Expanding a General Surgery Practice: Privileges, Ambulatory Care Centers and Hospital Interactions

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Julia Snow
University of Kentucky
Martin School of Public Policy and Administration

Committee Chair: Sarah Wackerbarth, PhD
Committee Member: Len Heller, PhD
Committee Member: Ed Jennings, PhD
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Executive Summary

The objective of this case study is to document the interactions between a general surgery practice group and a university medical center as the physician group establishes and seeks to expand its revenue base. The group proposes to lease or purchase a practice location where they can consult with patients and perform procedures. The practice location is near a competitive hospital, Saint Jose East. The surgeons currently have privileges at Saint Jose Hospital and request to continue the privileges.

The case study’s design and methods include benchmarking and financial analysis. The results of the study are:

- Benchmarking of operating room turnover times, hospital bed closings and clinic square footage justify expanding the physicians practice to an offsite location
- The expanded practice will increase patient satisfaction for the entire enterprise
- Financial analysis of the practice justifies the expansion
  - The practice will break-even in 39 months
  - Hospital downstream revenue will increase
  - The Division of General Surgery increased its contribution to hospital revenue by 27.5% during the trial period.

From a business standpoint, both the hospital and the Division will benefit from the off-site practice. The hospital’s operating rooms are over capacity and bed-shortages lead to frequent hospital closings. With the expansion, general surgeons can book overload cases and, when the hospital is closed, refer patients to Saint Jose Hospital. Additional hospital benefits include the increase in referrals from the new practice and the associate revenues.

Benefits to the Division include increased revenue, opportunities for increased patient, physician, and staff satisfaction, enlarged clinic capacities, expanded referral base and an outlet for admitting patients when the medical center is full.

The case study’s results indicate that it will be beneficial to the medical center to allow the practice to continue and expand. Objective
analysis is not necessarily the standard used to determine whether a proposal will be implemented. Decisions must align with an enterprises’ vision. During this expansion, a new Executive Vice President for Health Affairs was installed when the former executive retired. The new administration’s mission and vision for the Enterprise conflicted with the General Surgery’s efforts. The new focus is on product lines and emphasizes the health care centers brand name. Based on the analysis and executive committee approval, the general surgeons are allowed to continue leasing a temporary location, but they are not allowed to purchase a practice site. The practice was abandoned when the off-site hospital’s call requirements became overwhelming and the benefits of owning an off-site practice were denied.
Problem overview

Health care is one of the biggest policy issues facing America today. American is the only major industrialized nation without a nationalized health care system; 42.8 million are without any form of health insurance. The current system impacts America's competitiveness because the cost to employers of providing healthcare increases the costs of services and manufactured goods.

The healthcare policy debate affects academic medical centers in several ways. First, public medical centers are required to provide care to indigents through emergency rooms. Using the emergency room for care is expensive and inefficient. Second, government payments for healthcare are decreasing because of budget constraints. Physicians and hospitals continue to compete for these decreasing reimbursement dollars. Academic medical centers are facing declining reimbursement dollars because of managed care, decreased government spending on Centers for Medicare/Medicaid Services (CMS). Both hospitals and physicians seek to expand market share and improve their payor mix\(^1\) in this unstable policy environment.

Nutkey Medical Center (a pseudonym for an academic medical center located in the mid-west) is an academic teaching hospital with 470 beds and annual revenues of $318 million. This case study examines the efforts of a group of academic surgeons from Nutkey Medical Center to expand their surgical practice by opening an Ambulatory Surgery Center and performing operations at a local hospital. The group is legally incorporated as the Nutkey Surgical Associates.

\(^1\) Payor mix refers to the proportion of revenues realized from different types of payers. This is a measure used in the profile of health care organizations.
Nutkey historically operates in the black. In the past, hospital administration has been conservative in allocating resources for plant and equipment and in investing in new programs. Although the medical center is profitable, the aging facility and conservative marketing strategies limit Nutkey Medical Center’s growth.

