Introduction to Freestanding Emergency Rooms and Microhospitals

Speaker Biography

Colin McDermott, CFA, CPA/ABV is a managing director with VMG Health. McDermott specializes in providing financial, valuation, and transaction advisory services to healthcare facilities and organizations. McDermott has assisted numerous non-profit and for-profit clients with valuation analysis related to ASC 805 Business Combinations and has issued valuation opinions on the fair value of intellectual property and other intangible assets acquired as a result of the acquisition of acute care hospitals, ambulatory surgery centers, rehabilitation hospitals, and multi-specialty physician groups. imaging centers, laboratories, physician groups, home health agencies and other healthcare entities.

Speaker Biography

Vic Schmerbeck, *Executive Vice President of Strategy and Business Development*

Mr. Schmerbeck has served Emerus for more than five years first consulting on growth strategy and market capitalization, and now as the Executive Vice President of Strategy and Business Development. With more than 20 years of experience in investment and merchant banking specializing in healthcare services and health system markets, Mr. Schmerbeck is a sought-after speaker and panelist, providing thought-leadership on topics including the future of healthcare services and emerging health system markets.

Mr. Schmerbeck earned his bachelor's degree in Finance and Real Estate from Southern Methodist University and served on numerous private and public boards, providing guidance on financing and partnerships. As a community leader, Schmerbeck is involved with numerous charitable endeavors involving healthcare and at-risk children including The Salesmanship Club of Dallas, Children's Medical Center of Dallas, and The Rise School of Dallas.

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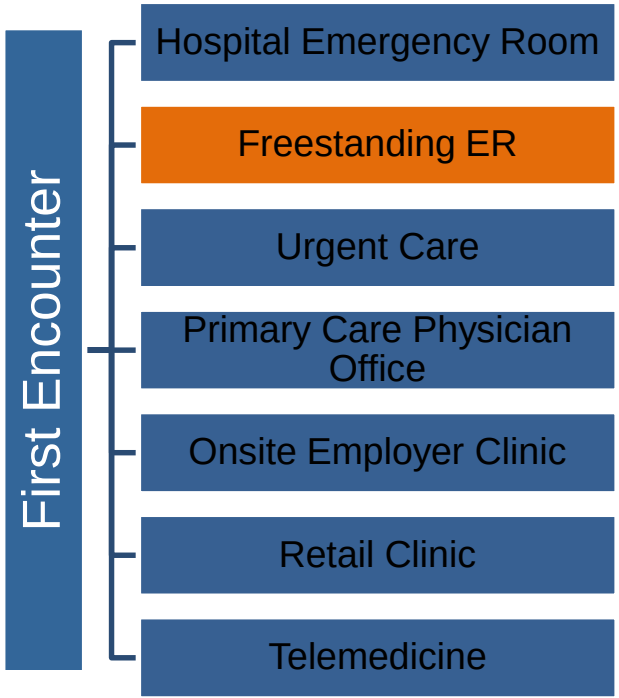
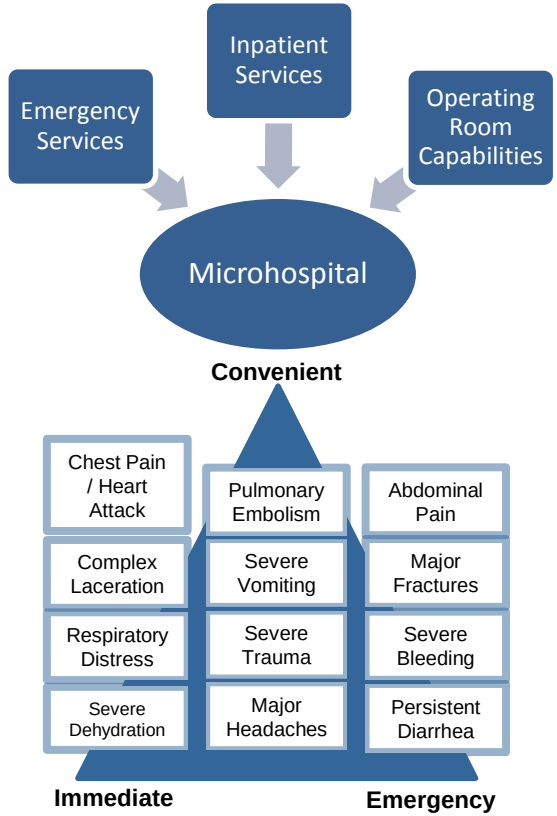
Industry Analysis

Entry Points into the Healthcare System





Continuum of Care

	Lower Acuity → Higher Acuity			
	Retail Clinic	**Primary Care**	**Urgent Care**	**Hospital ER**
Convenience	High	Low	High	Low
Delivery of Care	Low	High	High	High
Pricing	$80	$105	$140	$650+
Challenges	• Physicians not on-site • Do not diagnose / treat mid-acuity patients	• Shortage of PCPs • Appointments impair the ability to deliver timely care • Chronic Patient	• Patient awareness of urgent care model • Limited range of services	• Overcrowding • Long wait-times for non-emergency patients • Expensive for patients and providers
Provider Staffing Model	NP only (generally one)	Physicians and NPs and/or PAs	Physicians and NPs and/or PAs	Physicians, NPs, and PAs
Diagnostic, Lab Services Offered	None	X-Ray or None	• X-ray • Basic Lab	• X-Ray • Moderate – high complexity lab testing • CT/ultrasound

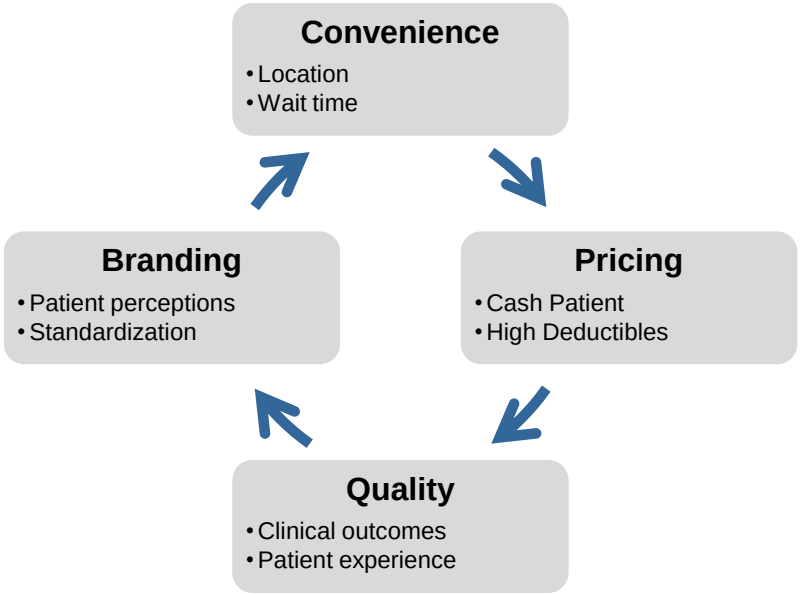
Freestanding ER Statistics

Table 1: Average Triage Level of Patients Seen in FEDs Compared to National Averages				
Triage Level	Study FED Average for 2013	National ED Average for 2013	Study FED Average for 2014	National ED Average for 2014
Level 1 (resuscitation)	0.11%	2.2%	0.19%	2.0%
Level 2 (emergent)	3.57%	8.6%	5.53%	7.8%
Level 3 (urgent)	43.79%	30.8%	44.12%	30.0%
Level 4 (semi-urgent)	45.40%	34.5%	44.27%	34.7%
Level 5 (non-urgent)	4.47%	23.9%	4.05%	25.4%

Source: NAFEC 2nd Annual National Freestanding Emergency Center Conference, 2016

Influences on Patient Preference

Time = the middle class's most important asset



- **Current system is inefficient**
  - Lack of physicians has led to backlogs of office visits
  - ERs are over-crowded and long wait times has been the norm
- **The "information age" has created dramatic implications for healthcare**
  - Consumerism and willingness for patient to "shop" more prevalent today than ever
  - More information available for patient to readily self-diagnose and choose appropriate setting of care
  - Greater understanding of how healthcare works and options (i.e. co-pays, deductibles, in-network vs. out-of-network, etc.)

