: Jani-King International, Inc.

New on the Scene
34  Methodist McKinney Hospital – McKinney, Texas

News & Views
35  PHA News in Brief
36  May 2010 Conference in Dallas a Success
36  Buyers Guide
The President’s Perspective
A Shift of Focus, a Change of Strategies

It has been extremely satisfying and interesting to see how the physician hospital industry has responded to the legislative blow that was received via the Orwellian titled Patient Protection and Affordable Care Act (PPACA), signed into law in March.

While many industries would have consigned themselves to their grim new fate, physician hospitals have come alive with a renewed determination to do what’s right for patients, physicians and our communities.

Only six weeks after passage of the bill, PHA hosted a very well attended conference in Dallas, TX with a theme of “next steps for physician owned hospitals”. Far from giving up the fight, attendees were energized with information about how to wage the old war against competition on new fronts and with new tactics.

Conference topics included:
• Alternative physician ownership structures
• Shaping the regulatory interpretation of PPACA
• Opportunities for legal challenges
• Bolstering political alliances and working for repeal

The diverse array of new strategies shared one core concept; that physician governance and control is essential to providing superior hospital care.

Putting strategy into action, on June 3 PHA and PHA member Texas Spine and Joint Hospital (TSJH) responded to PPACA in a big way by filing suit in federal district court in Tyler, TX. There are three claims upon which the suit is filed: first, that the physician hospital language in PPACA is a constitutional violation of due process; second, that it violates constitutional equal protection rights; and third, that the language is void as it is contradictory, vague and arbitrary. While technically the suit applies only to the Eastern District of Texas, we hope that a successful judicial outcome will be used as a legal platform to bring relief to the scores of physician hospitals under development that will be devastated by the new law.

PHA and its members have responded to an unjust law the same way we run our hospitals, with intelligence, passion and determination. We are here to make healthcare better and we are here to stay.

This is my last President’s Perspective piece for the PHA Pulse, as my two-year term as president of PHA comes to a close at our upcoming annual conference in San Francisco. It has been a pleasure and a challenge to lead a fantastic organization through very turbulent times. I have been honored to work with our board and Molly Sandvig, our amazing executive director who has championed the cause of physician hospitals tirelessly for more than 5 years. Molly and her staff share our dedication to physician hospitals and have fought fiercely in their defense.

I turn over the helm of PHA to the capable hands of president-elect Dr. Michael Russell from Tyler, TX. A long time board member, Dr. Russell is an articulate spokesman for our industry and is extremely active in political advocacy efforts to secure a successful future for physician hospitals. In addition, Dr. Russell was instrumental in bringing Texas Spine and Joint Hospital to our recently filed lawsuit as an essential co-plaintiff.

Thanks for an interesting and memorable two years! To better healthcare. All the best, Brett.

Brett Gosney
President, Physician Hospitals of America
CEO, Animas Surgical Hospital
As we are all quite well aware, the Patient Protection and Affordable Care Act (PPACA) has of course, passed in all its glory and surrounding regalia. Questions, clarifications, and general regulation surrounding the Act will be ongoing for months and years to come. And, depending upon the outcome of the elections this November as well as several recently filed lawsuits, substantial modification of the PPACA continues to be a very real possibility. Through this time of uncertainty, PHA is taking the fight for physician ownership and governance of hospitals to the streets and endeavoring to provide both long-term and short-term continued benefits for our members.

After hosting a positive and well-attended event this May in Dallas, Texas, PHA has turned its attention toward a series of new and continued projects to support and propel physician hospitals in months and years to come:

• Physician Hospitals of America and the Texas Spine and Joint Hospital (TSJH) vs. Kathleen Sebelius… On June 3, 2010, PHA and TSJH filed a joint lawsuit in the Eastern District of Texas, Tyler Division against the Department of Health and Human Services. PHA’s member hospital, TSJH, is located in Tyler and was barred by Section 6001 of the new law from pursuing a $37 million zoning-approved facility expansion. The suit alleges that the government violated plaintiffs’ rights to due process and equal protection as guaranteed by the Fifth Amendment, and also that the law is void because it is too vague to be enforced as passed. Plaintiffs’ due process allegation has two branches. We argue that it was unreasonable for Congress to halt retroactively the development or expansion of physician-owned Medicare facilities when these could have been grandfathered by the government, as expansions were during the moratorium instituted by the government during the 2003 - 2005 study of the impact of certain physician-owned specialty hospitals. We also contend it was arbitrary and irrational for government to target for adverse treatment only those facilities owned by doctors, and that the private political motives that prompted this are not a legitimate public purpose. Plaintiffs’ equal protection claim asserts the Congress unfairly burdened physician-owned hospitals with competition-killing strictures that benefit competitors, even though competitor nonphysician-owned hospitals are similarly-situated in the marketplace.

The case has been assigned to District Judge Michael Schneider, a former elected Republican member of the Texas Supreme Court. Judge Schneider has set the fastest possible path for this injunction case through his court. Motion briefs are due in August, and oral argument will take place September 29th. Judge Schneider could decide the case just after that, or conclude that there needs to a trial later in the year in order to resolve any remaining factual issues. No matter which side wins in District Court, an appeal to the Fifth Circuit court of appeals is anticipated.

PHA member hospitals may want to press for compensation on the grounds that stalled Medicare facility developments or expansions have caused physician-owned hospitals to lose substantial sums of money without just compensation, and that damages are required by the Constitution in such “taking” of private property situations. Please contact PHA’s lead counsel Scott Oostdyk at McGuireWoods as soon as possible if your hospital is in this position (soostdyk@mcguirewoods.com; 804-775-4743). In addition to being able to advise you on the prospect of recourse to get your investment back, Scott needs to know this information for purposes of upcoming PHA filings in the Texas litigation. We will apprise you of material developments in the litigation as they occur.

• PHA 10th Annual Conference and Exhibits, September 22-24th in San Francisco… PHA is full of activity finalizing the details surrounding what is sure to be a constructive, valuable and enjoyable event. Set at a beautiful property near the wharf in San Francisco, this year’s event will begin on Wednesday evening with Fred Lee, an entertaining speaker focused on hospital leadership Disney-style. We’ll then move into a full day of practical track sessions focused on physician hospital specific clinical, business/financial, long-term planning, and legal/public relations topics. Friday morning will provide a combination political and legal PHA update with Canadian physician, Dr. David Gratzer, providing his no-nonsense insight into

(continued on page 7)
Comments from Capitol Hill

The Swamy Speaks – Randy’s Top 10 Healthcare Dilemmas

One would think that the enactment of health reform would take all health care matters off the Congressional agenda, but nothing could be further from the truth. The massive new health reform law did not address a number of important issues and its very existence raises a whole new series of questions that will come home to roost sooner or later. These problems will go straight to the Congressional agenda. Even though the law is written in such a way to postpone some of these questions, political debate has no timetable, so we can expect to see demands for answers even before provisions are implemented. The outcome of the fall Congressional elections will certainly affect the agenda and how Congress approaches some of the issues.

Since making lists is a national pastime, I have decided to make my own, very personal and idiosyncratic, list of the top ten items Congress, and the Administration, need to pay attention to between now and the Presidential election. Since it is my own list, and only a list, I don’t have to answer my questions, but if anyone wants to ask me off these pages (PHA only gives me so much space), I would be happy to give my opinions.

1. Physician Hospitals. Enactment of the restrictions on physician ownership is democracy at its worst, where a powerful majority harms a weaker minority, with no proof of wrongdoing. Congress does not need to rescue community hospitals from the limited competition provided in certain communities by physician owned facilities. It is a shameful act and needs to be fixed. Legislation to fix the law has already been introduced in the House by Congressman Doc Hastings (R-WA).

2. Medicare Physician Payments. The debate over SGR is officially a mess. The issue has been talked to death without any resolution, although it looks like another short term fix may be close to completion. It might help if all the stakeholders stepped back and looked at the broader picture of how physicians get paid by Medicare and other health plans. Health care reform could certainly push change over time, but it would help if the doctors got ahead of the curve. As painful as redesigning the payment system may be, I think it is the only way to get this perennial issue off the table. If this can’t be done by the 2012 elections, then the SGR problem will limp on for another 10 years.

3. Medicare. I am a baby boomer and will be swimming in the Medicare pool pretty soon. I think the pool is going to be very crowded and no one is going to be happy. It is probably hopelessly optimistic to think that Congress will do anything truly fundamental with the whole program in the next two years and maybe even in my lifetime. Unfortunately, health reform really doesn’t see Medicare as much more than a piggy bank for other programs. I’ve read numerous articles on where Medicare dollars go (whether to the last 6 months of life or to the 20% of beneficiaries who take up 80% of the resources). If we know where the money is being spent, why don’t we focus more attention on that problem? Giving hospitals, SNFs, home health, etc. a regular payment haircut does not get at the underlying issues of how we spend the money. And, the answer does not lie in the Dartmouth Atlas, despite the Administration’s enthusiasm for that analysis. Even if Congress and the President can’t come to grips with the issue, it needs to be on the table.