At Nutkey Medical Center, the Division of General Surgery operates in a constrained environment; there are not enough operating room times, clinic or office space available, or adequate support systems to meet the Division's needs or allow the Division to grow. In fiscal year 2004, the Division’s efforts generated 23% of Nutkey Medical Center Hospital’s $318 million in annual revenue, yet the Division has limited impact on decision making at the hospital or the Nutkey Medical Center.

To finance operations the Department of Surgery, College of Medicine Dean’s Office, Nutkey Medical Services Foundation and the Enterprise tax clinical revenue (see table below). Taxes are levied to support other interests within the Medical Center the Dean’s office uses the funds to pay for education programs; the Department of Surgery to supplement less profitable divisions and for start-up programs; and Nutkey Medical Services Foundation to provide billing services, for malpractice insurance and for other projects.

<table>
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<tr>
<th>Overhead taxes by area</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Department of Surgery</td>
<td>5.4</td>
</tr>
<tr>
<td>College of Medicine Dean’s office</td>
<td>8</td>
</tr>
<tr>
<td>Nutkey Medical Services Foundation</td>
<td>16</td>
</tr>
<tr>
<td>Enterprise</td>
<td>2.25</td>
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<tr>
<td><strong>Total tax overhead</strong></td>
<td><strong>31.65</strong></td>
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For entrepreneurial efforts (new business), the Dean of the college rescinds the tax. Conceptually, this means if you earn $2 million in an entrepreneurial location, the providing unit receives $160K more into the revenue stream.

In order to expand capacity and increase income the Division formed the Nutkey Surgical Associates and opened a satellite clinic at Saint José
Hospital with plans to build an advanced procedure room to function as an Ambulatory Surgery Center. When procedures are performed in an Ambulatory Surgery Center, the physicians collect a larger fee because the payor does not reimburse a separate facility. In essence, the fees are larger because the provider is also collecting the facility fee. For example, when a surgeon operates at Nutkey hospital the payor pays the surgeon and the hospital separately, if the procedure is preformed in a physician-controlled location only the physician collects a fee.

During the final process of negotiating the contract for the General Surgery offsite clinic, hospital administration turned over replacing the former Chancellor with an Executive Vice President of Health Affairs (EVPHA). The EVPHA focuses on the hospital's "Brand Name" and believes local outreach efforts lead to brand dilution for the hospital.

The Division of General Surgery at the University of Nutkey Medical Center has four core missions: academic productivity (10%), clinical service (50%), resident and medical student education (35%), and professional development (5%). The Division receives a very small percentage of its funding from the state (≤10%), consequentially research and clinical revenue must be generated to pay for the operation of the Division and to finance the four missions. The Division needs additional sources of clinical revenue to support its educational, academic, service and clinical missions.

In 2002, the Division dismissed several General Surgery staff members and decreased faculty salaries to meet the payroll. Since this time, the Division has worked to expand business and control expenses.

The Division struggles financially to support the four missions for both external and internal reasons. Within the medical center, there are diminished referrals. Operating room and clinical care facilities are both at capacity. Capacity matters because the surgeons cannot schedule additional surgeries or schedule patients clinic visits within a reasonable time period.
The Surgical Oncology patients often need immediate care and the inability to schedule clinic or operating time negatively affects patient care. This is both a patient care issue and a growth issue; the Division cannot currently expand capacity at the medical center. Externally, declining state funding support an increase in home maintenance organization payers, declines in traditional insurance reimbursements, and a reduction in referrals by physicians combined with a decrease in state payments from Medicaid and leads to decreasing reimbursement dollars.

Operations at the Nutkey Clinic are inadequate because of the physical plant, cumbersome registration systems, inconvenient parking and the bureaucratic structure of patient care. The General Surgery clinic is disproportionately small compared to other Nutkey Medical Center health care providers' clinics. General Surgery also supports the clinical efforts of Pediatric Surgery by subsidizing the Pediatric Surgery clinic space, personnel and supplies. The Nutkey Clinic General Surgery clinic is not large enough, and when Pediatric Surgery is in residence, the space is over capacity. The General Surgery surgeons provide the space to Pediatric Surgery because neither the Department of Surgery nor the College of Medicine are willing/able to provide the dollars. Yet, Pediatric Surgery is essential for the training of General Surgery residents.