Freestanding ER Statistics

Table 2: Average Treatment Times for Patients in FEDs Compared to National Averages

Treatment Times (in minutes)	Study FED Average for 2013	National ED Average for 2013	Study FED Average for 2014	National ED Average in 2014
Median Time in Waiting Room (EHR)	3	17	10	16[1]
Time from Door to Diagnostic Evaluation by a Qualified Medical Provider (OP-20)	19	30[1] 25[2]	23	27[1] 24[2]
Treatment Time for Discharged Patients (OP-18a)	125	151[2]	142	156[2]
Treatment Time for Transferred Patients (0P-18d)	276	289[1] 243[2]	312	251[2]
Time to Pain Medication for Long Bone Fractures (OP-21)	46	55[2]	50	53[2]

1 = Emergency Department Benchmark Alliance
2 = Hospital Compare Data

Source: NAFEC 2nd Annual National Freestanding Emergency Center Conference, 2016

Freestanding Emergency Room Benefits

Patient Benefits	▪ Community based access to care without the hassle of a hospital ▪ Face-to-face with medical professionals within minutes ▪ Access to high quality professionals capable of handling all issues ▪ High satisfaction rates for freestanding ERs
Typical Health System Benefits	▪ Defensive • Protect primarily commercial market share • Capture inpatient volume • Maintain or expand local market presence and brand awareness ▪ Offensive • Potentially increase market share by adding new patients into network; more “front doors” into the healthcare system • 5-10% of freestanding ER patients will require a hospital admission • 30-50% of freestanding ER patients will need to follow-up for additional care • Gain market intelligence / inexpensive entry point into new markets or communities • Secure integrated delivery network; move towards value-based care ▪ Capital Allocation • Aligning investment with “retail” trends of patient preferences for healthcare services • Aligning investment with patient awareness and shift to lower cost environments • Ownership of freestanding ERs are generally profitable activities compared to the operations of ER departments within hospitals

Regulations/Accreditation

The regulatory environment for FSEDs is continuing to evolve.

- Each state has different regulations
- Reimbursement environment different by each state
- FSEDs are currently not required by federal law to accept all patients for emergency screening and stabilizing treatment regardless of a patient's ability to pay

Medicare does not recognize independent FSEDs as emergency departments.

- Cannot bill Medicare or Medicaid
- Hospital-affiliated facilities are paid as outpatient clinics ("Off Campus-Outpatient Hospital")
- The facility does not receive a separate payment for the use of the facility (no facility fee)

Hospital-based (HB) FSEDs are treated as any other hospital-based outpatient department.

- Fall under the same rules and regulations as the hospital
- Receives a facility fee

Federal Regulations

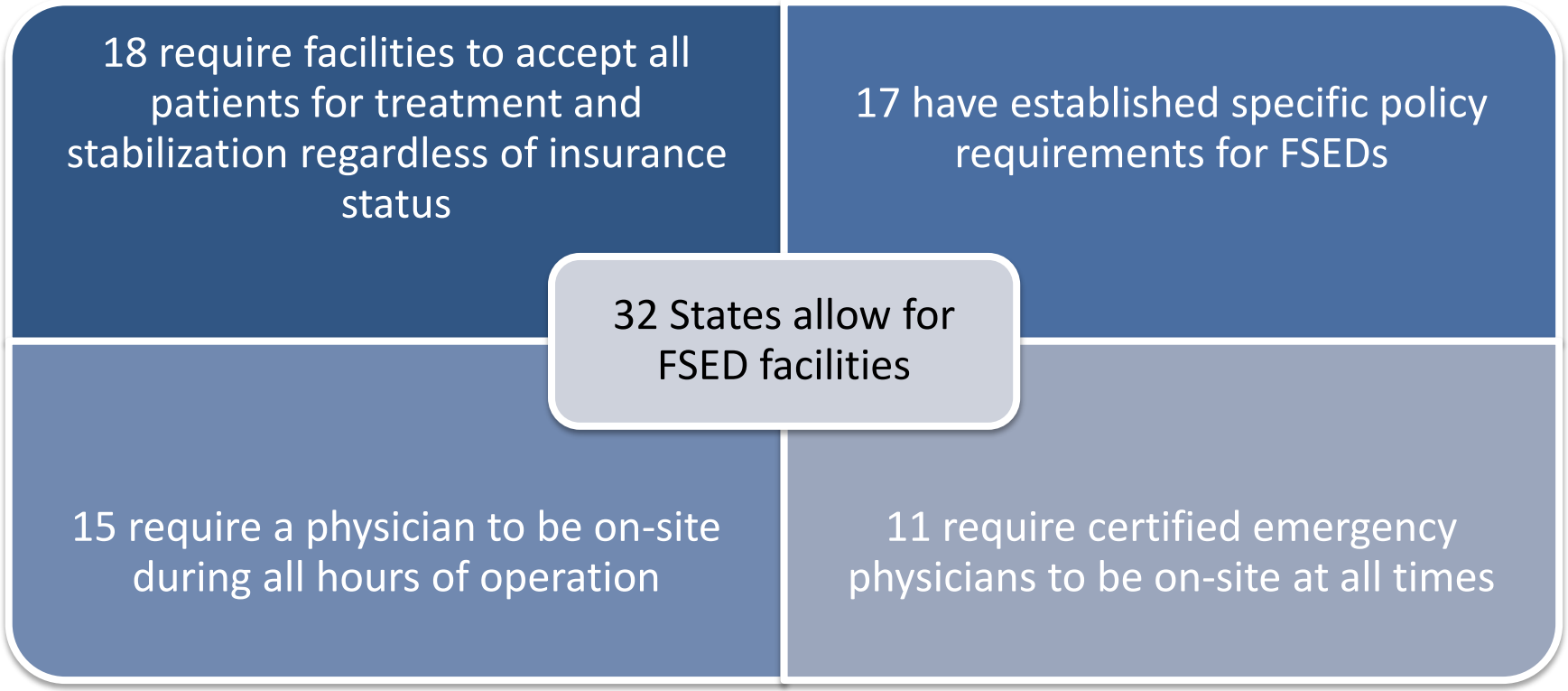
Stark	Anti-Kickback	False Claims Act
Civil laws prohibiting referrals of Medicare and Medicaid patients to entities where the referring physician has a financial relationship.	Criminal laws prohibiting arrangements where providers are directly or indirectly remunerated for referrals of Medicare and Medicaid patients.	Civil and criminal penalties for falsely submitting claims to the federal government whether knowingly or unknowingly.