4. Medicaid. Health reform opens the doors to another 16-20 million new enrollees in this already cash-strapped program, but does nothing to make essential changes to ensure these new folks will have any better health care access than they did before the law passed. As the richest society in the world, we probably have an obligation to help those who can’t help themselves, but I think Medicaid, which will soon be larger than Medicare, is a train wreck waiting to happen. That’s not fair or right for anyone, especially the people who depend on the program for medical care. Let’s agree that we can’t spend our way out of this problem and tackle the issue head on. I think enough Governors are nervous about the expansion to bring the issue back to the next Congress.

5. Medical Research. The National Institutes of Health (NIH) is one of the nation’s crown jewels, but do we plan to make the best use of the incredible talent in the agency and funded by the agency? The appropriations process, at least in recent years, has been more of an impediment to good science than a support. We can’t ask the private sector, aka Pharma, to pick up the tab either. They have obligations they need to respect and those are not necessarily consistent with developing the best science in all areas. That is not a criticism of drug or device companies, just the realities of capitalism. So, Congress, roll up your sleeves and figure out how to fund the best basic, clinical and translational research in a manner that has some passing relationship to business and research project planning, and while you are at it, make sure NIH is paying attention. The annual appropriations process offers invitation for Congress to act, if only the legislators will accept it.

6. Public Health. Congress put a lot of money into a public health fund in health reform. If used properly, it could greatly enhance the ability of our national, state and local public health agencies to do their important work.
Historically, most of the great advances in the nation’s overall health status have come from improved public health, like safe drinking water, food safety and purity, and immunizations. However, Congress needs to keep an eye on how the money is being used to make sure it is really producing results.

7. Innovation in Medical Care. One of my big gripes about the health reform bill is that it assumes that there is only one way to expand insurance coverage. There are probably 25 and they all should be used, since it is a given that this society does not respond well to one size fits all government. Besides, we don’t really know which of the methods of expanding coverage (tax credits, for example) will really work, so more experimentation is in order. The classic anti-innovation provision is the limit on physician ownership of hospitals, followed closely by extra taxes on device companies. Protectionism, which is the issue behind the physician ownership issues, won’t work in medicine any better than it works in international trade relations. Adding costs to medical devices simply to raise money to offset other parts of the legislation doesn’t make it easier for innovators to innovate. So Congress needs to back off the restraints it has built into health reform and instead pay more attention to motivating all parties to let their creativity soar.

8. Health Quality. Congress has paid more attention to this issue in the years since the Institute of Medicine (IOM) report on unnecessary morbidity and mortality in hospitals came out. However, there is a long way to go and the needs are urgent. Fortunately, we already know a lot about improving quality, but the knowledge is poorly and unevenly applied. Instead of waiting for the programs in the PPACA to develop, Congress should accelerate this important issue.

9. Health Manpower. Expanding insurance coverage will increase the demand for health services. Who will provide the care? The health reform bill includes an entire title (Title V) on health manpower programs, but lacks a sense of urgency. There are already shortages of primary care and specialty physicians as well as other kinds of health professionals. It takes time to train people for these positions and the urgency of these shortages needs to be given more attention. Congress should revisit what has already passed, refine it and jumpstart the programs.

10. Food and Drug Administration. The important role this agency plays in the daily lives of so many people is often overlooked. Congress gave FDA authority to regulate the development of biosimilars, the biologic equivalent of generic drugs, but there are other issues within the agency that need to be addressed. This agency’s authority must be clarified, strengthened, and sufficient resources must be provided by the Administration.

Health reform gives a push to many of these issues, but more is needed. The next Congress could have a full agenda if it is willing to tackle these problems in a serious way, without the same partisan rancor that slowed the progress of the health reform legislation. That may be too much to ask for, and there is no perfect answer to any of these issues, but they are all important and require attention.

Randy Fenninger, J.D., is a Senior Policy Advisor with Holland & Knight in Washington DC, and serves as PHA’s political lobbyist on Capitol Hill.

“healthcare reform”. Friday afternoon’s track sessions are focused on future ownership models for physician hospitals, continuing physician governance, and business/IT concepts. There will also be plenty of time for fun and entertainment, with planned networking activities on Wednesday and Thursday evenings, and a beautiful boat cruise to Sausalito for dinner, Friday evening. For additional detail or to register, see our website – www.physicianhospitals.org.

• During May and June, PHA assisted in hosting two large fundraising events in support of many of our Congressional champions as well as new candidates running for office. Successful events were held in Texas for the National Republican Congressional Committee (NRCC) and the National Republican Senatorial Committee (NRSC), with members of Congress and Senators in attendance such as Congressman Pete Sessions (R-TX), Congressman Joe Barton (R-TX), Congressman Sam Johnson (R-TX) and Senator John Cornyn (R-TX). Additional events will be planned throughout the year.

• A PHA funded compensation survey is currently in progress with dozens of physician owned hospitals participating. The goal of this survey is to present up-to-date and physician hospitals relevant information on executive salaries. The results will be ready for publication by PHA and our partner surveyor, MSA HR Capital – an Integrated Healthcare Strategies Practice, on or before the Annual Conference in September. If you are interested in the results, but did not participate, please contact PHA for additional information.

• In an effort to present the latest in timely information to our hospital members, PHA is offering a new series of Webinars focused on various industry hot topics. These webinars are free of charge to PHA members and we believe, will provide you and your staff with valuable information in areas of clinical, financial and business management. Webinars will be held on the fourth Tuesday of each Month at 3:00 pm Central time. Even though each webinar will be presented by a specific company outside of PHA, prior to each webinar member hospitals will receive an invitation and webinar access instructions from PHA. At this time, we have hosted one successful webinar, with partner corporation, Gallagher Healthcare. Information on additional webinar topics will be following shortly. If you have suggestions or recommended topics, please let us know!

Now, as in the past, PHA is dedicated to bringing new and continued value to our member hospitals. Keep your eyes open for new product development, corporate business partnership, and internal projects aimed at providing the best possible service to PHA members. As always, we welcome your additional questions, recommendations and suggestions! ☏
Physician-Owned Hospitals
Continued Financial Viability

The Impact of the Patient Projection and Affordable Care Act (PPACA)

By: Richard S. Cooper, McDonald Hopkins LLC, Shawn M. Riley, McDonald Hopkins LLC, Michael R. Lane, Navigant Capital Advisors, Gregory F. Hagood, Navigant Capital Advisors

General Impact

The Patient Protection and Affordable Care Act (“PPACA”) was signed into law on March 23, 2010 and amended on March 30, 2010. The PPACA added a new subsection (the “Subsection”) containing additional requirements that hospitals must meet in order to qualify for the “whole hospital” exception under Stark and be eligible for a Medicare provider number. In particular, the Subsection (i) requires that a physician-owned hospital must have a Medicare provider agreement in effect by December 31, 2010 to be eligible to participate in Medicare; and (ii) restricts existing physician-owned hospitals from adding beds, procedure rooms, and operating rooms after March 23, 2010. The PPACA also prohibits physician-owned hospitals from increasing the percentage of physician ownership (based on value) beyond the physician ownership percentage as of March 23, 2010. The Subsection will have a lasting effect on the long-term growth and financing strategies of physician-owned hospitals.

Capital Markets Overview

The general equity and debt markets have experienced a solid rebound since their collapse at the end of 2008. The S&P 500 is up 17% since January 2009. More notably, Navigant Capital Advisors’ index of public hospital stocks is up over 150% since the beginning of 2009, as investors generally view hospitals as the primary beneficiaries of healthcare reform. HCA filed to go public in May 2010 and other privately held hospital companies are expected to follow. In addition, private equity firms and traditional banks have been actively pursuing new opportunities, particularly companies with stable operating histories. Finally, there are a number of well capitalized Health Care REITs that have benefited from recent regulatory changes, including the adoption of the REIT Investment Diversification and Empowerment Act structure in 2008, which are actively looking to deploy capital through sale leaseback transactions with healthcare facilities. How this market improvement will impact physician-owned hospitals in general, is yet to be seen; however it is likely that the market will not be as robust for many physician-owned hospitals. The size of many physician-owned hospitals (markets are less robust for entities with EBIDTA smaller than $15 million) and the limitations imposed by the PPACA will dampen investor enthusiasm.

Key Issues Confronting Physician-Owned Hospitals

The Subsection places a practical limit on a hospital’s ability to gain additional capital through additional physician investors. The hospital may be required to buy-out existing physician interests so the ownership percentage does not increase or match it with non-physician capital, thus diluting individual investment percentages.

Because of this, hospitals need to look to other sources for financing. Sources of debt and capital are significantly concerned about the financial and competitive impact of the PPACA on physician-owned hospitals.