Hospital operations are troublesome. Frequent bed-closures, limited operating room capacity, slow operating room turnover, and a fifty-four year old hospital all lead to staff, physician and patient dissatisfaction. The General Surgery surgeons seek a solution that will benefit their colleagues at the Medical Center by increasing operating room capacity at the hospital. In the spring of 2004, the Nutkey Medical Center hired a consulting firm to analyze hospital operations. The consultant purports the Nutkey Hospital

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2 General Surgery's state appropriations have declined from $543K in 2001 to $471 in 2004, this is equivalent to $257K in billings.
cannot handle the return of all General Surgery cases until operating room capacity is expanded 3.

Seven of eighteen general surgeons left the University between 2002 and 2004. Hospital and clinical operations are cited by the physicians as the main reason for leaving.

Patient fee collections at the Nutkey Clinic and University Hospital are approximately 28% of billing. This percentage of fee collections is determined by payor mix. For every dollar billed by the Division, 28 cents is collected. Expenses must be paid out of collections. With a payor mix rate of 28% (after all expenses but physician salaries are paid) there is nine cents remaining for every dollar billed. Improving payor mix increases revenue.

Division operations are approximately 37% of collections. Tax overhead is an additional 31%. Unfortunately, tax overhead is increasing as other sources of funding are decreasing.

The faculty of General Surgery, in an effort to increase their referral base, increase operating room time, and provide better more efficient care, solicited the hospital administrative staff and received permission to open an outpatient clinic at the Saint Jose East starting in January of 2003 The terms and conditions are listed in appendix I - slide III. Between June, 2003 and April, 2004, the Division requested permission to purchase or lease practice space and to continue the pilot. The terms of the initial agreement have been met. The hospital agreed to a four-year pilot at Saint Jose East; six-month evaluations are to be conducted to determine if the project is mutually beneficial. Patients needing surgery are scheduled at the University of Nutkey Hospital - except for the terms listed in the original agreement. Case volume must be maintained by General Surgery at Nutkey Medical Center, in accordance with the original terms and conditions. In

Per D J Sullivan consultants conversation with J. Snow, May 2004
fact, case volume at the Nutkey Medical Center Hospital is being maintained at the pre-pilot level and surgery volume increased by 10%. The volume increase occurred despite the loss of six surgeons during the period.

<table>
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<th>Time line of case study</th>
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<tr>
<td><strong>January 2003</strong></td>
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<td>Received permission to start onsite clinic</td>
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The contract for the pilot has not been signed. The Executive Vice President for Health Affairs, in most incidences, is not allowing Nutkey Medical Center physicians to practice medicine at other hospitals. He believes competition by University physicians leads to brand name dilution; therefore, Nutkey physicians that are associated with competing hospitals decreases patients’ desires to receive care at Nutkey Medical Center. Exceptions are made. For example, the Divisions of Orthopedics and Oncology are allowed to practice at external hospitals. The reasons for exceptions are unclear. The decisions are made in closed committee meetings and posted on the Enterprise web sight.

Review of Literature

Hospitals and physicians are embattled in a quest for profitability, especially teaching hospitals. Health care providers must redistribute constrained resources because of market and legal limitations placed upon their revenue. CMS is a primary source of income for the healthcare industry; state legislatures and the US Congress are controlling revenues and costs by mandate. The Outpatient Prospective Payment System, implemented by the Balanced Budget Act, requires hospitals to control cost, increase efficiencies, and ensure payments are equal across venues (same payment whether in hospital or outpatient arena). When combined with Preferred Provider Organization and HMO negotiated pricing and the increasing number of
US citizens without health insurance, health care providers’ face decreasing revenue sources (Thevin, 2000). Teaching hospitals treated forty-four percent of the uninsured in 1997, for a loss of $17.5 billion (Rosco, 2004). Many shareholders (legislators, congressional representatives, taxpayers, government officials) believe teaching hospitals should be subject to the demands of the market (Rosco, 2004). Teaching hospitals revenues are not determined by costs, but by national Medicare reimbursement rates, insurance companies negotiate a percent of Medicare rates with the hospital. This reimbursement plan is not subject to market prices (Thevin, 2000). Michael Rosko analyzed the performance of teaching and non-teaching hospitals and estimates the costs of treatment in academic medical centers is approximately 40 percent higher.

