Hospital Acquisitions of Physician Practices
Legal Issues in Valuing, Negotiating and Structuring the Transaction

TUESDAY, NOVEMBER 12, 2013
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Today’s faculty features:

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Hospital Acquisitions of Physician Practices

November 12, 2013

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Typical Transaction Structures

**MSO Model**

- Health Care System
- Hospital
- MSO
- Physician Practice

Financial Flows:
- $$
- Assets

Management Services
Typical Transaction Structures

**MSO Model**

- MSO acquires tangible assets of the Physician Practice
- Physician Practice remains independent
- MSO provides turn-key management services to Physician Practice
  - Equipment
  - Physician extenders
  - Billing
  - Collections
  - Accounting
Typical Transaction Structures

**MSO Model**

- Purchase price limited to value of hard assets
- Physicians relieved of burdens of:
  - Capital investment
  - Administration of practice
- Physician Practice remains at risk for reimbursement and physician compensation
- MSO services must be provided at FMV
Typical Transaction Structures

*Full Asset Purchase/Employment*

- Health Care System
  - Hospital
  - Clinic
- Physician Practice
  - $$
  - Assets
- Employees

Transfer of Employees
- Assets of Physician Practice are purchased by Health System Clinic at fair market value
- Physician employees, along with clinical and non-clinical staff, become employees of Health System Clinic
- Physician employees are compensated at fair market value in Stark Law compliant employment arrangements
Typical Transaction Structures

Asset Purchase/PSA Arrangement

- Health Care System
  - Hospital
  - Clinic/Foundation
- Physician Practice
  - Assets
  - Employees
  - PSA Compensation
  - Professional Services

- PSA Compensation
- Professional Services
Typical Transaction Structures
Asset Purchase/PSA Arrangement

- Assets of Physician Practice are purchased by Health System Clinic or Foundation at fair market value
- Clinical and non-clinical staff become employees of Health System Clinic or Foundation
- Physicians remain employed by Physician Practice and enter into a long-term professional services arrangement to provide professional medical services to Health System Clinic or Foundation for fair market value compensation, which may include a medico-administrative fee
- Health System Clinic or Foundation retains right to bill for physician services
- Clinic or Foundation operated as 501(c)(3) organization
Typical Transaction Structures
Asset Purchase/PSA Arrangement

- Model works best in states where corporate practice of medicine is an issue
- Physician relieved of burden of capital investment and administration of Physician Practice
- Physicians remain responsible for their compensation (paid out of aggregate PSA compensation)
**Typical Transaction Structures**

**Stock Purchase/Merger**

- Health Care System
  - Hospital
  - Clinic
- MD Owners
  - Physician Clinic

*Can be structured as a stock purchase or merger*
Typical Transaction Structures
Stock Purchase/Merger

- If possible, can be used to avoid double tax on physicians
- Also, can be used to avoid changes in licensure or assignment clauses
- Can be used in non-CPM states
- In certain states, physician practice can be converted to traditional stock corporation to allow for stock purchase by Health System or merger
Typical Transaction Structures

*Real Estate Component*

![Diagram showing the relationship between Health Care System, Hospital, Clinic, and Real Estate Entity with MD Investors]
Typical Transaction Structures
Real Estate Component

- Often, physicians will hold practice real estate in a separate entity
- Transactions often structured to allow physicians to retain real estate and enter into leases with Health System
- Current leases can be renegotiated to longer term arrangements
- Lease valuations often are advisable
Physician Compensation Models

- Very few “guaranteed” salary models (mistakes of the 80s/90s transactions)
- Physicians generally compensated through production based models
  - Revenue *minus* expenses
  - Base compensation *plus* incentive compensation (incentive at risk)
  - Work relative value unit production (WRVUs allocated to CPTs)
  - Incentives for quality, good citizenship, etc.
- Physician participation in ancillaries
- Compensation must meet Stark Law exception
  - Fair market value a critical component
Critical Business Issues

- Valuation Issues
  - All regulatory analyses turn on FMV
  - Formal valuations close the gap between perception and reality
  - Most tax exempt systems insist on third party valuations of physician practices
  - Physician professional component generally has relatively low valuation
  - Most value embedded in ancillary businesses that spin off cash flow (imaging, ASC, lab)
  - Certain intangible assets have value
    - Workforce in place
    - Medical records
    - Trademarks and trade names
  - Use of “stay bonuses”
  - Payments for covenants not to compete
Critical Business/Legal Issues

**Due Diligence**

- Not uncommon to find physician practices with compliance issues
- Avoids later problems
- Possibility of self-disclosure
- Indemnity escrows
Critical Business Issues

- Transaction Issues
  - Purchase price
    - Consider tax consequences to physicians
    - Installment payments v. lump sum payment
  - No more “covenant light” deals
  - Certain percentage of “inked” physicians contracts as a condition to closing
  - Regulatory approvals
  - Indemnity escrows
QUESTIONS?