Principal concerns include:

• Impact on an overall investor exit strategy;
• Impact of the PPACA on obtaining additional physician capital;
• Loss of physicians and key employees due to concern about a facility’s future;
• Lack of flexibility to respond to market changes (such as ability to acquire or merge with other facilities);
• Impact of restrictions on growth and a facility’s ability to compete;
• Concern that other payors or states will follow the PPACA by imposing similar or additional burdens on physician-owned hospitals; and
• Concern that key vendors will materially alter business relationships with hospitals due to concerns about long-term viability.

Access to capital will become more difficult for many physician-owned hospitals, not only when obtaining new debt and capital, but also in maintaining existing debt and capital. Financing sources will reevaluate lending and investing polices to account for the impact of the PPACA. They may seek material changes in the terms and conditions of current
arrangements to account for increased risk, potential for decreased investment returns, and lack of a clear cut exit strategy. The inability to guarantee or clearly understand the impact of the PPACA will likely result in financing sources taking an even greater conservative posture. Debt sources will need to be convinced that a loan is secure over its term. Equity sources will want to feel that their investment is secure and will result in an acceptable rate of return compared to other investment opportunities, and that the investment will carry a meaningful opportunity for a “take-out” event.

Other existing market challenges remain:
• Increased regional consolidation of hospitals and integration of physician practices, resulting in changes to referral patterns and relationships with managed care payors;
• The potential for reductions in reimbursement from payors and dollars from federal, state, and even local grants and subsidies; and
• Requirements to invest considerable capital for infrastructure upgrades, such as EMR or acquisition of the technology to remain competitive.

Assessment of the Impact of the PPACA

A hospital should immediately assess the financial and strategic impact of the PPACA. The assessment should be realistic, detailed and well supported. The financial and competitive forecast for the facility will determine its course of action with all stakeholders. Hospitals should consider utilizing outside assistance to provide an objective and independent analysis of the situation. The analysis should identify strategic alternatives given the nature and magnitude of the impact of the PPACA. A hospital should carefully review and understand the implications of its legal commitments to lenders, investors and other stakeholders. A thorough review of financing documents and understanding when and to what extent it may be non-compliant (such as breaching a loan covenant) and the legal and financial implications of such non-compliance will allow the hospital to make educated decisions and catch material issues before they develop. A specific plan of action should be in place to prepare the hospital for a non-compliance event and the hospital should be familiar the legal rights and remedies available to it.

If the forecast is of continued viability, the hospital will need to demonstrate its ability to operate profitably over the long term. The hospital should establish that it can compete effectively despite its inability to increase physician ownership or to expand its facility. The hospital should identify specific, appropriate cost cutting measures that can be implemented to keep costs down and improve efficiency. The hospital should also identify new sources of capital that will be needed for operations and required “take-outs”, if any.

If the determination is that the hospital will experience material financial problems, it is imperative that the hospital determine how significant those problems will be and the anticipated time frame for such problems to manifest. That will allow the hospital to determine how much time it has to identify and implement a corrective course of action.

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Alternative Sources of Capital

Alternative sources of capital include:
- Sale to a tax exempt or investor owned hospital;
- Sale-leaseback with a REIT or similarly structured transaction; or
- Investment by a fund.

Sale to Tax Exempt or Investor Owned Hospital ("TE/IO")

These types of transactions will increase in the near future. They allow a TE/IO to gain access to a state-of-the-art facility while forging valuable physician relationships within its market. A TE/IO’s desire to consummate a transaction will depend on whether it believes the hospital can remain a viable competitor in the marketplace. While many TE/IO systems remain comfortable partnering with physician owners, they often are not willing to assume the existing provider number of a hospital in order to avoid potential reimbursement related liabilities attached to the provider number. If a buyer is unwilling to assume such risk, the transaction must be structured as a new hospital and thus, all physician ownership must be eliminated because of the inability to receive a new provider number under the PPACA. The future relationship will need to be specifically defined in terms of facility capabilities, operations and governance, as well as the service and financial relationship of the hospital with both the TE/IO and other facilities of the TE/IO.

The passage of the PPACA may also result in a TE/IO offering less attractive terms than it would have prior to the PPACA due to actual or perceived changes to the viability and the leverage of physician-owned hospitals. Hospitals should consider an auction process to generate interest from multiple parties in the assets, and potentially improve the deal terms and conditions. This issue will also exist in sale-leaseback and investment fund transactions (as discussed below), so the auction mechanism should be considered in each case. Under an auction process, the hospital is free to negotiate with multiple potential buyers at the same time rather than entering into exclusive negotiations with one potential buyer. A hospital should strongly consider obtain its own valuation prior to entering into any negotiations.

Sale-Leaseback

A sale-leaseback allows a hospital to sell its hospital facility to a buyer and enter into a long term lease. The hospital is no longer the owner of the facility, but becomes a lessee of the facility and remains the operator of the hospital. This allows the physician owners to convert equity into cash, retain possession and continued use of the property for the lease term, and in most cases, secure more cash for the hospital than a conventional mortgage would.

A sale-leaseback allows the hospital to structure the initial lease period to meet its needs and is free of balloon payments, call provisions and refinancing issues. It also offers lower fees because there are no points or appraisal fees. The sale-leaseback will also provide a hospital with renewal options while conventional mortgage financing has no guarantee of refinancing. Finally, the sale-leaseback can provide the hospital with an improved balance sheet...
depending on the structure of the transaction.

A hospital should consider that a sale-leaseback will cause the hospital to lose its residual property value. Further, the hospital would have to sublease any unused property rather than selling it and the hospital may encounter issues in obtaining financing to make improvements to the property. Sale-leaseback financing comes at a higher interest cost because interest rates in sale-leasebacks are generally higher than conventional mortgage financing. Additionally, a hospital must consider capital gains tax on the sale. A hospital contemplating a sale-leaseback must seek the advice of an experienced CPA.

**Equity Funds**

Equity funds have a significant amount of money currently sitting “on the sidelines”, looking for investment opportunities. Funds will weigh level of risk, rate of return, and likelihood for an acceptable “take-out” event against other potential opportunities. Single location hospitals may not be as attractive as chains unless the fund has a well-formed roll-up strategy. Most funds are looking to invest in an established management team that will be able to successfully build a regional platform. Hospitals should be aware that the fund may insist on complete “take-out” to avoid the restrictions of the PPACA. For some hospitals, a sale to a fund will have at least some elements of a “fire sale”. Arrangements with funds also require structured, long-term arrangements regarding facility capabilities, clinical matters, management, governance, and the services and financial arrangement between the physicians and the facility.

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**McDonald Hopkins LLC** has a national practice in the representation of physician-owned hospitals, including developing strategies for dealing effectively with the impact of the PPACA. The firm has offices in Cleveland, Cape Cod, Chicago, Columbus, Detroit, Jackson Hole and West Palm Beach.

**Michael R. Lane** is the practice line leader for Navigant Capital Advisors’ Healthcare Restructuring practice.

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**Navigant Capital Advisors** is the dedicated corporate finance business unit of Navigant Consulting, Inc. Navigant Capital Advisors provides independent and objective financial advice for restructuring and turnaround situations, mergers and acquisitions, private placements, capital raising, valuations and transaction advisory services.
The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (the “Legislation”) contain controversial and well publicized regulations that significantly restrict the growth capabilities of physician owned hospitals (“POHs”). For certain POHs, including the 60 or so currently under development, this legislation could have devastating implications. For the approximately 270 existing POHs that are grandfathered and allowed to operate under the legislation, the ultimate question for the physician, hospital or corporate shareholder is: Does this legislation negatively impact the value of my POH, and if so, by what magnitude?

Although determining the cumulative effect of the Legislation in its totality, including restrictions on aggregate physician ownership and the moratorium on new development, is crucial when contemplating individual POH value, this discussion focuses exclusively on the growth restrictions levied against POHs and the impact of these restrictions on value.

Regulatory restrictions are not the only challenges confronting POHs. In recent years, other obstacles—the recession, the credit crisis, state regulations, commercial reimbursement challenges, growing levels of hospital-employed physicians, and a growing dearth of available physician recruits—have changed the landscape in which POHs operate. Undoubtedly, the passage of the Legislation will exert its influence over the entire industry. Industry participants have echoed a common concern that growth restrictions will have a negative impact on hospital valuation. While this may ring true for some, it is inaccurate to assume all POHs will be similarly impacted. It is important to dig deep into the legislation, to understand its details and to determine how the new restrictions may—or may not—influence the value of your POH.

A Valuation Primer

The value of POHs are dependent upon two major inputs: expected future cash flow and the risk of reaching and sustaining those expected cash flows. These are the same principles that form the basis of all business valuation. Let’s break these down individually:

**Future cash flow.** Will your POH’s profits grow, stagnate or decrease over time? Will you earn more or less next year? In 5 years? In 10 years? There is a direct relationship between expected cash flow (earnings, profit, or distributions) and hospital value. Present and future cash flow is a function of revenue (comprised of volume and reimbursement) less operating expenses, debt service and expected capital needs.