Hospitals’ income is being reduced and the costs of billing to meet the federal Outpatient Prospective Payment System are increasing. Despite rising costs and decreasing revenue, hospitals must continue to provide the same level of care (Thevin, 2000).

Payor mix affects health care providers’ revenue. A higher percent of non-pay and Medicaid patients means less profit or no profit at all (Rosco, 2004). Teaching hospitals account for 33.46 percent of all Medicaid patients. (Rosco, 2004)

Outpatient visits increased by 62 percent in teaching hospitals during the 1990s. (Rosco, 2004) The shift of less complex cases to an outpatient setting means the inpatient cases are costlier and require additional resource inputs. (Rosco, 2004) The mean operating margin ratio (revenue/primary patient care operations) was -.22 during the 1990s. This operating margin ratio tells one that teaching hospitals do not cover variable costs by twenty-two percent. By this measurement, major teaching hospitals cannot support efforts by patient revenue alone (Rosco, 2004).
Rosco further suggest supplements to teaching hospitals must be increased or hospitals should be subject to market forces.

Graduate Medical Education (GME) is a major output of teaching hospitals, but it is expensive and reduces effectiveness of both physicians and staff. The cost is offset for the hospital by Medicare’s Indirect Medical Education (IME) payments and is based on the number of residents per bed. Medicare’s IME is a significant incentive for residency programs (Rosco, 2004). GME helps to compensates for the larger volumes of uncompensated care in which teaching hospitals engage (Rosco, 2004). Hospitals, and not physicians, receive the payments. Therefore, GME benefits the physicians’ education mission, but negatively influences the payor mix. The offsite clinical practice will enable the physician group to attract insured patients.

A major source of dispute between hospitals and physicians is Ambulatory Surgery Centers. Ambulatory Surgical Centers differ from surgical hospitals by focusing on product lines of care. Typically, they have lower revenue and expenses, and exist in an unregulated environment (Becker and Biala, 2000). Ambulatory centers are evolving to resemble specialized hospitals. Hospitals and Ambulatory Surgical Centers compete aggressively for health care payers (Becker and Biala, 2000).

Hospitals are responding by negotiating with payers that agree their surgeries will be performed at the hospital. Physicians, who naturally want to collect the insurance, are reluctant to trek between a hospital and an Ambulatory Surgical Center; therefore, they choose to operate only at the hospital (Becker and Biala, 2000). As Ambulatory Surgical Center become more adept at handling complex surgical cases, less complicated cases are being moved to procedure rooms in the physicians’ offices (Becker and Biala, 2000).
An outcome of the legislated market place for health care is controlled payment. Physicians and hospitals are competing for the same financial resources and the same client base. Physicians have different relationships with hospitals; some are direct employees of the hospital while others have privileges. The General Surgery group at Nutkey University is employed by the Nutkey University, yet several of the physicians are paid to oversee units in the hospital as independent contractors.

The Bristol Group surveyed 52 hospital CEOs and physician leaders at New England hospitals to understand the relationships between hospitals and physicians. The study noted many acute problems between physician leaders and the hospitals: staffing shortages, patient quality care issues, and physicians perceive unsatisfactory financial reimbursement schedules. Hospitals are competing with Ambulatory Surgical Centers that may be owned and operated by staff physicians (McGowan, 2003). Physicians express concerns about call schedules and hospital strategies to back selected providers and specific clinical services. Robert McGowan (2003) discusses physicians as partners and competitors of the hospitals in which they work illuminating the need for trusting relationships between hospitals and physicians. For example, the physician champion for Nutkey Surgical Associates is also the Director of both the Nutkey Hospital’s Intensive Care Unit and Trauma Services Director. Thus, the physician is both a partner with the hospital in managing its clinical units and a competitor in his efforts to grow his practice. These physicians seek to improve quality at the Medical Center while simultaneously growing their practice (McGowan, 2003).