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November 12, 2013

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Key Deal Maker/Breaker Issues

- Strategic Alignment
- Trust/Relative Trust
- Tax Structure
- Governance
- Other financial Terms/Valuation (purchase price, comp, comp guarantees)
- Term/Duration
- Termination
- Restrictive Covenants/ROFOs
- Unwind Rights (if any)
- Addition of New Physicians
- Break-Up Fees?
- Dispute Resolution
Regulatory Issues

- Federal Issues
  - Federal Anti-Kickback Statute
  - Stark Law
  - False Claims Act
  - Civil Monetary Penalty Law
  - Tax Exemption Issues
  - HIPAA
Regulatory Issues

- Select State Law Issues
  - State anti-kickback statutes
  - State Stark laws
  - Corporate practice of medicine
  - Fee splitting
  - Covenants not to compete
  - Clinic/facility licensure
  - Certificate of need
  - State privacy/security laws
  - Fiduciary issues
  - Physician licensure standards/professional ethics
Anti-Kickback Statute

- Prohibits knowing and willful offer or receipt of remuneration intended to induce or arrange for referrals of business paid for by Medicare/Medicaid programs

- Civil monetary and criminal penalties
  - CMP of $50,000 per violation
  - Criminal penalties: $25,000 per violation and/or up to 5 years in jail
  - Exclusion
Anti-Kickback Statute

- Any purpose test and problem of mixed motives
  - ACA § 6402(f)(2): violation does not require actual knowledge of AKS or specific intent to commit a violation
  - ACA 6402(f)(1): claim for items or services resulting from AKS violation constitutes a false claim under the False Claims Act

- Safe harbors

- Advisory opinions not available on FMV
Anti-Kickback Statute

- Is the purchase price a disguised kickback from the buyer (overpayment) or seller (underpayments) to induce post-deal referrals?
AKS and Practice Acquisitions

- Practice acquisition safe harbors
  - Practitioner-to-practitioner safe harbor
  - Practitioner-to-other entity (hospital) safe harbor
    - Practice acquired is *located in a HPSA*
    - Sale completion with 3 years
    - Seller not in a position to refer after sale completion
    - Purchaser must use diligent and good faith efforts to recruit a successor within 1 year to take over the practice
  - Most practice acquisitions are *not* safe-harbored

- Bona fide employment exception and safe harbor
AKS Valuation Issues

- Valuation Importance – independent appraisal of fair market value in arms-length transaction may negate adverse inference of improper intent.
- Fair market value means the value in arm’s-length transactions, consistent with the general market value.
- “General market value” means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.
AKS Valuation Issues

- Legitimate business purpose and commercial reasonability

- Goodwill – payment for intangibles to physician who continues in a position to refer is suspect (OIG letter to IRS (Dec. 22, 1992); OIG letter to AHA (Nov. 2, 1993))
  - Professional v. practice level goodwill
  - No professional goodwill in absence of enforceable non-compete
  - No EBITDA, no goodwill/Trade-off of compensation and price?

- Discounted free cash flow/discounted earnings approach may take into account the value of future anticipated cash flows (from selling physicians?)
  - See e.g., OIG Adv. Opinion 09-09 (footnote 5) – contribution of ASCs to hospital-physician joint venture should not include intangibles valued on cash flow/going concern basis
  - See PharMerica settlement
Anti-Kickback Statute Issues

- DCF Valuation (con’t)
  - Differences of opinion and approach
    - Hypothetical willing buyer/seller v. referrals from actual sellers
    - Blend with other valuation methods
    - Value on a “re-start” basis?
    - Carve-out governmental business (but, some state all-payor statutes)?

- Other matters affecting value under income approach
  - Salary to selling physicians post-sale
  - Over-coding
  - Revenue growth assumptions
  - Deferred capital investments
  - Size of practice
Anti-Kickback Statute Issues

- Market Approach Valuation Issues: Need true comparables
  - Same specialty and mix of services?
  - Same market?
  - Same time period?
  - Same context?
  - Private vs. public company transactions
  - See Sta-Home Health Agency vs. Commissioner, Case No. 02-60912 (5th Cir. July 11, 2006) (Inappropriate market approach to valuation based on public company comparables for home care company with no invested capital and no history of profitable operations/no goodwill)
Anti-Kickback Statute Issues

- Market Approach (con’t)
  - Problem of tainted comparables
    - “Depending on the circumstances, the ‘volume or value’ restriction will preclude reliance on comparables that involve entities or physicians in a position to refer or generate business.” 66 Fed. Reg. at 944

- Other Issues
  - Earnouts of sellers who remain in a position to refer
  - Use of attorney-client privilege
  - Valuator certifications
Stark Law

- Prohibits a physician who has a direct or indirect financial relationship with a DHS entity from referring patients to the DHS entity for "designated health services" for which payment may be made under the Medicare or Medicaid program; unless a specific exception applies
  - "Designated health services" includes all inpatient and outpatient hospital services, lab, imaging, pharmacy, DME, radiation therapy, PT, occupational and speech therapy, perenteral and enteral drugs, nutrients, and supplies, prosthetics, orthodics, and home health services
  - $15,000 civil monetary penalty assessed against physician for each prohibited referral
  - DHS entity must refund DHS billed pursuant to a prohibited referral
  - $15,000 civil monetary penalty assessed against DHS entity for billing for service rendered pursuant to a prohibited referral, unless it can show that it did not have actual knowledge and did not act in reckless disregard or deliberate ignorance of the prohibited referral
  - $100,000 civil monetary penalty for circumvention schemes
  - Requirement to report to HHS financial relationships with physicians upon request; $10,000 penalty for failure to report
  - Potential exclusion
Stark Law

- Stark law – purchase price transaction creates financial relationship that will prohibit referrals to hospital buyer (or other DHS entity) unless an exception applies
  - Strict liability/Zero tolerance law
  - Stark analysis has changed with “stand in shoes” rule
    - Stock transactions – payment to physician (direct)
    - Asset transactions – payment to medical group (indirect)
    - Direct compensation exception needed for physician owners (other than titular-owners)
    - Direct or indirect compensation exception for titular owners and non-owners (e.g., employees)
Stark Law