Those components that serve to reduce expected cash flow (i.e., operating costs) will increase in value over time due to inflationary pressures. As such, in an effort to avoid declining levels of profitability, a hospital must counter increased costs with growth in either volume, reimbursement or some combination of the two. For certain POHs, the growth restrictions resulting from healthcare reform could significantly handicap their ability to grow or sustain profits by eliminating one traditional method of revenue enhancement – volume growth. Capacity constrained hospitals must then look to enhance revenue by pursuing growth in reimbursement or by introducing new (or growing existing) ancillary service lines that do not require an expansion of beds, operating rooms or procedure rooms.

**Risk.** Risk and value are inversely related. Higher risk results in lower valuations and vice versa. In determining value, an accurate projection of expected cash flow must be coupled with an assessment of the inherent risk in reaching and sustaining those levels of cash flow. An accurate determination of risk will include an analysis of the macroeconomic environment as well as specific industry and entity-level risk factors. Examples of common risk factors are illustrated in the chart on the next page.

The growth restrictions promulgated by the subject legislation introduce significant risk. At the industry level, it is generally assumed that growth restrictions will negatively impact POHs. The theory supporting
this is that facility growth restrictions limit a POH’s growth capabilities, flexibility, and ability to compete effectively in the face of unstrained competition. However, assigning uniform levels of specific entity risk to each POH, regardless of their unique sensitivity to the Legislation, is oversimplistic and inappropriate. The impact of growth restrictions must be analyzed individually to gauge each POH’s exposure to these restrictions.

In order to analyze entity specific risks related to the growth restrictions introduced in the Legislation, we developed a systematic decision tree based on a series of questions. The results of the sequential answers to the key questions yield a sensitivity to the growth restrictions relative to other POHs. The decision tree is illustrated below.

In order to assess the specific entity risk exposure your POH has related to the Legislation, it is important to address the following two overriding questions:

1. Is your POH presently or expected to have capacity constraints with respect to patient beds, operating rooms or procedure rooms?
   When analyzing the impact that growth restrictions may have on a particular POH, the logical first step is to identify if your exposure is immediate or long-term. While facilities often choose to operate at, or near capacity for efficiency purposes, this also serves to reduce the hospital’s flexibility in meeting market or physician demand. Persistent capacity issues can lead to significant challenges including:
   • Diminished patient / physician satisfaction due to an overcrowded patient environment and inability to accommodate physician / patient schedules
   • Difficulty in recruiting new physicians due to limited preferred block times
   • Inability to meet the demands of a growing market
   • Decreased flexibility in responding to competitive threats

2. Will current or future capacity constraints threaten market share or profitability?
   Often, the flexibility to implement long term expansion plans serves as a buffer against competition and capital expansion in the local marketplace. More nimble competitors that lack growth restrictions may be more adequately suited to pursue expansion plans to better serve marketplace demand. In other markets, growth restrictions may not significantly hamper a POH’s ability to compete effectively and sustain or grow market share. Such markets include those with stable population bases and an established, passive healthcare provider market.
An Illustration of the Extremes

Certain POHs will be severely impacted by the Legislation. These are those that have immediate capacity constraints, rising costs, and competition that threatens market share. On the other extreme, POHs with no capacity constraints may also have no existing or optimal plans to expand, creating an environment with little to no specific entity risk related to the Legislation. In order to illustrate the discrepancy to which two separate POHs can be impacted, let’s look at two extreme scenarios.

Example #1 provides results to the series of questions that yield a low specific entity risk. Example #2 provides results that are uniformly “Yes”, which results in a severe indication of specific entity risk. For the overwhelming majority of POHs, specific entity risk related to the Legislation growth restrictions will not fall at either extreme but rather yield a moderate specific entity risk profile.

Summary

Each POH will be uniquely impacted by the growth restrictions introduced by the Legislation. Whether or not the new regulations affect the value of your POH depends on the specific dynamics of your hospital and the likely impact on current and expected cash flows. The capacity requirements, competitive environment and strategic positioning of each POH are unique. As such, a broad based determination of the impact of growth restrictions on the POH industry as a whole is inadequate. To understand the effects of the regulations on the value of your POH, it is important to properly assess risk at the specific entity, as opposed to industry-wide level.

Only a current, honest assessment of value will allow for hospital management to plan appropriately for the future and create an environment where value can be maximized for shareholders under the new restrictions. ♦

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**Elliott Jeter** is a partner at VMG Health. He provides valuation and transaction advisor services to health care services clients in a wide variety of healthcare market segments. Mr. Jeter is a frequent speaker and has written numerous articles about emerging healthcare issues.

**Kevin McDonough** is a senior manager at VMG Health. He provides the firm’s clients with a broad range of services including valuation, transaction advisory, feasibility and operational consulting.

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### Specific Entity Risk Example

<table>
<thead>
<tr>
<th>Example Hospital</th>
<th>#1</th>
<th>#2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Bed/OR Capacity?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Expected Future Bed/OR Capacity?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Does Capacity Threaten Market Share?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Does Capacity Threaten Profitability?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Location in a Growing Market?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Location in a Highly Competitive Market?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Profile:</td>
<td>Low</td>
<td>Severe</td>
</tr>
</tbody>
</table>

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Beyond Ownership – Improving Your Bottom Line Through Internal Enhancement

By Cherilyn G. Murer, JD, CRA, President/CEO, Murer Consultants

Whether in sports, politics, business or health care, few things make an organization a target quicker than success. After several years of rising profits, it is no surprise that physician-owned hospitals find themselves in the cross hairs of Congress and large community hospitals.

After a series of attempts, Congress ultimately succeeded in imposing tight restrictions on the growth and development of physician-owned hospitals. Provisions in the controversial health care reform bill signed into law by President Obama effectively prevent the expansion of existing physician-owned hospitals and prohibit the development of new facilities after this year.

Although the reform law represents a significant challenge for physician-owned hospitals, it does not spell the end. Opportunities for physician-owned hospitals to improve their bottom lines and provide services to greater numbers of patients still exist. Careful strategic planning, creative problem-solving and sound financial management will leave hospitals well-poised to thrive, even in the current regulatory environment.

Murer Consultants has long been a supporter of physician-owned hospitals, advocating that there should be no discrimination simply on the basis of ownership. Rather, a high standard of compliance, applicable to all who maintain a fiduciary responsibility for the provision of medical care to patients, should be maintained. The ownership of a facility should not be prescribed by government’s licensure and certification of a hospital; conversely, government should assure that there is consistency in enforcement of compliance standards applicable to all hospitals regardless of ownership make-up.

STRATEGIES FOR SUCCESS

Moving forward in a post-reform climate, physician-owned hospitals would be well-advised to refine internal processes and programs to maximize utilization of existing resources.

Consider the following:

• Reviewing and evaluating the hospital’s clinical mix, not only from a quantitative measure of daily census, but qualitatively as well regarding diagnostic mix and patient acuity.
• Developing and enhancing clinical competencies, assuring that such competencies support the acuity level of patients and the specialties being practiced.
• Carefully reviewing and revising capital equipment lists to ensure correlation with present and projected patient acuity and volumes.
• Reviewing and re-negotiating managed care contracts to reflect the services being provided, assuring fair market value.

Many organizations have found success in negotiating package pricing with managed care companies. A typical package may include:

• Payment for some or all of the services associated with a particular procedure or line of service, including hospital, surgeon, anesthesia, radiology, and other provider services; and
• All pre-, intra-, and postoperative care.

Negotiations will be most successful when the provider has a solid understanding of its patient population and the historical outcomes for various procedures. Providers should target well-defined procedures that are not generally subject to wide fluctuations in costs.

Organizations may also wish to consider seeking provider-based status for outpatient clinics. Securing provider-based status can yield significant benefits for health systems interested in exploring new ways to increase reimbursement, allocate costs and build partnerships across facilities and disciplines. One of the key benefits of provider-based status is to serve as

(continued on page 18)
We’re Here to Help

As physician-owned hospitals are racing to meet the deadlines for Medicare Certification, The Joint Commission will assist in every way possible to help eligible hospitals move through the process of the deemed status accreditation option.

The Centers for Medicare & Medicaid Services (CMS) require that the deeming process include an unannounced survey from an accrediting body. Once your organization is in full compliance with any findings that arise at the time of survey, a letter is sent to CMS recommending Medicare Certification if there are no condition level deficiencies identified during the survey process.

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a catalyst to ensure true and effective integration of the health system. Provider-based status can also result in lower operating costs, reduced administrative burdens, greater flexibility to finance physician practices, and more effective long-term planning at the system level.