Hospital administrators’ stress factors include weak financial reimbursement, staffing shortages, problems from medical errors, changing medical technologies, customer expectations, capacity constraints related to an aging population and increasing competition from private physician for profits (McGowan, 2003). Physicians stress factors’ include the desire to
maintain clinical autonomy, have reasonable compensation, manage their own business enterprises, control increases in malpractice insurance, and to balance home and work life (McGowan, 2003).

According to a Kaiser Family Foundation nationwide survey, 87% of physicians surveyed responded that their moral is declining and 60% are responding that their enthusiasm for practicing medicine is dropping. Reasons for the decline include managed care, paperwork, less time for individual patients, limitations placed on specialists, and curtailment of clinical autonomy. These physicians also report a decline in the quality of healthcare (Harris, 2002).

Physician income is declining because of changes in third party reimbursement schedules, malpractice insurance premiums (increased 50-100% in the last four to five years) and overhead costs (McGowan, 2003). Financial pressures are forcing physicians to see 35-40 patients a day; this volume is a major stress factor. Physicians cannot maintain income by working harder; they must control costs or increase remuneration to maintain salary (McGowan, 2003). Therefore, physicians do not support major financial decisions that are made by hospital administration without adequate medical staff input.

The physicians that formed the Nutkey Surgical Associates state that they cannot work any harder, they are exacerbated by the paper work, and the volume of patients they must see because of the smaller number of physicians and the increasing difficulty of maintain revenue while controlling costs. More administrative work is falling on the physicians.

Hospital management views physicians as greedy when they invest in freestanding enterprises that directly compete with hospitals for patients. Physicians iterate that they cannot get their patients into the hospital in a timely manner. Hospitals may not have the operating room capacity to support additional physicians (McGowan, 2003).
Hospitals are negotiating reimbursement without negotiating similar
increases for the physician staff partners, causing resentment from the
physicians (McGowan, 2003). At Nutkey, the contracts with Payors for the
hospital and the physicians are performed by separate entities that rarely
interact. Each group is concerned only with their fee.

Physicians are moving services to their offsite and office practices,
and are less willing to volunteer their services on medical staff committees.
Physicians are also less willing to provide daytime call and seek to do more
procedures in their offices where they can make more money (McGowan, 2003).

Only 43 percent of physicians responding to the Bristol group study
view physician/hospital relationships positively, compared with 77% of
hospital administrators (McGowan, 2003). The study recommends physicians
involvement in decision-making, including clinical priorities and strategic
planning. Involvement gives physicians a reason to cooperate with the
hospital, and this involvement is perceived as very important by physicians
if there is to be alignment between hospitals and physicians (McGowan, 2003).

According to Unland, (2004) physicians are the most threatening problem
facing hospitals today. Physicians are moving testing and procedures to
their clinical offices, investing in Ambulatory Surgery Centers and
diagnostic centers, and establishing independent hospitals based on their
specialties. The number of cases performed in these settings is increasing.
Hospitals complain that physicians are removing their revenue sources.
Physicians are tired of battling with hospital administration to control
power and revenue; physicians seek greater medical control over their
patients. Hence, they are moving the more profitable patient care to
Ambulatory Surgical Centers.

The lifting of the more profitable services out of the hospital means
fewer dollars are available to support less profitable services. There are
benefits and disadvantages to physician owned Ambulatory Surgical Centers.
Advantages include better patient care and potentially fewer lawsuits. Disadvantages include referral problems and the potential for physicians to take riskier/more expensive cases to the hospital, for physicians to recommend unnecessary procedures, and for physicians to overprice services (Unland, 2004).