- Principal **direct compensation** exception for practice acquisitions is **isolated transaction exception**
  - Compensation exception only (not applicable if stock, warrants, options or other investment interests are part of purchase consideration)
  - Isolated transaction standards: Aggregate payments fixed in advance (no earn outs)
  - Payable even if default by buyer (negotiable note or guaranteed by third party)
  - FMV, not taking into account volume or value of referrals or other business generated between the parties
    - Similar to valuation issues under AKS if seller will continue to be in position to refer
    - Particularly acute if selling medical group provides DHS/ancillaries
    - Advisory opinions on fair market value not available
Stark Law

- Isolated transaction exception standards (con’t)
  - No other transactions for 6 months except:
    - Other Stark Law excepted transactions
    - Commercially reasonable post-closing adjustments
  - **Indirect compensation** analysis for physician owners of selling medical group and for acquisition by non-DHS affiliate of Hospital
    - Purchase price must be FMV and not vary with v/v of referrals

- Burden of proof is on defendant
  - Violations are not remedied until referring physician/DHS entity repays excess compensation or arrangement is terminated
Stark Law

- *Drakeford v. Tuomey*, CA No. 3:05-2858-MBS (US District Court, SC, 9/13/13)
  - Part-time employment agreements with 19 endoscopists found to violate Stark Law and FCA where compensation is 31% in excess of collections from personally performed services, and each service performed results in a facility fee payment to the Hospital
  - Jury finds that compensation takes into account v/v of referrals for DHS
  - No valuation opinion obtained
  - Treble damages under FCA of $237 million
Stark Law

  - Payment for non-compete from hospital to cardiology group in connection with sublease to hospital of nuclear medicine camera was found to violate Stark Law, notwithstanding fixed fee and independent appraisal of FMV
  - Court finds that appraisal method takes into account volume/value of anticipated referrals from cardiology group based on expected referrals in the absence of an interest in its own cardiac imaging service
Stark Law Issues

Other Stark Law Issues

- Sale of physician lab or DHS services – not permitted if price is based on anticipated post-transaction referrals by physician owners
- Installment sales – permitted if integral to transaction and payments guaranteed even if buyer defaults
  - Secured debt instrument treated as investment interest (isolated transaction exception does not apply)
- Investment interests in buyer (DHS entity)
  - Stock options and convertible securities issued as “compensation” are not investment interests
  - Investment interest exceptions for rural providers, and publicly traded securities
  - No small entity exception
Stark Law Issues

- Associated transactions (e.g., employment, consulting, lease agreements) must meet other Stark Law exceptions
  - Employment
    - Identifiable services
    - FMV and commercially reasonable
    - Not take into account v/v of DHS referrals
  - Personal services
  - Space rental or equipment rental
  - Fair market value
  - Indirect compensation
- All based on FMV
Tax Exemption Considerations

- 501(c)(3) Exemption Standards
  - No inurement
  - Not more than incidental private benefit

- Revocation authority and intermediate sanctions
  - Modern Health Care Services (d/b/a LAC Facilities) 94 TNT 216-38 (Nov. 3, 1994) – revocation
Tax Exemption Considerations

- **Carracci (Sta-Home) case** – proposed revocation and intermediate sanctions overturned due to IRS valuation errors

- **Lessons of Carracci Case**
  - Select a qualified appraiser with particular expertise and experience
  - Properly take into account third party payor methodologies and rates
  - Use true market comparables
  - Follow process for rebuttable presumption of reasonableness (to shift the burden to the IRS to establish that appraised value is incorrect)
Tax Exemption Considerations

- Rebuttable presumption process
  - Approved by board or committee with no conflict of interest
  - Rely on appropriate data as to comparability
  - Determine that the property transfer is at FMV
  - Document basis of decision within 60 days after decision
Tax Exemption Considerations

- Other Exemption issues/cases
  - Charitable deduction for donation of assets with value in excess of benefits received/Penalties for valuation misstatements (IRC § 6662)
  - Derby case, T.C.M. 2008-45 (Feb. 28, 2008) (Disallowance of claimed charitable contribution to Sutter Medical Foundation by physicians associated with Sutter West Medical Group)
  - Bergquist case, 131 T.C. 2 (July 22, 2008) (Tax court reduces charitable deduction of $401.79/share to $37/share for contribution of PC stock, and imposes valuation misstatement penalties)
Regulatory Compliance

Advice

- Document proper purpose of acquisition: community benefit
- Disclaim improper purpose: induce referrals
- No evidence of improper purpose
- Independent appraisal of FMV
- If sellers will continue in position to refer, valuation method cannot take into account future referrals by sellers

  - Goodwill value generally cannot be recognized in the absence of EBITDA and an enforceable non-compete
  - Cannot value unenforceable non-competes (e.g., MA)
  - Cannot value DHSs on basis that takes into account v/v of future referrals
  - Avoid earn-outs, but installment sales permitted
  - Avoid exclusive use agreements
Regulatory Compliance

- Advice re: Independent Appraisal of FMV
  - Select knowledgeable appraiser who has experience with medical practice valuations and is sensitive to health regulatory issues
  - Diligence appraisal for health regulatory compliance
  - Obtain compliance certification from appraiser, to the extent possible
  - Make sure valuation takes into account all aspects benefits received by sellers in transaction documents
  - Rely on true market comparables
  - Do not use going concern value (income or market approach) for practice that is otherwise going out-of-business
Regulatory Compliance

Advice re: Tax Exemption

- Follow steps for rebuttable presumption of reasonableness if buyer is a tax-exempt entity
- Properly value any assets contributed to exempt organization

- Assure that charitable deduction is reduced by value of any benefits received by “seller” in connection with donation
Hospital Acquisitions of Physician Practices