It is also important to establish a rapport and level of comfort with Medicare administrative contractors, fiscal intermediaries and state licensing agencies. Particularly for facilities in the start-up phase and still under development, it is critical to impress upon Medicare contractors and governmental agencies the sense of urgency that exists for physician-owned hospitals. Contacts made within such organizations can serve as important allies as you move forward in securing state licensure and/or Medicare certification.

Most importantly, physician-owned hospitals must assure that their focus remains on providing the highest level of patient care possible. Health care organizations can refine internal processes, identify areas of inefficiency, eliminate waste, and assure regulatory compliance (and thus, timely reimbursement) by utilizing quality-based benchmarks.

Organizations are well-advised to implement a quality reporting structure that touches on all areas of operation. Appropriate measures could include:
- Mortality
- Acquired Infections
- Average payment per patient
- Payor mix (Medicare and Medicaid v. Managed Care)
- Cost per patient day
- Appropriate and timely documentation

Such benchmarks will provide a well-rounded snapshot of the hospital from a patient care perspective, as well as a financial perspective.

LOOKING AHEAD

In order to achieve operational and financial success while still acting in a manner consistent with the spirit of the reform legislation, physician-owned hospitals must be innovative, utilizing creative approaches to the delivery of care. With an increasing emphasis on integration of health services, organizations may avail themselves of new models that reduce administrative burdens by joining research, delivery, financing and public health mechanisms.

As physician-owned hospitals move forward with organizational decision making, it will be critical to identify and evaluate the feasibility of various proposals for growth and improvement, as well as the risk, time and financial cost associated with each option.

The future should always be viewed with optimism. With change and/or turmoil comes opportunity for revisions, enhancements and breakthroughs in structure and scientific achievement in the field of health care delivery.

Cherilyn G. Murer, J.D., C.R.A. is CEO and founder of the Murer Consultants, a legal based healthcare management consulting firm in Joliet, IL, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727-3355 or viewed on her web site: www.murer.com
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The pressure to reduce costs at hospitals has never been higher than it is today. Organizations are looking for every opportunity to reduce costs with a preference for lowering non-salary expenses over reductions in staff. A key weapon in the effort to reduce non-salary expense is the optimal use of a group purchasing organization (GPO). More than 96% of hospitals in the U.S. access at least one GPO for contracting services; however, most hospitals are not maximizing the savings opportunities available to them through their chosen GPO(s). The reasons for this lack of optimization are plentiful – focus by hospital staff on other priorities, contract information overload, difficulty in deciphering some GPO agreements, and lack of supplier support, just to name a few. Here are just four reasons of many, that now is the time to put your GPO to work on your behalf.

1. Supply Chain Cost Savings

At its core, a GPO is built to save its members money on the supplies and services they use to perform their business. The U.S. healthcare industry spends an estimated $300 billion annually in medical and non-medical supplies and it is on this portion of a healthcare institution’s cost structure that a GPO makes a significant positive impact. An April 2009 study by Dr. Eugene Schneller of Arizona State University estimated that GPOs save U.S. hospitals more than $36 billion annually, while a July 2009 study by Dr. David Goldenberg, formerly with Muse and Associates, and Rowland ‘Guy’ King, former chief actuary for the Health Care Financing Administration, found that GPOs annually save up to $64 billion. The average price savings experienced by healthcare organizations using a GPO can range between 10% and 15%.

GPOs deliver these savings by aggregating the purchasing power of many hospitals to balance the negotiating equation between purchasers and vendors. This leverage results in pricing that is more favorable for the group of hospitals than if each tried to negotiate pricing on their own. GPOs whose members show a willingness to commit to the GPO’s contract portfolio and demonstrate the ability to move product spending between suppliers often are able to command additional value from the supplier community.

2. Broad Contract Coverage

In addition to product savings, GPOs provide healthcare organizations with a wide array of contracts encompassing everything from bedpans to orthopedic implants and from food to furniture. On average, a GPO’s contract portfolio will cover about 75% of a hospital’s product needs with some GPOs covering as much as 90%.

Without the safety net of a broad GPO contract portfolio, healthcare organizations soon find themselves working to reduce costs in one product category only to find the savings going out the door as the expense of products in an unrelated category are skyrocketing. Hospitals purchase tens of thousands of items and asking a procurement department to keep tabs on market pricing, contract terms and conditions, and product supply for all those items is an impossible task with the limited resources allocated.

3. Organizational Efficiency

The phrase “doing more with less” may have never been as relevant as it is today in healthcare procurement. As some hospitals reduce purchasing staff, the need to lower supply costs is not going away. In fact, the need is growing and a GPO is able to complement and, in most cases, supplement the procurement department to assist in addressing this need.

Healthcare organizations need their staff resources focused on the initiatives that are going to bring the highest return on the resource investment. If a procurement director is spending his/her time negotiating a contract for bedpans or band-aids when that time could be spent on high-end surgical or cath lab products, the organization is not getting the most out of the resource.

Every healthcare organization has unique procurement needs whether it’s a one-time capital expansion project or a high-volume orthopedics or cardiology program. It is in these areas of high spend or unique situations where the organization’s procurement staff is best suited to tackle issues and, where necessary, negotiate custom pricing and terms and conditions. Furthermore, the procurement team often needs to focus on the logistics related to getting the right products to the end-user. These critical functions should not be interrupted by functions that a GPO can ably handle on behalf of the organization.

4. Your Watchdog and Advocate

Partnering with a GPO means having someone who constantly monitors market conditions to ensure that your organization is receiving the best price on all the products you use. Because procurement departments lack access to external pricing information, over time many organizations discover that the price they negotiated just last year is no longer very good. A GPO should serve as the watchdog over your pricing, using their view into the market to maintain the competitiveness of the contracts you utilize. Done well, this responsibility of a GPO should allow you to maintain focus on mission-critical functions of the
organization versus chasing the market on supply pricing.

Supplier disputes invariably occur and a GPO can serve as your advocate in those disputes, particularly as it relates to pricing and contract terms and conditions. Issues that cannot be resolved quickly at a local level can be turned over to the GPO to elevate to a corporate level with the supplier which often leads to a positive resolution for your organization and saves the procurement staff from having to chase down a corporate representative to resolve the problem.

In addition to the four primary benefits listed above, some GPOs provide supply chain consulting assistance along with data and information services that allow you to compare your supply costs against like-sized organizations.

**Selecting and Utilizing a GPO**

So should you utilize a GPO at your organization? The answer is unequivocally “yes”. Trying to perform all the functions of a well-established GPO is not only costly in terms of resources, but it draws vital resources away from your organization’s core competency – quality patient care.

When selecting a GPO, assess your needs and ask potential partners how they address each of them. Do you need maximum flexibility and choice of manufacturers in order to meet the requirements of your clinical staff or is your organization willing to provide a high level of commitment to the GPO and its contract portfolio in order to obtain better pricing? Do you need a GPO to merely serve as a backstop to the work your procurement team currently performs or are you looking to partner with a GPO that can act and perform as an extension of your purchasing department?

If you currently utilize a GPO, ask them to provide you with the means to optimize the value available through your partnership. Your GPO should consistently bring opportunities for cost reduction to your attention. It is the reason for their existence. Key focus areas include:

- Review and audit of your distribution agreements - medical/surgical, pharmacy, housekeeping, foodservice and diagnostic imaging
- Commodity purchases including generic pharmaceuticals
- Physician preference items – benchmark your pricing within cardiology and orthopedics versus other similar organizations
- Business service contracts – for many hospitals these outsourced services provide huge savings opportunities

Your GPO should be able to provide you with a host of savings opportunities after a review of just these four areas. Many of the opportunities provided will not require a product conversion and should be easily achievable.

A group purchasing organization should be viewed and treated by your organization as a valuable resource in your battle to contain and reduce supply chain costs. Selecting the right partner is the important first step and thoughtful consideration should be given to finding a GPO that is aligned with your goals and needs. Once you select a GPO or if you already use one, you should demand the same level of productivity and results from your partner that you do from any of the employees within your organization. Doing so will undoubtedly improve your bottom line.

As costs spiral ever higher for today’s health care organizations, sound financial management is more critical than ever. To manage expenses while improving outcomes and service levels, look to Provista for strategic supply chain solutions that deliver bottom-line results. One of the nation’s largest group purchasing organizations, Provista helps more than 13,000 acute and non-acute health care facilities reduce and control their supply costs while streamlining the procurement process.

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 потому что жизнь это не только финансовый контроль.
When I was in grade school, if someone asked me “What do you want to be when you grow up?” my answer was always the same – I’m going to be a doctor. I’m not sure where that came from with no physicians in my family; it must have been a calling. Nevertheless, it was one of those statements that once made is difficult to retract. So, my life’s course seemed set.

When driving past the new high school in Port Arthur, Texas the summer before 10th grade, I told my dad that I was going to spend the next 16 years becoming a surgeon. When you’re only 14 years old that’s an eternity. Now, pushing 60, I look back fondly on those formative years and the hopes and dreams that filled them.