"HIPAA"	"EMTALA"	"PPACA"
The Health Insurance Portability and Accountability Act ("HIPAA") of 1996 regulates the privacy of individually identifiable health information.	The Emergency Medical Treatment and Labor Act ("EMTALA") requires anyone coming to emergency department to be stabilized and treated.	The Patient Protection and Affordable Care Act ("PPACA") does not specifically address regulation of urgent care centers.

State Regulations

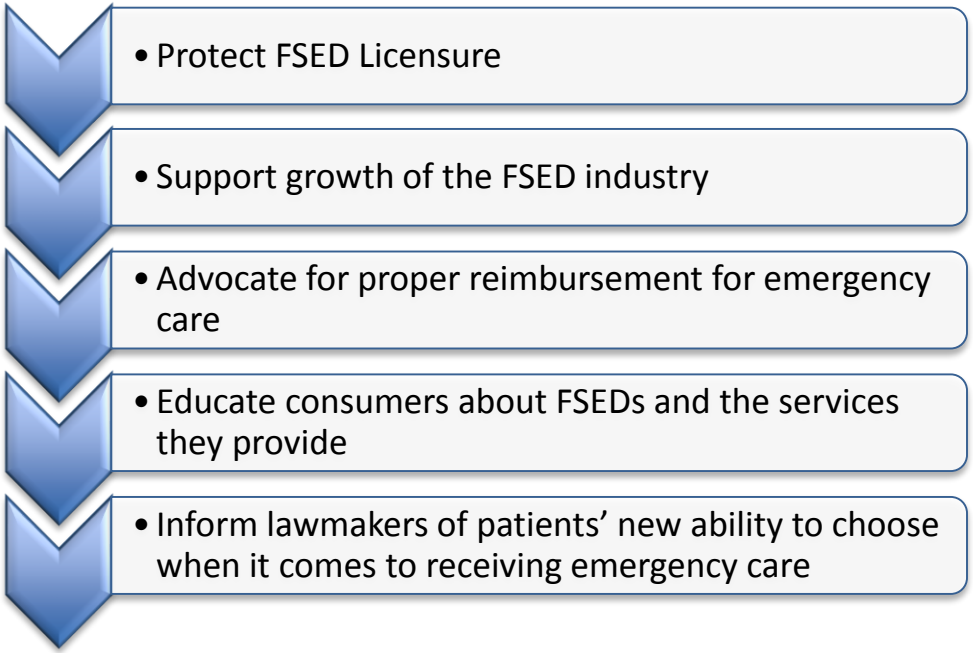
Licensing	Ownership	"CON" Laws
While each state is different, all have requirements for education, written examination, and a clinical examination for providers.	States may regulate who can own and operate a medical care practices and the level of control owners and managers may exercise.	Some states require urgent care providers to apply for a "certificate of need" ("CON") to receive permission to operate..

Regulatory Overview



Current Regulatory Environment

- **Texas Association of Freestanding Emergency Centers (TAFEC) top legislative priorities:**



Current Regulatory Environment

‘Balance Billing’

- Health plans from insurance providers are lowering FSED reimbursement rates, which pins these costs on the medical care provider and ultimately the patient
- Insurance providers claim that FSEDs are increasing cost of healthcare by remaining “out of network”
- TAFEC claims that by using the “prudent layperson” standard, patients with life-threatening conditions should be categorized and billed at the in-network rate per Texas state law
- TAFEC is proposing the definition and implementation of a “usual and customary” reimbursement rate statute
  - Rate would take average charges for specified procedures by FSEDs and assign a uniform reimbursement percentage
  - FSEDs would forfeit ability to balance bill patients upon acceptance

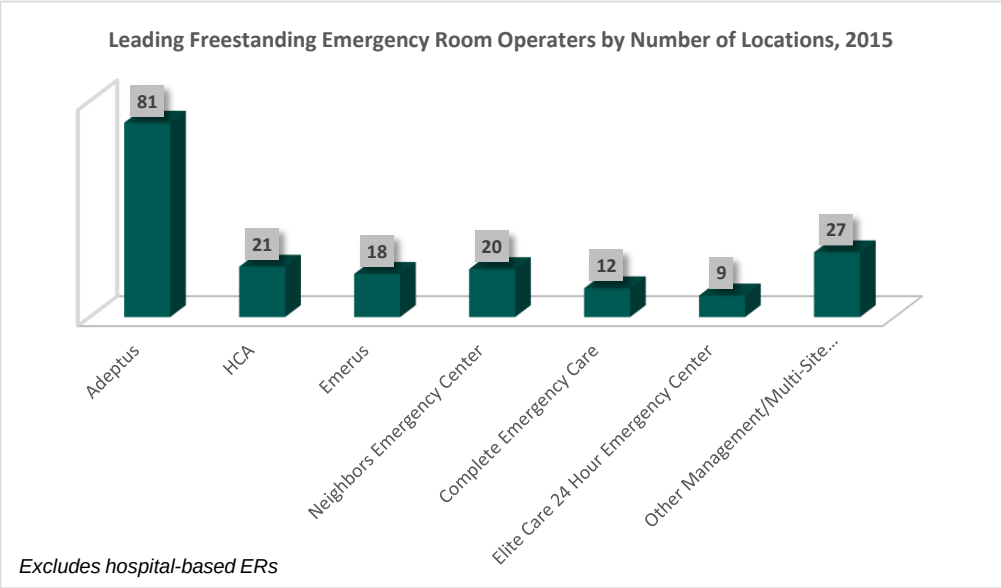
FSED Transparency

- Senate Bill 425 went into effect on January 1, 2016
  - Aim was to increase transparency at FSEDs in an attempt to distinguish FSEDs further from urgent care centers

- Required FSEDs to post a notice in all rooms stating the following:
  - The facility is a freestanding emergency medical care facility
  - The facility charges rates comparable to a hospital emergency room including a facility fee
  - The facility and/or physician providing medical care at the facility may not be a participating provider in the patient’s health benefit plan provider network
  - The physician providing medical care at the facility may bill separately from the facility for the medical care provided to a patient

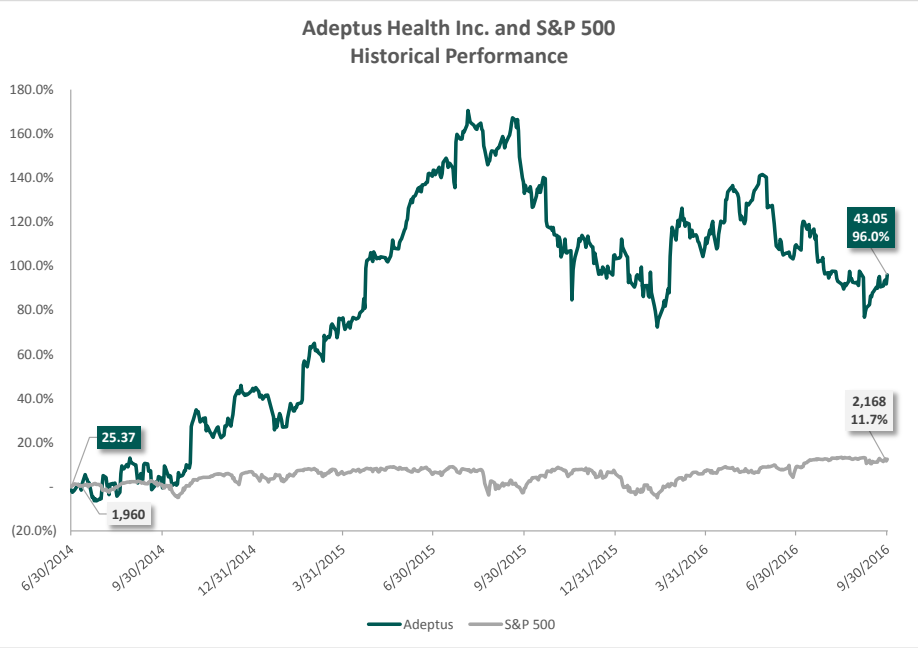
Market Participants

Market Participants



- Adeptus/First Choice is the largest player in freestanding ER
- As of 2015, 90% of independent FSERs were located in Texas
- 400+ estimated FSERs as of 2015