November 12, 2013

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Physician Practice Consolidation Drivers
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Pressure on Physicians

- Increased Payor Leverage
- Risk & Population Mgmt.
- Limited Access to Capital
- IT Needs
- Regulation
- Consumerism
- Practice Patterns
- PPACA

Increased M&A Activity
Increased transparency and regulation is driving industry towards commoditization
Physician Practice Consolidation Drivers

Breakdown of National Health Expenditures, 2011

Hospital and specialist physician utilization is at the center of cost reduction efforts

U.S. GDP, 2011

$2.70 Trillion

Other, 33.2%
Nursing Home Care, 5.5%
Prescription Drugs, 9.7%
Physician Services, 20.1%
Hospital Care, 31.5%

Physician Practice Consolidation Drivers

Consumerism

Traditional fee-for-service insured and managed care

BORDERS® → amazon.com®

BLOCKBUSTER® → NETFLIX

San José Mercury News

CALIFORNIA

Californians flock to new health care exchange

By JULIET WILLIAMS Associated Press
Health Care Industry Trends

Consumerism from Increased Patient Responsibility

Patients are bearing a greater portion of health care costs as a result of health benefit redesign.

- High-deductible health plans constitute 20% of enrollment for employer-sponsored insurance.

- Individual deductibles for covered workers have nearly doubled over the past seven years.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits
While the growth in total physicians has been moderate, there has been a significant increase in the number of employed physicians:

- PPACA, advances in medical technology and physician shortages have caused hospitals and health systems to accelerate the direct employment of physicians.
- In 2012, employed physicians represented about half of all physicians, up from approximately 40% in 2010.

### Estimated Physician Demand Trends

Sources: Barclays – "13th Annual Barclays Nashville Bus Tour Takeaway From a Timely Visit" – April 12, 2013 and Association of American Medical Colleges (Excludes expected physician supply needs as a result of health care reform)
While the growth of total physicians has been moderate, there has been a significant increase in the number of employed physicians

- Current trend toward hospital employment of physicians is different from the 1990s, when hospitals typically approached physicians about employment opportunities rather than the reverse.
- Today, many physicians, specialists in particular, are seeking hospital employment to relieve them of the stress of high malpractice rates, the struggle for reimbursement, administrative duties and the general risks and hassles of private practice.
- Changes in reimbursement structures, advances in medical technology and physician shortages have caused hospitals and health systems to accelerate the direct employment of physicians.
- Healthcare reform promotes the use of Accountable Care Organizations ("ACOs"), which will depend on close physician/hospital cooperation to improve quality of care and reduce costs.
- Physician employment by the hospital is one way to achieve the strategic, financial, and information technology alignment between physicians and hospitals that is needed to implement the ACO model.

In 2012, employed represented about half of all physicians, up from approximately 40% in 2010.

Physician Employment Trends

<table>
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<tr>
<th>Year</th>
<th>Independent</th>
<th>Employed</th>
<th>Change</th>
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<tr>
<td>2010</td>
<td>387,874</td>
<td>258,582</td>
<td>+5.2%</td>
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<tr>
<td>2011</td>
<td>364,371</td>
<td>286,291</td>
<td>+30.9%</td>
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<tr>
<td>2012</td>
<td>338,404</td>
<td>676,808</td>
<td>-12.8%</td>
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Search Assignments Featuring Hospital Employment

Sources: Association of American Medical Colleges (Excludes expected physician supply needs as a result of health care reform) and Merritt Hawkins Review of Physician Recruitment Incentives.
Since the mid-1990’s, the managed care industry has seen significant consolidation

- In many markets, providers are price takers
- Providers in markets that consolidate either horizontal (hospital/hospital) and/or vertically (hospital/physicians) are better able to offset concentration of payors
- PPACA limits on payor premium profits are shifting payor focus to provider business and reconfiguring the payor landscape to control risk dollars

Managed Care Companies (as a Percentage of Total Market Capitalization)

![Managed Care Companies Chart]

- 1995 – Total $40.6 billion
  Top 5 = 67% of total
- 2000 – Total $54.5 billion
  Top 5 = 83% of total
- 2012 – Total $144.7 billion
  Top 5 = 86% of total

Increased Payor Leverage
Population and risk assumption will require better integration of providers

- Reimbursement pressures will require “venue neutrality”
- Re-admission penalties and reimbursement for “episodes of care” require closer coordination
- Accountable care and population management require integration of care continuum
Key Constituents of the Delivery Ecosystem

- Providers in care delivery ecosystem have different incentives
- FFS mechanisms incentivize admissions
- Care of a patient is not tracked among providers
- Bundled payments and ACO structures will drive coordination
- Cost and outcomes will define where patients and $’s will go
- Physicians/clinicians and managed care will all fight for a leading role

**The Key Question**
Who will control the ultimate economics of the system?
**Physician Practice Consolidation Drivers**

Health Care IT Industry Perspectives

Technology requirements are becoming daunting for practices as:

- Reimbursement away from fee for service creates need for sophisticated IT capabilities to address increasing reimbursement complexity.
- Increasing proliferation of standards necessitates investments in IT.
- Next wave will be focused on analytics to leverage HITECH infrastructure toward actionable results.
  
  - Ultimate foundation for Population Health Management + True Evidence Based and Personalized Medicine.

- “ACO Tools” represent convergence of IT infrastructure.