After high school, I attended Lamar University in Beaumont, Texas and after three years was fortunate to be accepted at the University of Texas Medical Branch – Galveston. While medical school was a wonderful experience, I couldn't wait to get off “the island”, so when the opportunity came to graduate in three years I jumped at it. From Galveston I pursued a surgical residency at the University of Texas Health Science Center in San Antonio, Texas. I was convinced that I wanted to be a cardiac surgeon. However, shortly before completing my general surgery training, it became clear to me that cardiac surgeons were totally reliant on one procedure, coronary artery bypass. It was also clear that cardiologists were actively seeking new methods to treat their patients without surgery. This “light bulb moment” helped make my decision to remain in general surgery.

Starting my solo surgical practice in 1979 in the Dallas/Fort Worth metroplex presented an entirely different set of circumstances than most young surgeons experience today. There were no recruitment agreements, only practice startup loans. I wasn't just starting a practice, I was also starting a business – something for which I was totally unprepared. But in those days, the medical community was very collegial. The entire medical staff of the hospital gathered on a monthly basis for general staff meetings at the local Bar-B-Q place. Somebody would give a lecture on the newest antibiotic or give us a pitch for the latest “pulse oxygen monitoring gadget” that we didn't think we really needed at that time. Mostly it was a social event, and everybody knew everybody! I really miss those days and the camaraderie they engendered.

For the first 10 years, general surgery was a somewhat pedestrian specialty, but all that changed in late 1989 with the introduction of laparoscopic cholecystectomy. The moment I saw my first gallbladder taken out through the umbilicus, I knew my surgical career would never be the same. For me, the excitement was more than just removing the gallbladder through minimal incisions, it was the idea that I was actually part of a changing surgical paradigm. Over the next 10 years, I aggressively pursued laparoscopic surgery both as a practitioner and as an academic endeavor. What an incredible journey that was. I was given numerous opportunities to teach various laparoscopic courses to colleagues across the US and even in several foreign countries.

One of the things that I discovered during those early years of laparoscopy was that medicine was becoming more and more a business. In this growing industry called healthcare, the various “stakeholders” were exerting control over what I did, treating it like a commodity. As this trend continued, I became increasingly frustrated with my role being defined as a “provider” rather than a physician.

In 2002, an opportunity arose to invest in a new physician owned hospital in Southlake, Texas. While initially it seemed like a bit of a gamble, the chance to regain an element of control was alluring and the fact that the physicians would be partnering with Texas Health Resources, one of the largest hospital conglomerates in Texas, made the risk manageable. We went on to build one of the most successful surgical hospitals in North Texas, and I have been privileged to serve on our board of managers since 2004. Our hospital has won numerous awards, including being named one of the top 100 places to work by Modern Healthcare magazine for the past two years. I am convinced this is due in large part to the direct input of physicians in all aspects of the hospital.

In recent years my practice has continued to evolve, as I remain committed to the concept of offering patients the latest in minimally invasive surgical care. In that spirit, a year and a half ago I introduced “incisionless” surgical options for treating chronic gastroesophageal reflux disease and for revising failed gastric bypass procedures. To me, the only constant in surgery is change. I’m certain that before my career is over there will be at least one more major paradigm shift, but my sense is it will be organizational rather than technical.

The medical profession is under attack and I believe that to salvage our time honored profession physicians must become more politically active.

(continued on page 24)
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For the last 10 years I have served on the Board of Trustees of the American Society of General Surgeons, and am currently the immediate past president of that organization. I have also assumed the position of ASGS delegate to the AMA, and yes, I watched with great dismay as the AMA leadership passively supported the recent healthcare reform legislation. I very nearly walked out of each of the last two meetings of the House of Delegates in protest. But I recognized that both the Congress and the public perceive the AMA as THE voice of America’s physicians. So, rather than allow others to continue to employ that powerful voice, I am determined to work with other practicing physicians to change the AMA, starting with the leadership. If necessary, we intend to change the entire structure of the AMA to allow the true voice of America’s doctors to be heard.

Among the most important issues that must be addressed in the coming months and years is the repeal of that portion of the new healthcare law prohibiting physicians from owning the facilities in which they practice. This is simply un-American. Likewise, Medicare is unsustainable in its current state, but just eliminating the SGR is insufficient. Congress will simply replace it with another price-fixing program designed to control costs and medical decision making. Such payment programs consistently drive wedges between patients and physicians and must be completely eliminated. Also, a national system of tort reform is desperately needed to ensure all Americans retain access to quality physicians. And speaking of quality, the only individuals who possess the knowledge and understanding required to evaluate quality medical care are physicians. Government panels and insurance boards are ineffective at best and potentially self-serving when given control through “Pay for Performance” programs.

I believe it is time for America’s physicians to collectively stand up for what is right, both on behalf of their profession and their patients. We must insist that control of our healing art be returned to those who have been called to this noble service and who have sworn a sacred oath to protect our patients. I believe the reemergence of the physician will be the next great movement in American medicine and I intend to be part of that movement, “when I grow up.”
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Many medical organizations in the United States have a neuroscience department, but none can say they offer complete clinical, surgical, and rehabilitation services devoted to the neurosciences. The NeuroMedical Center in Baton Rouge, La. is the exception.

Neurosurgeon Thomas B. Flynn, M.D., founder of The NeuroMedical Center, was the only board-certified neurosurgeon between Baton Rouge and Shreveport, La. in 1967. He saw the need Louisiana had for quality, experienced physicians specializing in the brain, spine, and nervous system. Dr. Flynn dreamed of creating a physician-owned facility focusing solely on the neurosciences.

Over the years, Dr. Flynn encountered many critics who did not believe an organization devoted only to the neurosciences could survive in Louisiana. Despite his criticism, Dr. Flynn formed The Baton Rouge Neurological and Neurosurgical Associates in 1978 with two neurosurgeons and one neurologist. The physician base expanded and outgrew many locations over the years. In 1986, it was renamed The NeuroMedical Center and in 2004, it was relocated to Baton Rouge’s Perkins Rowe, a new upscale planned community. It was here that The NeuroMedical Center opened its surgical hospital in 2004 and rehabilitation hospital in 2005.

The NeuroMedical Center Surgical Hospital (NMCH) is a 23-bed facility with four operating rooms, three pain procedure rooms, an in-house laboratory, certified sleep center, and a qualified team of neurological specialists, treating over 6,000 patients a year. By the end of 2010, NMCH will be home to nine neurosurgeons, nine neurologists, six physiatrists, and two neuroradiologists, in addition to physician staffs credentialed at the clinic and rehabilitation hospital. These physicians meet on a regular basis and educate each other on new practices and techniques, while also providing patient consults.

As a physician-owned specialty hospital, it’s believed that a multidisciplinary team approach provides the best care for patients. There is a close working relationship between the surgical hospital, The NeuroMedical Center Clinic, and The NeuroMedical Center Rehabilitation Hospital. These three entities also house imaging services, inpatient and outpatient physical, occupational, and speech therapies, and provide access to social workers and case managers. All disciplines work together to diagnose and tailor treatment plans for patients. This unique relationship also allows the team of neuroscience specialists to follow patients throughout their entire treatment and recovery process.

NMCH CEO Robert Blair understands the physicians’ vision to provide both specialized and progressive care in contrast to the diverse offerings of a general-care center. “We don’t want to operate as a massive medical center performing every service under the sun,” Blair said. “We want to provide the region’s most comprehensive, specialized care in the neurosciences, including surgery and rehabilitation. Our ultimate vision is to establish a nationally-known center of excellence for treatment of the brain, spine, and nervous system.” The hospital is committed to direct

(continued on page 28)
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patient care, low nurse-to-patient ratios, spacious private rooms, and low complication and mortality rates. “By the way, our current mortality rate is at zero percent,” Blair added.

Positive patient outcomes and the ultimate patient experience are not far-reaching goals. “Many of our patients tell us they feel like they are staying in a hotel with deluxe concierge staff,” Blair said. “Our dedicated employees provide the backbone of our family-oriented atmosphere. Our patients are simply an extension of our existing family, and are treated as such.”

The NeuroMedical Center Surgical Hospital continually receives some of the highest ratings in the state from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys. Nearly 100 percent of the hospital’s patients indicate they would recommend this facility to a family member. Nurses and other hospital staff are continually mentioned by name in patient satisfaction surveys.

A Natchez, Miss. resident writes, “I was not only pleased, but impressed with the way all staff conducted themselves. Thank you all for your courtesy and kindness during my surgery. It helped me through a difficult time. I will always be grateful to my physician and the staff of The NeuroMedical Center for your caring attitudes.”