There is an imbalance of Medicaid reimbursement at the state level because of economic problems and decreasing tax base, a burden that trickles down to hospitals and physicians. Federal legislation requires hospitals to provide free care to indigents. As the indigent population has grown by 15%, greater numbers of this population seek care at emergency rooms creating a competitive disadvantage. Unland (2004) notes that hospitals in this manner are not operating as free markets. He states hospitals make the costs up in the cross subsidizing of health care and this is a threat to the financial stability of community hospitals. The Nutkey Surgical Associates threaten the hospital with their efforts to create a separate group for well-insured patients.

As physician ownership of Ambulatory Surgical Centers increases, hospitals fear physician owned specialty and ambulatory hospitals will create excess capacity in the health care industry. Hospitals also fear physicians will provide unnecessary services to the patients and believe physician owned facilities will impact negatively on hospital profitability. Hospitals purport Ambulatory Surgical Centers may cherry-pick the healthy, insured patients, which will increase Ambulatory Surgical Center profits. Hence, hospitals believe Ambulatory Surgical Centers have an unfair advantage. Health care insurance executives are delighted to contract with Ambulatory Surgical Centers where the cost is lower. However, Ambulatory Care Centers are less successful when the hospital’s brand name is well established (Casalino, et al., 2003). Devers and Brewster, 2003). The Executive Vice President for Health Affairs moved to the area from a hospital whose name
brand is nationally established and this past experience impacts on local decisions. For example, he has directed the Enterprises pharmacy not to fill prescriptions from non-Nutkey physicians. He will turn away revenue to ensure the brand concept.

To compete, hospitals may create their own specialized facilities at the risk of alienating vital specialists. Hospitals may also eliminate competition from physicians that own Ambulatory Surgical Centers by refusing staff privileges to participants, a form of economic credentialing. The American Medical Association (AMA) has asked the Office of Inspector General to investigate whether or not economic credentialing violates the federal prohibition against kickbacks for referrals. Although hospitals successfully defended themselves in lawsuits to date, it is not yet clear how the courts and antitrust agencies will ultimately view such activities. (Casalino, et al, 2003)

In May of 2005, General Surgery discovered Nutkey Medical Center administration no longer approved the purchase of an outreach clinic located at the Saint José office park. At this time, the Division discovered the Saint Jose Hospital’s malpractice certificates from the hospital. University physicians pay overhead taxes to Nutkey Medical Services Foundation to provide malpractice insurance through a self-insurance fund that is administered via the hospital. A hospital committee signs off on all malpractice coverage. The committee rescinded mal-practice coverage effective July 1, 2005. Two years of effort had been invested into the new practice and over $80,000, excluding physicians’ salary and benefits. In response to inquiries from the Division, the Executive Vice President for Health Affairs stated the Executive Committee denied the practice.

Research questions

What are the potential advantages and disadvantages that academic General Surgeons face by expanding their practice to include an Office
Building and Ambulatory Care Center and continuing privileges with the Saint Jose Hospital located in the same office park? Are the physicians’ requests a reasonable business practice?

From the perspective of the enterprise, should this expansion and granting of privileges be allowed? What will the clinical outcome be for the enterprise?

Methods

The purpose of this research was to describe and analyze the costs and benefits of General Surgery continuing and expanding its onsite clinic practice at the Saint Jose East office park. General Surgery asked permission to present justification to continue and expand the pilot to the Executive Vice President for Health Affairs’ Executive Committee. The request had been initially denied and several times delayed. Surgery advocates on the Executive Committee eventual prevailed and allowed General Surgery’s presentation. The analysis presented was based on benchmarking of operating room turnover times, of hospital closures, and clinic space. Financial analysis included evaluation of current and projected income and expense, a five and 10-year break-even analysis, fee collections, expense analysis, downstream revenue projections, payor mix and evaluation of General Surgery’s contribution to Nutkey Medical Center’s total revenue.