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**Government**
- 1999 IOM study
- Stark Law / EMR accreditation
- ARRA / HITECH
- Reform: Exchanges/ACOs

**Health Care Providers**
- Remote diagnosis
- Comparative effectiveness / Evidence-based medicine
- Quality-based reimbursement

**Technology**
- HL7/HIPAA/ICD-10 data standards
- Security and Storage cost/function improvements
- “The Cloud”, SaaS models, wireless access, “mHealth”

$2.5 Trillion Industry

Improved Interoperability

ACOs Require New RCM & Clinical IT

Physician EHR Adoption

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*Source: Cain Brothers’ research, CDC, HIMSS.*
The RAND Corporation recently reported on the concerns expressed by physicians:

- The majority of physicians are frustrated with the costly IT systems
  - Many think that IT has yet to deliver on the promise of improved efficiency
- Many like aspects of IT but consider the usability, interoperability and functionality of IT systems to be huge barriers
- The wide array of systems, many not integrated, creates confusion and inefficiency
- More and more federal regulations around EHR and EMR are further complicating patient record keeping and diverting resources from patient care

Technology requirements combined with government regulations is becoming daunting for practices:

- There are more pages of regulations for Medicare than in the Internal Revenue Service code
- Regulations are more becoming more complicated and more restrictive

Regulation by the Federal government has spawned a whole new industry on compliance
Market Participants
After a ten year hiatus, private and strategic capital is flowing back into the physician practice management industry

- Acquirors are taking a more strategic and diligent approach to practice acquisitions
- Transactions are increasingly being vetted by one or more independent, third party valuation firms to support and/or determine purchase price
- Physicians being offered production-based fair-market value compensation structures with incentives to align with hospital interests linking compensation to:
  - Productivity
  - Collections
  - Clinical efficiency
  - Integration efforts
  - Quality, safety and patient satisfaction
  - Income from ancillary activities
- Certain value of the deal may be derived from ancillary services (e.g. imaging, laboratories, ambulatory surgery, sleep studies and clinical research)
- Allow physicians a certain level of autonomy while also offering physicians with an ongoing role in group governance and management of the physician group
- Hospitals are much more price conscious and are highly aware of the need to comply with the federal and state anti-kickback statues and Stark laws
- Best of breed groups that have worked together for a long period of time in a specific practice area are providing care at a lower cost with better outcomes
- Physician networks have become the key to major initiatives around quality, safety, disease management, and IT standardization
Recently there have been significant strategic and financial investments into physician groups – many of them have been “game changing”

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<td>Advisory Board Company</td>
<td>Goldman Sachs Pharos Capital Group</td>
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<td>Clayton, Dubilier &amp; Rice</td>
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<td>DaVita</td>
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<td>Dignity Health</td>
<td>University of California San Francisco (UCSF)</td>
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<tr>
<td>Enhanced Equity</td>
<td>UnitedHealth Group</td>
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Source: Company press releases and CapitalIQ
## Market Participants
### Physician Groups and Hospitalists

($ in millions)

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<th>Announced</th>
<th>Closed</th>
<th>Target</th>
<th>Acquiror</th>
<th>Enterprise Value</th>
<th>LTM Revenue</th>
<th>LTM EBITDA</th>
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<td>09/17/13</td>
<td>Pending</td>
<td>Arizona Integrated Physicians</td>
<td>DaVita HealthCare Partners (NYSE: DVA)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>07/01/13</td>
<td>07/01/13</td>
<td>3 Physician Groups in WI, NJ, and OH</td>
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<td>04/16/13</td>
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<td>03/21/13</td>
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<td>NA</td>
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<tr>
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<td>01/08/13</td>
<td>San Francisco Physicians Internationale Inc</td>
<td>Team Health Holdings Inc</td>
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<td>NA</td>
<td>NA</td>
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<tr>
<td>10/22/12</td>
<td>11/20/12</td>
<td>CHG Healthcare Services</td>
<td>Leonard Green &amp; Partners, Ares Management</td>
<td>$1,100.0</td>
<td>NA</td>
<td>~11.0x</td>
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<tr>
<td>06/13/12</td>
<td>10/01/12</td>
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<td>Blount Memorial Hospital</td>
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<td>05/21/12</td>
<td>11/01/12</td>
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<td>DaVita Inc</td>
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<tr>
<td>06/27/11</td>
<td>10/04/11</td>
<td>Continucare, Inc.</td>
<td>Metropolitan Health Networks, Inc.</td>
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<td>9.4x</td>
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<tr>
<td>05/31/11</td>
<td>05/31/11</td>
<td>California Cancer Specialists Medical Group</td>
<td>City of Hope</td>
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<tr>
<td>04/13/11</td>
<td>05/04/11</td>
<td>Cogent Healthcare Inc</td>
<td>Hospitalist Management Group LLC</td>
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<tr>
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<td>US Radiosurgery LLC</td>
<td>Alliance Oncology LLC</td>
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<td>02/14/11</td>
<td>05/25/11</td>
<td>Emergency Medical Services Corp</td>
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<td>$2,962.7</td>
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<td>01/04/11</td>
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<td>11/22/10</td>
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<td>06/02/09</td>
<td>06/02/09</td>
<td>Associates in Neonatology PA</td>
<td>MEDNAX Inc</td>
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<td>4.0x</td>
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<td>10/17/08</td>
<td>10/17/08</td>
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<td>EmCare Inc</td>
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<td>1.4x</td>
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<td>04/17/08</td>
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<td>HealthTronics Inc</td>
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<td>US Oncology Inc</td>
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<td>11/14/07</td>
<td>01/04/08</td>
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<td>Sheridan Healthcare Inc</td>
<td>Hellman &amp; Friedman LLC</td>
<td>$925.0</td>
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Source: Source: Company press releases, SEC filings, Capital IQ, Irving Levin and Cain Brothers’ estimates
NM = Not Meaningful; NA = Not Available