With every discharge, Chief Nursing Officer Monica Nijoka writes to each patient. As CNO, she believes in adding the personal touch. It’s rare that a patient ever leaves the hospital without knowing Nijoka by name. She has been a leader in the nursing community for over 30 years and believes in treating every patient with individual care. “At NMCH, we are blessed with the ability to have a low nurse-to-patient ratio and treat each patient with the tailored care they deserve,” said Nijoka.

While quality of care is the principal value of The NeuroMedical Center, the physicians believe that the organization’s efficiency is vital to continued operation. Neurosurgeon and NMCH Chairman of the Board Horace Mitchell, M.D. said, “One of the benefits of being a physician-owned facility is that we can cut through much of the red tape which so often plagues healthcare system operations. Through structural organization and purchasing methods, we seek to provide services in the most cost-efficient manner.”

Both the number of services offered and the number of physicians offering them have grown tremendously in the recent years. The growth of The NeuroMedical Center continues to spread its patient base throughout the state of Louisiana, as well as Mississippi, Texas, and Arkansas.

“Although the majority of our volume comes from South Louisiana, we see strong trends of residents traveling from surrounding states, which are known to have neuroscience capabilities,” says Blair. “Our vision of national excellence is becoming less of a dream and more of a reality.”

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**Ambulatory Surgery Centers**

**California**
- Barranca Surgery Center
  T: (949) 552-6266
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**Head Office**
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MSH 257 Canada
T: (416) 848-7380
Toll Free: 1-877-402-7162
OSHA is the regulatory agency responsible for establishing and enforcing standards aimed at reducing workplace injuries and making the workplace safer for employees. Under the Occupational Safety and Health Act of 1970, OSHA is authorized to conduct workplace inspections and investigations to determine whether employers are complying with standards issued by the agency for safe workplaces.

OSHA should not be confused with Joint Commission, AAAHC, or any other accrediting body. As a federal agency, OSHA has very different expectations and processes. Accrediting organizations fall under the category of nongovernmental agencies. They evaluate a facility’s practices in complying agency specific standards and policies, whereas OSHA evaluates a facility’s practices as they relate to the facility’s ability to protect the safety of its employees.

Additionally, there are differences between state and federal plans. States must adopt standards and enforce requirements that are at least as effective as federal requirements. So, be sure to check with your individual state to make sure there are not additional requirements that need to be met. There are currently 26 states and territories with OSHA-approved safety and health plans: Alaska, Arizona, California, Connecticut, Hawaii, Indiana, Iowa, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, Puerto Rico, South Carolina, Tennessee, Utah, Vermont, Virgin Islands, Virginia, Washington and Wyoming. These states are also listed on the OSHA website, www.osha.gov, which has a great deal of useful information.

Inspection Priorities

Surprise visits are the norm for inspection officers at OSHA, the Occupational Safety and Health Administration. So facility staff need to be prepared for an OSHA officer to walk through the doors at any time.

When a compliance officer arrives at a facility, the officer will provide his or her credentials and ask to speak to the facility administrator or someone in charge. The officer will then have an opening conference, a walk-through and a closing conference.

There are specific OSHA regulations that apply to health care workers. Examples are hazardous communication, personal protective equipment (PPE) and blood-borne pathogens.

**OSHA will assess a facility based on established inspection priorities:**

- **Imminent danger:** An imminent danger is any condition that can be expected to cause death or serious physical harm immediately.
- **Catastrophes and fatal accidents:** Investigation of fatalities and accidents resulting in a death or hospitalization of three or more employees.
- **Complaints and referrals:** Formal employee complaints of unsafe or unhealthy working conditions or a workplace hazard. An inspection could also be based on a news report, which is considered a referral.
- **Programmed inspections:** Inspections aimed at high-hazard industries or occupations. OSHA selects these inspections based on injury incidence, previous citations, and exposure to toxic substances. Currently there is not a nationwide emphasis on hospitals or on ASCs, but there is an emphasis on nursing homes. Facilities in states with a state plan would have to check to see if a hazard in their particular type of facility is a focus item.
- **Follow up inspections:** An inspection to determine if the employer has corrected a previously cited violation.

**During an inspection, remember the following:**

- Ask for a copy of the complaint and or a copy of the applicable safety and health standards. This is important since there is a difference between a
  - **programmed inspection:** comprehensive and covers the entire facility and a
  - **complaint:** which will only cover the areas the complaint is about.
- Make sure someone is with the officer at all times.
- The officer determines the route and the amount of time for the inspection.

*(continued on page 32)*
Jani-King’s Healthcare Housekeeping Services Division is a leader in small to medium physician owned healthcare facilities. The Jani-King program provides a total turn-key operation to include the following:

- Certified staff that meets all accreditation requirements to work in the healthcare environment
- Managers and supervisors who can manage the uniqueness of smaller operations
- All policies and procedures for the housekeeping department
- All chemicals, supplies and equipment for cleaning and disinfecting your facility
- Process improvement tools to maintain high level of patient satisfaction
- Daily, weekly and monthly tracking systems to ensure service levels are maintained
- Certified Housekeeping OR Technicians that are trained to provide quick turns for in-between case cleaning

The total turn-key program was designed to provide a fixed price for all services. As an owner and provider you have many more areas that require your attention. The Jani-King program eliminates the need for you to hire, provide workman’s compensation and benefits for the housekeeping staff.

For a free DVD of the Jani-King Healthcare Housekeeping Services program please email:
mregna@janiking.com or bmarion@janiking.com

1.800.JANIKING | www.janiking.com
• If the officer finds a violation he or she has the discretion to expand the inspection.
• The officer may stop and question employees and this can be done in private. The employee is protected under the Act from any employer discrimination.

There are a number of items you should have ready to present for an inspection:
1. OSHA Log
2. Written Exposure Plan and Safety Related Policies
3. Posting Requirements
4. Required Inspections
5. Documentation of Employee Training

Each of these is covered in further detail in the following paragraphs.

OSHA Log
OSHA mandates that the employer keep records of occupational injuries and illness:
• OSHA form 300 is maintained by calendar year
• OSHA form 300 needs to be retained for five years (may vary by state)
• OSHA form 300A should be signed by the facility administrator at the end of the year and posted in a conspicuous place for all employees
• OSHA form 301 is the injury and illness report as a follow up record (seven days after an incident)

Written Exposure Plan and Safety Related Policies
Many of the OSHA standards require that you develop, implement and maintain a written exposure plan, policy, procedure, program or rule. You must be able to speak to and produce these written policies, as well as demonstrate compliance. All OSHA policies should be reviewed, updated and approved annually by the facility’s governing board:
• Exposure Control Plan
• Emergency Preparedness Plan
• Fire Prevention Plan
• Safety Management Plan
• Interim Life Safety Plan
• Blood Borne Pathogen Plan-Exposure/Post Exposure
• Hazardous Waste Management Plan
• Utility Management Plan
• Health and Safety Policies for Employee Exposure and Safety

Posting Requirements
OSHA workplace poster (OSHA 3165) form 2203 Job Safety and Health Poster should be posted informing employees of the protection and obligations of the employer. This should be posted in a conspicuous place.

Required Inspections
Facilities are required to maintain appropriate inspections and maintain appropriate documentation of such inspections. This is usually handled under the Safety Committee and Infection Control.
• Ladders
• Fire Extinguishers
• Alarm System
• Hand washing

Documentation of Employee Training
Many of the OSHA standards require appropriate employee training and documentation of such training and competence. Training should be demonstrated during the initial employee orientation and refreshed annually. The training should be specific to an employee’s job description and exposure to specific conditions:
• Fire Drill and Extinguisher Training (Fire Plan)
• Emergency Preparedness
• Hazardous Waste
• Infection Control and Personal Protective Equipment
• Blood borne Pathogens and Post-Exposure Treatment
• Medical Gas
• TB Exposure Plan

It is crucial that you have appropriate policies that document your practice, and that you are following the policies. Use the e-tools that OSHA has to offer on its website to assist with a safety inspection. Recognize that you will need to build a culture of safety in your facility and make sure everyone participates.

It is easy to be intimidated or worried about an impending OSHA inspection but with an organized plan and staff education, OSHA inspections should become a routine part of your operations.

Additional Resources
1. Occupational Safety and Health Administration. www.osha.gov
2. www.ormanager.com/toolbox/documents/OSHAChecklist
Each and every day, tens of thousands of patients, visitors and staff walk through the doors of hospitals, surgery centers and medical offices, leaving behind what can be seen and not seen.

Over the last several years outbreaks of viruses including Norovirus, C-MRSA, Avian Bird Influenza H5N1 and more recently Swine Influenza H1N1 have been reported around the world. These viruses and microorganisms are not going away. In fact, the concern is that they will become stronger and have a much larger impact on society. So what can be done to help reduce these diseases from spreading and causing businesses to shut down?

First, organizations must understand that disinfecting the surface one time after an outbreak is not sufficient to ensure the facility is properly protected on a regular basis. This is an ongoing process and every organization must have the proper procedures in place to ensure that the facility surfaces have reduced bio-loads each and every day. These actions require the Right Staff, Right Training, Right Chemical and Right Equipment at the Right Time.