Market Participants



Company Name	Ticker	Market Capitalization	Total Debt	Minority Interest	Cash & Short-Term Investments	Total Invested Capital	TTM Revenue	TTM EBITDA	TIC / Revenue	TIC / EBITDA
Adeptus Health Inc.	ADPT	$703,905	$134,267	$88,716	$3,718	$926,888	$406,583	$57,170	2.3x	16.2x

Footnotes:

(1) Source: Capital IQ as of September 30, 2016.

(2) Total Invested Capital ("TIC") is defined as Market Value of Equity plus Interest-bearing Debt.

Participant Commentary

Adeptus Quotes

- *“Partnerships with leading health care systems are a key driver of our growth”*

- *“We fully expect that there will be over 5,000 FERs in the next 10 years”*

– Tom Hall, **Chairman & CEO**

M&A Activity

Adeptus

- JV with Dignity Health (10/22/2014)
  - 7 FSEDs, Arizona General Hospital contributed
- JV with University of Colorado Health (4/21/2015)
  - 16 FSEDs and hospital locations in Colorado Springs and Denver areas contributed
- JV with Ochsner Health System (9/2015)
  - Multiple FSEDs and hospital contributed, locations TBD
- First Texas Hospital (11/4/2015)
  - Full-service hospital opened in Carrollton, Texas; 25 FSEDs available as HOPDs
- JV with Mount Carmel Health System (2/2016)
  - Construction and operation of FSEDs in the Columbus, Ohio area; none currently open
- JV with Texas Health Resources (5/11/2016)
  - 27 FSEDs and Carrollton hospital contributed by Adeptus
  - Adeptus receives an annual preferred return up to a specified amount on its investment *prior* to proportionate distributions to the partners
- All accounted for under the equity method of accounting

Benchmarks

Typical Facility Metrics

- **Location is the most important determinant of success**
  - Quality and patient satisfaction are also important
- **Standard "retail" approach that looks at local population, payor mix and proximity to local hospitals**
- **Successful locations near bank branches, Chick-fil-a, Dunkin Donuts, CVS, Walgreens and busy shopping centers**

Facility Metrics	Urgent Care	Freestanding Emergency Room
Operating Hours	Business hours, after hours and limited weekend times	24/7
Patient Entrapment Area	~8 - 10 miles suburban ~18 - 20 miles suburban	~3 - 5 miles suburban ~20 - 25 miles suburban
Typical Square Footage	2,500 - 3,500 square feet 6 - 8 exam rooms	7,000 - 8,500 square feet 6 - 9 exam rooms
Land & Building Costs **Major Equipment Required**	~$1.0m - $2.0m X-Ray	~$4.5m - $6.0m CT, Ultrasound, Lab Equipment
Start-Up Capital Required - Leased Facility & Equip	Capital Expenditures: $400-450k Operating Losses: $300-350k	Capital Expenditures: $500-600k Operating Losses: $500-750k

Financial Metric Summary

- De novo urgent care centers can cash flow positive in 9 months depending on patient volume
- Freestanding ERs can cash flow positive within 2-4 months depending on patient volume

Facility Metrics	Urgent Care	Freestanding Emergency Room
Payor Mix	~20% government / 80% commercial Discounts std. for self pay patients	~25% government / 75% commercial May be out-of-network with some payors
Billing Policies	Medicare reimbursement through Part B; no Medicaid reimbursement	Hospital-affiliated facilities are able to accept government payors unlike freestanding
Reimbursement per Patient **Break-Even Patient Volume**	~$135 - 145 ~25 - 20 patient visits per day	~$1,200 - 1,800 ~10 - 8 patient visits per day
Operating Costs	Mostly Fixed: ~$100k - $120k per mo. Leased space & equipment	Fixed: ~$400k - $500k per mo. Leased space & equipment

Freestanding ER – Monthly Expense Profile

Monthly Operating Expense Break-Down	
ER Physicians	$128,000
Other Staff	57,000
Facility Rent & Taxes	20,000
Equipment Rental (i.e. CT)	8,000
Other Facility (Utilities, etc.)	50,000
Medical Supplies, Lab, Radiology	25,000
Advertising & Marketing	20,000
Billing & Coding (Assumes 5.5%)	31,000
Management Fee (Assumes 8.0%)	45,000
Other General & Administrative	17,000
	401,000

Staffing Roster			
Position	FTEs	Salary / FTE	Annual Salary
ER Physicians ($175 / hour)	4.6	$336,000	$1,530,000
Nurse	4.6	75,000	340,000
Tech	4.6	50,000	230,000
Administrative / Front Desk	4.6	30,000	140,000
	18.2	491,000	2,240,000

- **Onsite ER physicians are typically required 24/7; although laws may vary state to state**
- **All staffing costs are typically fixed**

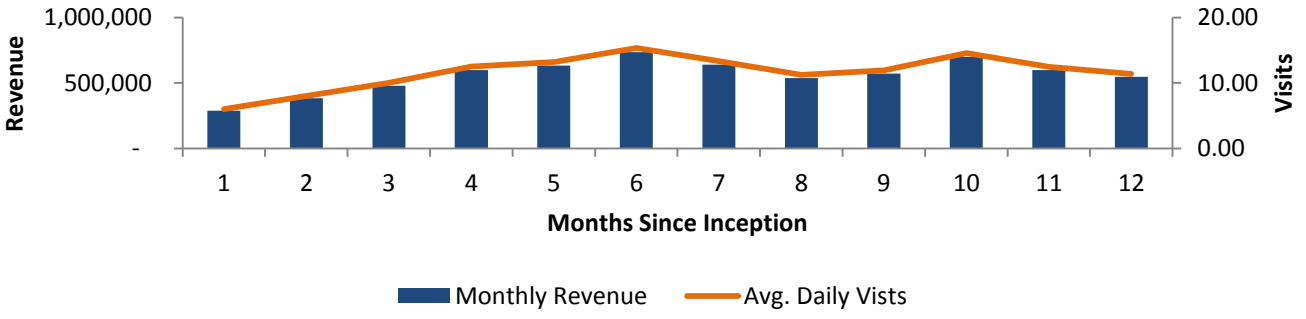
Freestanding ER – Typical Year 1 Cash Flow