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<thead>
<tr>
<th>Mean</th>
<th>Median</th>
<th>Low</th>
<th>High</th>
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<td>1.2x</td>
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<tr>
<td>8.3x</td>
<td>8.8x</td>
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Market Participants
50 Largest U.S. Medical Groups

<table>
<thead>
<tr>
<th>Rank</th>
<th>Medical Group</th>
<th>State</th>
<th>Offices</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Kaiser Permanente Medical Group</td>
<td>CA</td>
<td>484</td>
<td>7,842</td>
</tr>
<tr>
<td>2</td>
<td>Cleveland Clinic</td>
<td>OH</td>
<td>173</td>
<td>1,472</td>
</tr>
<tr>
<td>3</td>
<td>Henry Ford Medical Group</td>
<td>MI</td>
<td>218</td>
<td>1,224</td>
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<tr>
<td>4</td>
<td>IU Health Physicians</td>
<td>IN</td>
<td>267</td>
<td>1,202</td>
</tr>
<tr>
<td>5</td>
<td>University Washington Physicians</td>
<td>WA</td>
<td>181</td>
<td>1,199</td>
</tr>
<tr>
<td>6</td>
<td>Mercy</td>
<td>MO</td>
<td>349</td>
<td>1,115</td>
</tr>
<tr>
<td>7</td>
<td>North Shore Long Island Jewish</td>
<td>NY</td>
<td>259</td>
<td>1,044</td>
</tr>
<tr>
<td>8</td>
<td>Carolinas Primary Care</td>
<td>SC</td>
<td>236</td>
<td>1,024</td>
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<tr>
<td>9</td>
<td>Aurora Medical Group</td>
<td>QI</td>
<td>206</td>
<td>1,013</td>
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<tr>
<td>10</td>
<td>Novant Medical Group</td>
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<td>923</td>
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<td>11</td>
<td>Palo Alto Medical Foundation</td>
<td>CA</td>
<td>55</td>
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<tr>
<td>12</td>
<td>Vanderbilt Medical Group</td>
<td>TN</td>
<td>145</td>
<td>876</td>
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<tr>
<td>13</td>
<td>Lehigh Valley Physicians Group</td>
<td>PA</td>
<td>301</td>
<td>863</td>
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<td>14</td>
<td>Duke University Physicians</td>
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<td>824</td>
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<tr>
<td>15</td>
<td>Scott &amp; White Clinic</td>
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<td>98</td>
<td>778</td>
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<tr>
<td>16</td>
<td>Emory Clinic</td>
<td>GA</td>
<td>99</td>
<td>762</td>
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<tr>
<td>17</td>
<td>Intermountain Medical Group</td>
<td>UT</td>
<td>145</td>
<td>717</td>
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<td>18</td>
<td>Marshfield Clinic</td>
<td>WI</td>
<td>53</td>
<td>709</td>
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<td>19</td>
<td>Yale Medical Group</td>
<td>CT</td>
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<td>674</td>
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<td>20</td>
<td>Ochsner Clinic</td>
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<td>21</td>
<td>Geisinger Medical Group</td>
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<td>UW Health Clinics</td>
<td>WI</td>
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<td>23</td>
<td>Umass Memorial Medical Group</td>
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<td>619</td>
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<td>24</td>
<td>University Minnesota Physicians</td>
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<td>25</td>
<td>Allina Health Medical Clinic</td>
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<td>575</td>
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<table>
<thead>
<tr>
<th>Rank</th>
<th>Medical Group</th>
<th>State</th>
<th>Offices</th>
<th>Physicians</th>
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<tbody>
<tr>
<td>26</td>
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<td>41</td>
<td>556</td>
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<td>27</td>
<td>UC Davis Medical Group</td>
<td>CA</td>
<td>48</td>
<td>545</td>
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<tr>
<td>28</td>
<td>Nyes Adult Specialties</td>
<td>PA</td>
<td>71</td>
<td>530</td>
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<tr>
<td>29</td>
<td>Duluth Clinic</td>
<td>MN</td>
<td>94</td>
<td>526</td>
</tr>
<tr>
<td>30</td>
<td>Wheaton Franciscan Medical</td>
<td>WI</td>
<td>161</td>
<td>524</td>
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<tr>
<td>31</td>
<td>Advocate Medical Group</td>
<td>IL</td>
<td>111</td>
<td>523</td>
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<tr>
<td>32</td>
<td>Dartmouth-Hitchcock Clinic</td>
<td>NH</td>
<td>70</td>
<td>522</td>
</tr>
<tr>
<td>33</td>
<td>Lahey Foundation</td>
<td>MA</td>
<td>38</td>
<td>522</td>
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<tr>
<td>34</td>
<td>California Emergency Physicians</td>
<td>CA</td>
<td>56</td>
<td>480</td>
</tr>
<tr>
<td>35</td>
<td>University Of Florida Physicians</td>
<td>FL</td>
<td>88</td>
<td>480</td>
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<tr>
<td>36</td>
<td>Park Nicollet Clinic</td>
<td>MN</td>
<td>69</td>
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<tr>
<td>37</td>
<td>Arizona Medical Clinic</td>
<td>AZ</td>
<td>113</td>
<td>471</td>
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<td>38</td>
<td>Jefferson University Physicians</td>
<td>PA</td>
<td>63</td>
<td>467</td>
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<tr>
<td>39</td>
<td>Providence Medical Group</td>
<td>OR</td>
<td>99</td>
<td>452</td>
</tr>
<tr>
<td>40</td>
<td>Health Texas Provider Network</td>
<td>TX</td>
<td>107</td>
<td>447</td>
</tr>
<tr>
<td>41</td>
<td>UC San Diego Medical Group</td>
<td>CA</td>
<td>111</td>
<td>445</td>
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<tr>
<td>42</td>
<td>University Medical Group</td>
<td>SC</td>
<td>83</td>
<td>444</td>
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<td>43</td>
<td>Fairview Physician Associates</td>
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<td>CA</td>
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<td>427</td>
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<td>45</td>
<td>Medical College Physicians</td>
<td>WI</td>
<td>43</td>
<td>414</td>
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<tr>
<td>46</td>
<td>Pediatrics Medical Group</td>
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<td>413</td>
</tr>
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<td>47</td>
<td>UT Physicians Houston</td>
<td>TX</td>
<td>57</td>
<td>411</td>
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<td>48</td>
<td>Carolina Family Care</td>
<td>SC</td>
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<td>49</td>
<td>LSU Healthcare Network</td>
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<tr>
<td>50</td>
<td>HealthPartners</td>
<td>MN</td>
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<td>398</td>
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</table>
HealthCare Partners is a game changer for medical groups and affiliated physician networks