It is critical for facilities to have an ongoing surface disinfection program with highly trained individuals who understand proper disinfection techniques and who know what surfaces have the biggest impact on the facility. Jani-King, a leader in environmental services, incorporates the use of EPA hospital grade disinfectants such as the 3M line of cleaning products and Rubbermaid’s HYGEN microfiber system to assist in providing front line protection to the facility and the people who work or visit there.

A most important point, is that the staff providing the cleaning and disinfecting of the facility must understand how to break the chain of infection. Poorly trained cleaning crews that incorporate improper procedures can actually do more harm than good by spreading the virus. Jani-King employs proven techniques such as using color-coded cloths on specific surfaces to help reduce cross contamination and further protect your facility, employees and visitors on a regular basis.

**Green and Sustainable**

As sustainability and the environment continue to be a more pressing factors in how all businesses operate, healthcare centers are searching for new technology and processes that meet their objectives. Whether those objectives are designed to improve patient safety, infection control or sustainability, the demand is for immediate action by vendors and partners that are experts in their respective industries.

Jani-King’s 40-year history and expansive system of regional support offices allows the company to develop cutting edge programs that can be quickly implemented into the field. When those services reach local customers, Jani-King’s support system doubles-up to ensure that the right processes, equipment and chemicals are delivered during each clean.

The physical act of cleaning isn’t much different than it was 40 years ago, but it has evolved to some degree. Through the use of microfiber cloths and mops, chemical usage is less and results are greater. Cleaning processes have also improved to deliver better service at a better rate. For healthcare facilities, partnering with Jani-King means you’ll have a partner that delivers best practices based on your demands and the needs of your patients while helping you watch the bottom line.

As the global leader in healthcare environmental services, Jani-King understands the critical nature of infection control in healthcare. Whether you’re managing a hospital, outpatient facility, medical office building or surgery center, the Jani-King environmental services program ensures proper disinfecting and procedures that exceed the toughest healthcare standards and regulations.

Jani-King’s Environmental Services Program is based on best practices from organizations such as the American Society for Healthcare Environmental Services (ASHES), Association for Professionals in Infection Prevention (APIC), Association of peri Operative Registered Nurses (AORN), and the Centers for Disease Control (CDC).

All authorized Jani-King franchise owners and their environmental service staff must complete Jani-King’s Healthcare Certificate Program and meet all local, state, federal and Joint Commission standards prior to servicing any healthcare account.

For more information please go to www.janiking.com
New on the Scene

Methodist McKinney Hospital
Creating an Optimal Healing Environment

Over the last 10 years, the U.S. Census Bureau has, on multiple occasions, named McKinney, Texas, one of the fastest growing cities in America. Currently boasting a population of approximately 120,000, the Dallas suburb also enjoys an expanding and innovative medical community. The most recent example of this innovation and growth is Methodist McKinney Hospital, which opened its doors to McKinney and the surrounding communities of Collin County in February 2010.

The hospital project took root in 2006 when several area physicians recognized the need to increase health care access in Collin County, and responded to their patients’ demand for a more intimate delivery model. The physicians sought to develop a new kind of hospital for McKinney, one that would go beyond providing excellent medical care. They wanted to develop a hospital that would also meet deeper needs by creating an environment to promote optimal healing.

Partnering with Nueterra Healthcare, a Leawood, Kansas-based health care development and management company, and Methodist Health System, a not-for-profit health system based in Dallas, the physicians began to see their vision realized. The joint-venture partnership of Methodist McKinney Hospital combined the physicians’ passion for quality patient care, the development and management expertise of Nueterra Healthcare, and the brand strength and resources of Methodist Health System.

Throughout the hospital’s development, the partners maintained focus on these founding principles: to design a superior health care delivery model; to align with physicians and treat them as integral partners; to create a healing environment that integrates patient care and patient experience; to create a destination medical campus; and to decrease outmigration of healthcare services to surrounding communities.

Nestled in McKinney’s beautiful Stonebridge Ranch residential community, Methodist McKinney Hospital provides inpatient and outpatient care, as well as, outpatient diagnostic imaging, laboratory services and 24-hour emergency services. As directed by the founding principals, patient experience is top-of-mind in all aspects of the hospital, from the fireplace that greets guests upon entry to the hotel-like inpatient rooms.

The 65,000+ square-foot hospital includes six large operating rooms, two procedures rooms, 15 inpatient nursing beds, and a 24-hour emergency room. Their growing medical staff includes a wide array of specialties including allergy & immunology, family medicine, gastroenterology, general surgery, gynecology, internal medicine, neurosurgery, orthopaedics, ortho-spine surgery, otolaryngology, pain management, physical medicine & rehabilitation, podiatry and urology.

Poised for success, Methodist McKinney Hospital is the fruition of the founding members’ goals. The physicians and staff now look towards the future as they strive to become an integral community partner in health and wellness.
National Republican Congressional Committee Event Held at Physician Home in Texas

An event supporting the National Republican Congressional Committee (NRCC) was held at the home of Dr. John Gill in Dallas, Texas on Monday, May 3, 2010. Dr. Gill is an orthopaedic surgeon at Texas Institute for Surgery at Presbyterian Hospital of Dallas in Dallas, Texas. Representatives Joe Barton (TX-6) and Sam Johnson (TX-3) as well as special guest Chairman Pete Sessions (TX-22) were all present at the event.

R. Blake Curd Event Held at Physician Home in Dallas, Texas

An event supporting Candidate Dr. R. Blake Curd was held in Dallas, Texas on Wednesday, May 5, 2010. The event was held at the home of Dr. Robert Henderson, a spine surgeon, of Pine Creek Medical Center. Funds were raised for Dr. Curd’s candidacy for U.S. Representative in South Dakota. Dr. Curd is a PHA Board member, orthopaedic hand and vascular surgeon, owner in Sioux Falls Surgical Hospital in Sioux Falls, SD, and is currently serving his first term as a SD State Legislator.

Dallas Physician Owned Hospital Winner of North Texas Business Ethics Award

Texas Institute for Surgery at Texas Health Presbyterian Dallas in Dallas, Texas was recently named one of four winners of the North Texas Business Ethics award. The annual award honors companies that demonstrate a firm commitment to ethical business practices in everyday operations, management philosophies and response to crises or challenges. Texas Institute for Surgery was also a finalist in the 2009 Greater Dallas Business Ethics Awards.
early 215 members and non-members of PHA met in Dallas, Texas May 6-7, 2010 to receive the latest information on physician owned hospitals and possible future models.

The first evening of the conference was very interesting and informative. The conference was kicked off with a legislative and regulatory update from PHA Lobbyist, Randy Fenninger. He was then followed by Scott Oostdyk and Victor Moldovan from McGuire Woods, who provided a legal update on PHA’s progress with a federal lawsuit. The evening’s speakers concluded with physician advocate John Gill, MD of Texas Institute for Surgery at Presbyterian Hospital of Dallas, Michael Russell, MD of Texas Spine and Joint Hospital, and Texas State Senator Bob Duell, speaking on the positive impact of political activism by physicians.

The second day of the conference was a full day of educational sessions. The morning started with Keynote Speaker John C. Goodman, PhD. Dr. Goodman is the President & CEO of the National Center for Policy Analysis. Conference attendees then had an option to attend twelve break-out track sessions for the remainder of the day, where they received up-to-date information from very knowledgeable speakers in regards to the different models that are available to physician owned hospitals post healthcare reform. ♦
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REGISTRATION INFORMATION
First/Last Name _____________________________________________________________
Degree (as you wish it to appear on your badge) __________________________________
Title ______________________________________________________________________
Facility/Company ____________________________________________________________
Address ___________________________________________________________________
City ______________________________________________________________________ State _______ Zip ________________
Phone (       ) __________________________  Fax (       ) ____________________________
Email ______________________________  Cell Phone ____________________________
Web Site __________________________________________________________________
Guest Name (if registering) ___________________________________________________

PHA MEMBER REGISTRATION FEE

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PHA NON-MEMBER REGISTRATION FEE

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TOTAL AMOUNT ENCLOSED $__________

THREE CONVENIENT WAYS TO REGISTER

Mail to: PHA, 5900 S. Western Ave, Ste 102, Sioux Falls, SD 57108
Enclosed is a check, payable to PHA. Check # ________________________________
Fax to: Fax registration form with credit card information to (605) 731-2575
Call: (605) 275-5349
I authorize PHA to charge my:  
Visa  
Mastercard  
American Express  
Discover
Credit Card Number: ________________________________
Expiration Date: ________________________________
Printed Cardholder Name: ________________________________
Signature: _______________________________________
Cancellation: Written cancellation requests must be received by September 17 and refunds are subject to a $100 processing fee. No refunds will be made after September 17.

QUESTIONS

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