	Monthly Collections			Cash Basis		Cash Flow	
Month	Avg. Daily Visits	NR per Visit	Revenue	Collections	Expense	Monthly	Cumulative
Month 1	6.0	$1,600	$297,600	$59,520	$414,367	($354,847)	($354,847)
Month 2	8.0	1,600	358,400	309,760	374,267	(64,507)	(419,353)
Month 3	10.0	1,600	496,000	385,920	414,367	(28,447)	(447,800)
Month 4	12.5	1,600	600,000	516,800	401,000	115,800	(332,000)
Month 5	13.2	1,600	654,400	610,880	414,367	196,513	(135,487)
Month 6	15.4	1,600	737,032	670,926	401,000	269,926	134,440
Month 7	13.4	1,600	662,987	722,223	414,367	307,856	442,296
Month 8	11.2	1,600	556,800	641,749	414,367	227,383	669,679
Month 9	11.9	1,600	572,800	560,000	401,000	159,000	828,679
Month 10	14.6	1,600	723,200	602,880	414,367	188,513	1,017,192
Month 11	12.5	1,600	599,226	698,405	401,000	297,405	1,314,597
Month 12	11.4	1,600	565,086	592,398	414,367	178,031	1,492,629
	11.7	1,600	6,823,530	6,371,462	4,878,833	1,492,629	2,985,257

- **Assumes monthly revenue is 20% collectable within the same month of service (due to co-pays & self pays) and 80% collectible in the proceeding month**
- **Cash flow positive is approximately 4 months after opening in the model above**

Freestanding ER – Sample P&L

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Year 5
Revenue:										
Patient Vists per Day	11.7	12.2	12.7	13.2	13.7					
Avg. Net Revenue per Patient	$1,600	$1,600	$1,600	$1,600	$1,600					
Total Net Operating Revenue	6,823,530	7,106,870	7,398,870	7,690,870	7,982,870	100.0%	100.0%	100.0%	100.0%	100.0%
Operating Expenses:										
Employee Salaries & Wages	1,559,193	1,605,969	1,654,148	1,703,772	1,807,532	22.9%	22.6%	22.4%	22.2%	22.6%
Physician Salaries & Wages	1,525,651	1,571,420	1,618,563	1,667,120	1,768,648	22.4%	22.1%	21.9%	21.7%	22.2%
Employee Benefits	346,233	356,620	367,318	378,338	401,378	5.1%	5.0%	5.0%	4.9%	5.0%
Occupancy Costs	607,555	615,261	626,770	644,119	683,346	8.9%	8.7%	8.5%	8.4%	8.6%
Drugs & Medical Supplies	220,583	230,742	256,128	263,420	278,713	3.2%	3.2%	3.5%	3.4%	3.5%
General & Administrative	356,151	333,484	310,124	286,764	263,404	5.2%	4.7%	4.2%	3.7%	3.3%
Management Fee - 8.0% of revenue	545,882	568,550	591,910	615,270	638,630	8.0%	8.0%	8.0%	8.0%	8.0%
Total Operating Expenses	5,161,248	5,282,045	5,424,961	5,558,803	5,841,650	75.6%	74.3%	73.3%	72.3%	73.2%
EBITDA	1,662,283	1,824,824	1,973,909	2,132,067	2,141,219	24.4%	25.7%	26.7%	27.7%	26.8%



Microhospital Model

EMERUS

Microhospital Long Term Strategy

Provide care at the right place and cost, where people live, work and play, in a capital efficient manner

- Single access point for multiple levels of care and specialty
- Differentiated to prepare for population health initiatives
- Provide value to patient, provider and payor
- Focus on industry leading clinical quality and patient satisfaction
- Test bed for innovation – pricing, quality and efficiency
- Clinical and capital efficient facilities

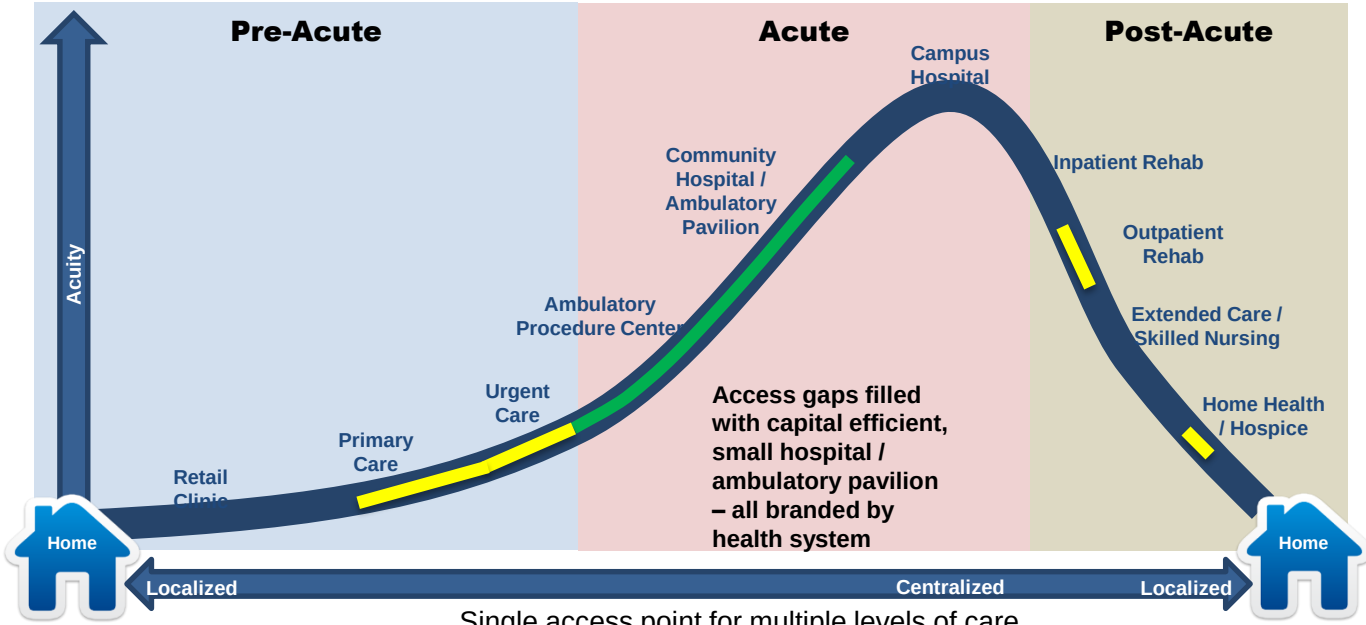
Excellence

Community

Innovation

Continuum of Healthcare

Provide efficient, cost effective care by combining services of Community ED, Outpatient Ambulatory Center and Physician Services in one healthplex conveniently located close to home



Single access point for multiple levels of care

- Microhospital
- Consolidation of other service lines

Continuum of Healthcare

- Health system branded healthcare destination
- Multiple levels of care and cost
- Allows providers to direct patient to the right setting and the lowest cost
- Highly efficient community based solution

Emergency
- Acute episodic needs
- Highest level of care

Collocated Services
- Primary Care
- Walk-in
- Specialty Care
- Telehealth
- Others

Outpatient
- Rehabilitation
- Imaging
- Others

Where Microhospitals Fit

FSER

- Licensed by State (TX & CO)
- **Not recognized by CMS** (Medicare, Medicaid, etc)
- Not required to be affiliated with a hospital

EX: First Choice, Elite, Legacy, etc. – tend to be low volume, high price (OON)

Satellite ER

- Department of a hospital
- Provider based rules
- Recognized by CMS
- Geographic restrictions
- Exposure of hospital license and Medicare number