- Patient-focused, physician-centric leader of integrated care
- Largest network of physician groups
- Opportunity to grow by entering into new markets

### HCP Payer Mix by State

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<th></th>
<th>California</th>
<th>Florida</th>
<th>Nevada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>479,073</td>
<td>40,166</td>
<td>33,942</td>
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<tr>
<td>Government</td>
<td>99,263</td>
<td>4,164</td>
<td>28,016</td>
</tr>
<tr>
<td>Total</td>
<td>578,336</td>
<td>44,330</td>
<td>61,958</td>
</tr>
<tr>
<td>% of Total</td>
<td>84%</td>
<td>6%</td>
<td>9%</td>
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</tbody>
</table>

Source: CapitalIQ, company filings and Wall Street research

(1) Data as of 2010 and excludes September 7, 2012, acquisition of ABQ Healthcare Partners, which employs ~185 physicians and serves ~180,000 patients in New Mexico
HealthCare Partners Business Overview

- Focus on proactive patient management, improving care / outcomes and eliminating waste
- “Starting point of its business model is its patient database and EMR”
- Model consists of primary care physicians and specialists in addition to care managers, disease managers and social workers
- Ability to negotiate with payers in the event of unforeseen circumstances

### Summary HCP Financials

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<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012P</th>
<th>2013P</th>
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<td>Revenue</td>
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<td>$1,800</td>
<td>$2,100</td>
<td>$2,400</td>
<td>$2,609</td>
<td>$2,835</td>
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<tr>
<td>Growth %</td>
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<td>13%</td>
<td>17%</td>
<td>14%</td>
<td>9%</td>
<td>9%</td>
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<tr>
<td>Operating Expenses</td>
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<td>1,540</td>
<td>1,722</td>
<td>1,911</td>
<td>2,099</td>
<td>2,278</td>
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<tr>
<td>Operating Income</td>
<td>$246</td>
<td>$260</td>
<td>$378</td>
<td>$489</td>
<td>$510</td>
<td>$557</td>
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<td>Margin %</td>
<td>15%</td>
<td>14%</td>
<td>18%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
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<tr>
<td>D&amp;A</td>
<td>24</td>
<td>26</td>
<td>29</td>
<td>31</td>
<td>32</td>
<td>33</td>
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<tr>
<td>Stock Based Comp.</td>
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<td>7</td>
<td>7</td>
<td>8</td>
<td>10</td>
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<tr>
<td>Adjusted EBITDA</td>
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<td>$293</td>
<td>$414</td>
<td>$527</td>
<td>$550</td>
<td>$600</td>
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<tr>
<td>Margin %</td>
<td>17%</td>
<td>16%</td>
<td>20%</td>
<td>22%</td>
<td>21%</td>
<td>21%</td>
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### HCP Acquisition History

<table>
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<th>Company Name</th>
<th>Year</th>
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<td>Arizona Integrated Physicians</td>
<td>2013</td>
</tr>
<tr>
<td>Nevada Cancer Centers</td>
<td>2013</td>
</tr>
<tr>
<td>ABQ Healthcare Partners</td>
<td>2012</td>
</tr>
<tr>
<td>Advanced Medical Center</td>
<td>2010</td>
</tr>
<tr>
<td>Talbert Medical Group</td>
<td>2010</td>
</tr>
<tr>
<td>Rainbow Medical Center</td>
<td>2010</td>
</tr>
<tr>
<td>Fremont Medical Centers</td>
<td>2009</td>
</tr>
<tr>
<td>Northridge Medical Group</td>
<td>2009</td>
</tr>
<tr>
<td>Physician Associates of the Greater San Gabriel Valley</td>
<td>2008</td>
</tr>
<tr>
<td>Arroyo Seco Medical Group</td>
<td>2007</td>
</tr>
<tr>
<td>Pinnacle Health System</td>
<td>2006</td>
</tr>
<tr>
<td>JSA Healthcare Corporation</td>
<td>2006</td>
</tr>
<tr>
<td>Harriman Jones Medical Group</td>
<td>2005</td>
</tr>
<tr>
<td>Greater Valley Physicians Associates</td>
<td>2001</td>
</tr>
<tr>
<td>Greater Valley Medical Group</td>
<td>2001</td>
</tr>
<tr>
<td>Unified Physicians of the South Bay</td>
<td>1997</td>
</tr>
<tr>
<td>Memorial Medical Group</td>
<td>1997</td>
</tr>
<tr>
<td>Alliance of Private Practice Physicians</td>
<td>1996</td>
</tr>
<tr>
<td>Bay Shores Medical Group</td>
<td>1994</td>
</tr>
<tr>
<td>3 Companies merge to form HCP Medical Group</td>
<td>1992</td>
</tr>
</tbody>
</table>