EX: HCA

Microhospital

- Independently licensed by State as a hospital
- Recognized and separately licensed by CMS
- Inpatient and operating room capabilities

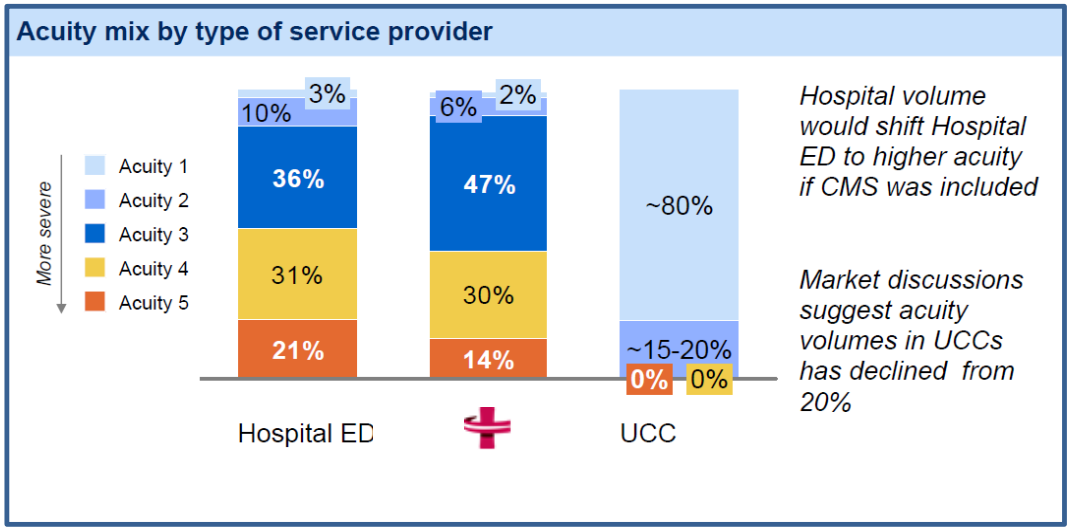
EX: EMERUS + Health System Partner

More than just emergency care

- **Short stay inpatient**
- **Observation**
- **Expansion: Telehealth, O/R, ICU**
- **Low cost community based solution**

Microhospital Capability

- Acuity on par with community based hospitals
- Higher level of care capabilities than FSED (Observations and Inpatient)
- Microhospitals see a distinct and different patient population than UCCs



*Source: Truven Health Analytics, CMS, McKinsey Research

Value Proposition

Provider

- Coordinated transfers to higher level of care: ~8% of ED visits
- Coordinated transfers to primary/specialty care providers: 34% of ED visits
  - *Assist to build patient/provider relationship, get the patient to the right place the first time*
- Brand promotion
- Fill market gaps
- Clinical and quality improvement
- Reduce overcrowding
- Ability to co-locate primary and specialty care in MOB space in facilities

Payor

- Provide clinical access points for patient populations
- Reduced costs through lowered re-admission rates
- Quality care
- Improved outcomes
- Minimal litigation rate
- 0.13% physician complaint rate

Patient

- Exceptional quality and patient satisfaction levels
- Reduced wait times
- Faster discharge times
- Shorter length of stay
- Compassionate and patient friendly care model
- Access both primary and secondary care at single location

Microhospital Performance

Performance Metric	Emerus	National Average
OP4C. Aspirin at Arrival (chest pain) Percent of Patients Receiving	100%	97%
OP5. Average Time to ECG - Chest Pain	2 minutes	7 minutes
OP18. Median Time from ED Arrival to ED Departure for Discharged Patients	75 minutes	173 minutes
OP20. Door to Diagnostic Evaluation to Qualified Medical Personnel	9 minutes	33 minutes
OP 21. Average Time to Pain Management for Long Bone Fracture	42 minutes	54 minutes
OP22. Left Without Being Seen (percent)	0.9%	2.0%
ED1. Average Time from ED Arrival to ED Departure for Admitted ED Patients	166 minutes	338 minutes
ED2. Average Time from Admit to ED Departure for Admitted ED Patients	39 minutes	132 minutes
EDBB. Unscheduled 72 hour ER Readmission Rate (bounce-backs)	1.2%	16.0%

Satisfaction Metric	Emerus
PG Overall Score	90.3%
MD Complaints as a percentage of visits	0.13%
Overall Physician Satisfaction	88.3
Overall Nursing Satisfaction	91.7
Liklihood to Recommend	86.9

1 Includes all Emerus owned and managed facilities across multiple markets and brands 12/2014 – 12/2015
2 In Emerus' case, # of minutes to see ER physician NOT other clinician
3 Source: Hospital Compare, www.medicare.gov -- Overall hospital readmission rate

Industry Innovation

Case Rate	• Lower dependence on charge master • Prepares for price transparency • No carve-outs • Rates easily understood by patient • Simplicity and lower cost of revenue management for system
Bundle Pricing	• Bundle pricing of facility and provider • Also helps prepare for price transparency • Eliminates bill shock from patient receiving multiple bills • Requires control of providers • Has been challenge for some payors to execute
48 Hour Guarantee	• Pilot program with Baylor: 48 hour guarantee for related complaint • Increase patient satisfaction through quality improvement • Increase patient/provider trust
Urgent Care Case Rate	• Pilot program with Baylor • Urgent Care pricing strategy for low acuity visits (levels 1&2) • Eliminate bill shock and improve patient satisfaction
Collocation of Primary Care	• Utilize MOB space for collocated Primary Care • Increase coordination of care with partner system • Ensure patient is seen at the right place the first time – improve patient satisfaction

*Program tests with partner alignment, may not be ideal in all situations

Major Goals

- **Fully leverage the fixed asset**
- **Price simplicity and efficiency to bend the cost curve**
- **Increase patient satisfaction by eliminating pain points**
- **Synergy with partner hospital for an efficient, seamless operation**

Prototype Facility

- Independently licensed hospitals
- 30,000-50,000 sf. – Including hospital and MOB space
- 8 ER beds, 8 - 10 in-patient beds
- 24/7 and staffed with board-certified ER physicians
- On-site x-ray, CT, ultrasound and lab
- Transfer Agreements with partner hospitals
- Facility becomes a hospital and healthplex with ancillary services to include imaging, physical therapy, primary care, rotating specialists, surgery centers…etc

#AICPAhealth

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Why Emerus

OUR CORE VALUES

Excellence

Community

Innovation

Integrity

Empathy

Emerus Experience

Emerus is the nation's first, largest and most experienced operator of micro-hospitals

- 8 joint-venture partnerships
- 17 micro-hospitals in operation (21 by end of 2016)
- 20+ new facilities currently under development (12 facility openings in 2017)
- Over 130 years of combined, executive-level healthcare/business experience
- 3 consecutive years winning Press Ganey Guardian of Excellence
- 5 board-certified, ER trained physicians on executive team
- 29 national marketing awards
- VERIFIABLE PARTNER RELATIONSHIP REFERENCES

Emerus Excellence

Press Guardian of Excellence Award is given to organizations who have achieved the **95th percentile or higher** for the composite overall rating based on the standard Press Ganey Quarterly Reports during the course of the year

Emerus Services

Construction

- National Developer
- Real Estate Capital Funding
- Site Selection (with Business Development)
- Construction, Design, Build
- Architectural Planning
- State & Local Permitting with Hospital & healthcare experience
- Project Management

Clinical

- Protocols, Policies & Procedures
- Governing Body, Medical Executive Committee
- Admissions & Transfer Management
- Quality, Core Measures, HCAHPS
- Compliance, HIPAA (shared with Clinical)
- Physician Credentialing

Finance

- Annual Operating and Capital Budgeting
- Central Billing Office Management
- Financial Auditing & Reporting
- Purchasing & Supply Management
- Managed Contract Review (with Business Development)

Business Development

- New Market Opportunity
- Hospital Partner Relations
- Site Selection
- Analytics: Demographics, Payer Mix, Managed Contracts Rates
- Legal Review

Information Technology

- Network (wired & wireless), Telecommunications, and Infrastructure
- Electronic Health Records & Revenue Cycle System
- Integration, Interoperability, Interfaces, Health Information Exchange
- Cloud Hosted PACs & Radiology Portal
- Business Intelligence & Analytics

Marketing

- Opening Ceremony
- Traditional: Billboard, Print, Radio, TV
- Patient Relationship Management / Customer Satisfaction, Yelp Reviews
- Innovation: Social Networking, YouTube, Facebook
- Physician Referrals
- Employer Group Relationships
- Competitor Maps
- Website, Press Releases, Media Events

Human Resources

- Payroll
- Benefits
- Company Culture & Employee Satisfaction
- Recruiting & Talent Management

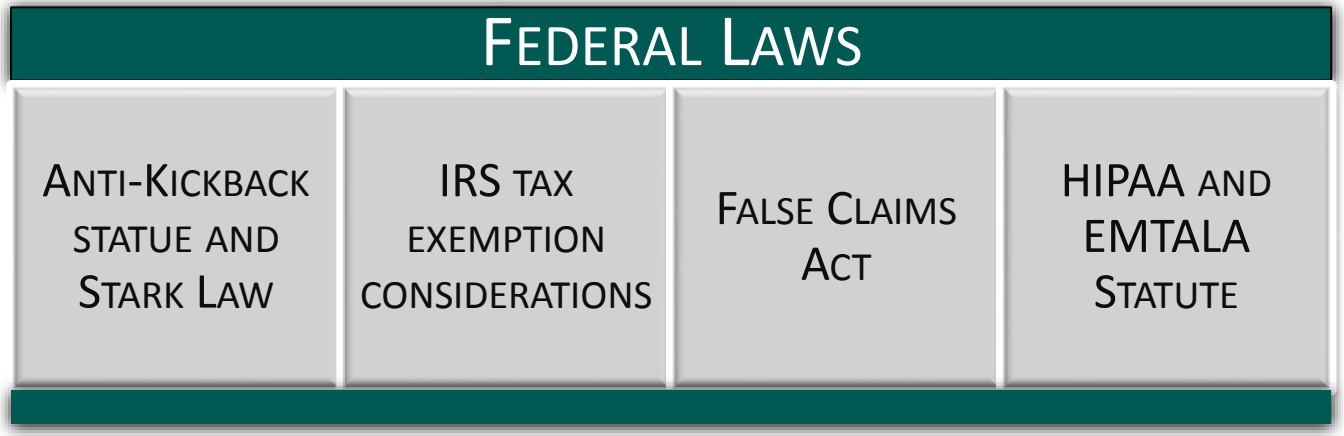
Valuation

Valuation

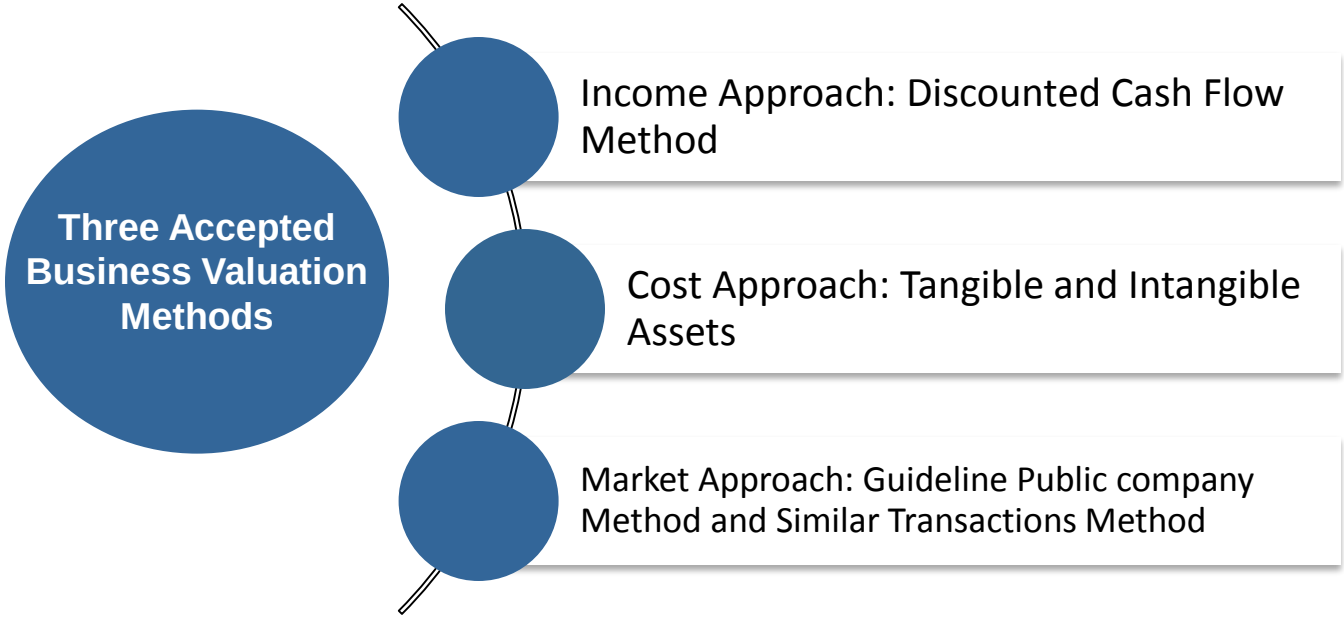
Relevance to Fair Market Value

Why does Fair Market Value ("FMV") matter?