Source: CapitalIQ, company filings and Wall Street research
Valuation Issues and Fairness Opinions
Valuation Issues and Fairness Opinions
Valuation Considerations

- “Value” is an opinion, not a "price” and depends on facts and circumstances
- There is no single answer as what constitutes fair market value. The standard is a reasonably defensible opinion of value
- Traditionally, the question of valuation was determined by hospital buyers anxious to placate their physician partners
- Generally, physician practices generate minimal free cash flow beyond what is needed for working capital and servicing debt
  - The value of physician practice assets to be acquired will be constrained by the expected cash flow generated from these assets after physician compensation is paid
- To the extent physician compensation remains the same or even increases after an acquisition, expected cash flow to the hospital from the practice may be limited and the value of the practice is limited
- Hospitals must be careful to not pay a strategic premium to buy a practice above fair market value
- Third-party valuations have become a staple of physician/hospital relationships

Valuation Issues and Fairness Opinions
Process

How to Avoid Past Mistakes

- The 1990’s physician practice acquisition craze resulted in overpaying for practices, salary guarantees and failing to actively manage acquired practices
- Today’s transactions are often hotly negotiated and heavily scrutinized
- The size and complexity of these transactions has increased the need for third-party opinions
- The value of physician practice assets is constrained by the expected cash flow after physician compensation is paid
- Ancillary revenues are often a key value component

Managing Physician Expectations

- Physician practice acquisitions are as much about physician emotions and expectations as they are about deal points
- Most physician practice leaders over-value their practices
- Gaps in expectations can create challenges for hospital acquirers
- Discuss and negotiate physician employment contracts very early in the process with careful consideration for the following:
  - Hours of practice
  - Control that can be exercised by the hospital
  - The ability of the hospital to relocate the physician’s practice
  - Compensation formulas and benefits
  - Covenants not to compete

Valuation Issues and Fairness Opinions
Board Duties

- Board members have a number of duties including *duty of care* that requires them to be reasonably informed when making specific decisions on behalf of their stakeholders.
  - Transactions involving change in control
  - Purchase or sale of significant assets

- A formal opinion, most often referred to as a “fairness opinion,” rendered by an expert also serves as evidence that a board and its members have conducted a process that was sufficient and consistent with meeting its fiduciary obligations

- Overall attention to corporate responsibility and recent interest in the general topic of fairness opinions by nonprofit regulatory bodies are all signals that boards need to be careful in using and contracting for fairness opinions

- Boards should review their organization’s individual circumstances match specific recommendations to their needs.

- Fairness opinions are often obtained where:
  - Boards are likely to be second-guessed about its ability to act on behalf of all stakeholders
  - Regulatory review is more aggressive
  - Tax opinions and legal opinions are required to complete a transaction
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Purpose

- Fairness opinions are appropriate for both investor owned companies, whether publicly owned or privately held, and nonprofit organizations.

- The fairness opinion itself is a short letter from a firm considered expert in the area of health care M&A and finance expressing the expert’s opinion that the transaction is fair from a financial point of view.
  - The opinion should be supported by detailed analytic calculations using standard industry valuation methodologies
  - Discussed with the board prior to the board making a final decision on a transaction

- Some health care transactions may also benefit from obtaining a valuation opinion instead of/or in addition to a fairness opinion
  - Anticipated regulatory review processes

- A valuation opinion specifically estimates the fair market value of what is being considered, which might be the equity of a company, a line or lines of business, or an asset or group of assets, with or without related liabilities
A fairness opinion can serve as an important contributor to a board’s decision making. It also shows evidence that a board followed a reasoned and deliberative process, and it can be used to defend board members against potential legal challenges.

- IRS
- OIG
- Stakeholders.

A fairness opinion is a determination by an expert that a proposed business transaction is “fair from a financial point of view” as of a specific date.

The opinion is usually issued to the stakeholders of an organization or those with governance responsibility and fiduciary duties owed to the stakeholders.

Expert firms that deliver fairness opinions have experience in the relevant market and in related financial matters.
## Valuation Issues and Fairness Opinions
### Business Considerations

| Financial Impact                                    | • Valuation  
|                                                   | • Funding sources  
|                                                   | • Pro forma financial impact on hospital system  
|                                                   | • Corporate allocations  
| Debt Capacity and Access to Capital                | • Balance sheet  
|                                                   | • Income statement  
|                                                   | • Opportunity cost (capital allocation tradeoffs)  
| Impact on Organization Culture                     | • Shared vision and mission  
|                                                   | • Corporate citizenship  
|                                                   | • Fit with larger enterprise  
| Impact on Medical Staff                            | • Independent medical staff  
|                                                   | • Other employed physicians  
|                                                   | • Recruitment and retention  

Valuation Issues and Fairness Opinions
Business Considerations

Resource Assessment
- Management
- Systems
- Scalability

Compensation Structure
- Impact on value
- Incentives for productivity
- Alignment of other incentives
  - Core measures
  - Citizenship
  - Education and research

Other Issues
- Clinical care coordination and quality impact
- Non-compete restrictions
- Impact on third-party relationships and contracts
- Community impact and perception
- Brand impact; especially if operations continue to be operated under same business model