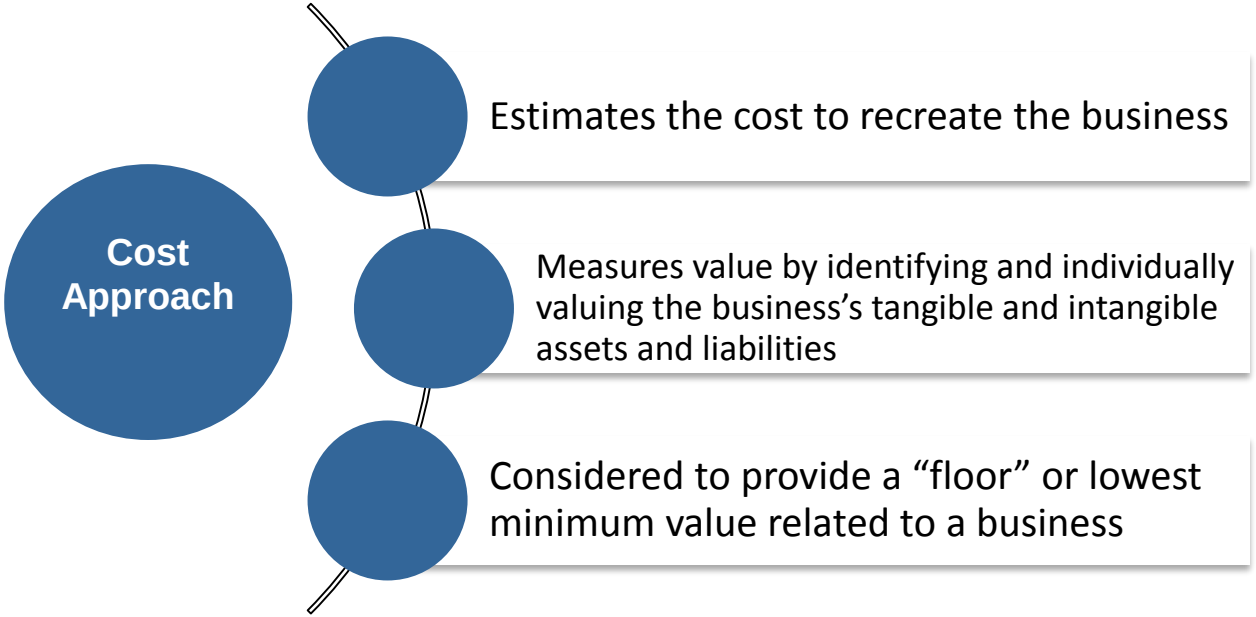
- Compliance with laws
- Operational due diligence
- Key regulatory issues



The Valuation Process

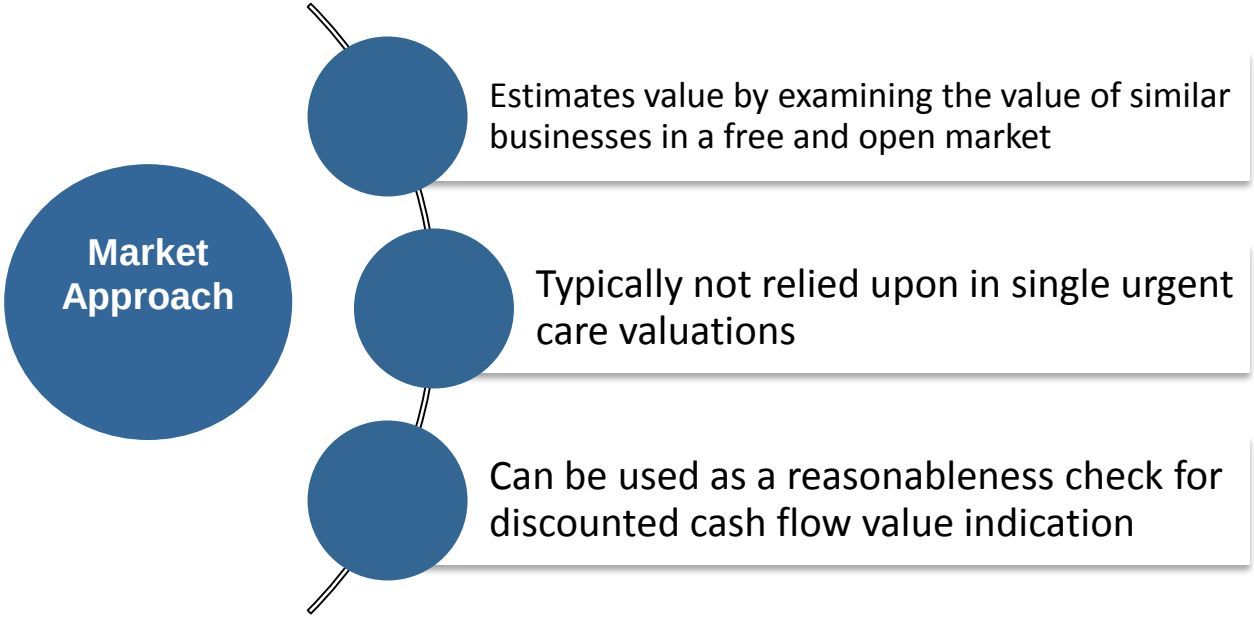


The Valuation Process



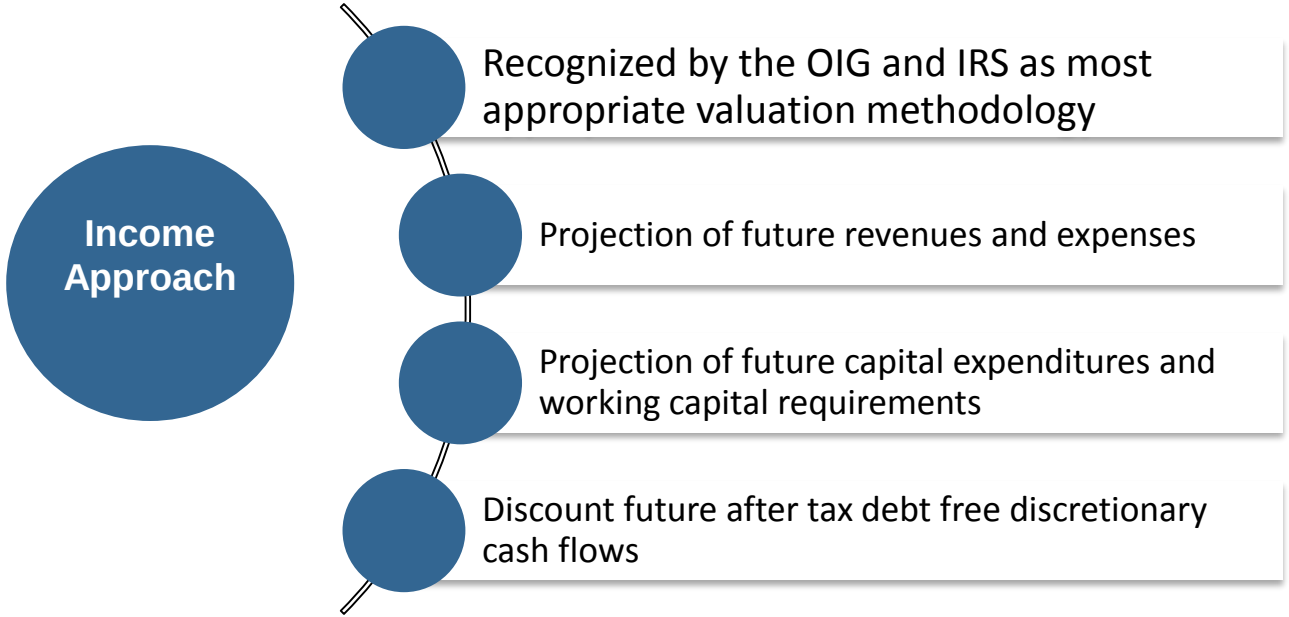
- ***Disconnect between buyers and sellers over historical losses***

The Valuation Process



- ***Large transaction multiples are not relevant to local transactions***

The Valuation Process



- ***Present Value of Future Cash Flows = Fair Market Value***

Transaction Structures

- **Control vs. Minority Valuations**
- **Very different security interests in the same business**
- **Control interest**
  - Generally greater than 50% interest
  - The right to manage the facility
  - The right to dictate partnership agreement terms
  - Ultimate control over important decisions
- **Minority Interest**
  - Generally less than 50% interest
  - No management authority
  - No decision making authority
  - Subject to terms of management agreement

Q & A

Thank You