Benchmarking

Benchmarking measures output (products, services, or activities) against the best levels of performance, in order to understand opportunities. The main reason the general surgeons were leaving the University was because of the University hospital’s operating room substandard performance. The Enterprise would be willing for the Surgeons to build an office building to see patients; the hospital’s concern was with the physicians performing operations at Saint Jose. There was no objection to the group performing procedures at the new location, although the Enterprise was not yet aware of
the details. Hence, benchmarking was performed against Saint Jose to demonstrate the depth of problems with the University Hospital.

From the perspective of the physicians, the competition for the University was Saint Jose, because this was where Nutkey Surgical Associates proposed to perform overflow operations and to provide service to patients who did not want to go Nutkey. Therefore, operating room turnover times and hospital bed closings were benchmarked between Saint Jose and the Enterprise. Clinic square footage was benchmarked against other University Divisions and Departments to emphasize the problems with the clinic space assigned to General Surgery.

**Operating room turnover times.** The Nutkey Medical Center Hospital Associate Chief of Staff published a monthly hospital performance report that listed operating room turnover times; operating room turnover times were obtained from this report (Appendix I - slide 14).

**Hospital closings.** The Associate Chief of Staff published a monthly bed access report. Bed closure data was obtained from this report (Appendix I slide 12).

The administrator for Saint Jose East provided the facility’s operating room turnover times and Bed Closure information.

**Clinic square footage comparison.** Clinic administration was contacted for information about the square footage of Internal Medicine and Family Practice clinics for comparison purposes. These two were selected for comparison randomly by Nutkey Clinic Administration (Appendix I - slide 14).

**Financial analysis**

Financial analysis of the Nutkey Surgical Associate’s options to purchase or lease office space was completed to justify the expansion. The Division reviewed many options and decided to present three options to the Enterprise for approval. The strategy was that as the Enterprise would not approve a straight out purchase of space; because of this risk the surgeons
did not want to simply lease because of their desire to create equity. Therefore, the decision was to enter into a lease to purchase agreement. A budget based on the lease to purchase options for 3, 5 or 10 years was completed (Appendix II and III).

Financial data were reviewed for FYs 2001, 2002, 2003 and 2004, and projected through 2014. The five and ten year budget assumptions were as follows:

Revenue Projection. Revenue assumptions were based on historical data. Nutkey Medical Services Foundation was instructed to provide all billings and collections data for Nutkey Surgical Associates. Revenue was assumed to increase by 10% for the first three years and a more modest 3% for the remaining ten years.

Expense assumptions. Expenses varied for the project depending on the terms of the lease. The lessee provided data for three, five and ten-year leases.

Lease to purchase agreement. The three and five year lease options were similar because neither had equity. Two income projections were completed as the cost of the lease to purchase agreements varied depending upon whether the agreement was for 3, 5 or 10 years.

The major difference between Option 1, the three or five-year lease, and Option 2, the ten-year lease, was ownership. The three and five year leases provided no equity and the ten-year lease allowed the tenant to share in cash flow and residual value. Termination of the lease before the fifth year required repayment of tenant improvement costs.

Expenses were projected, including startup costs, fit-up costs, salaries, fixed operating expenses and variable fixed costs. Salaries were projected based on current salaries and fringe benefits mandated by Nutkey University human resources and assumed an annual 3% salary and benefit increase. Three percent increase was based on the increases over the last
three years. In year four, a second certified medical attendant would be added. (Appendix IV).

Starts up costs (Appendix V) were based on actual costs obtained from suppliers. The costs of decorating, furnishing, staffing and maintaining the practice were also determined. The lease included a $45 per square foot fit-up costs; current market price of the fit-up was determined to be $60 and the difference was extrapolated.

Along with fixed and variable direct costs, income and break even analysis were projected. Operating expenses were detailed in appendix II and III. Other operating expenses were derived from the General Surgery Clinic at Nutkey Clinic. Medical Group Management Association benchmark data were used to determine variable costs per Relative Value Unit for operations. Costs were assumed to increase at 3% per year. The basis for the assumption was the Nutkey Medical Center’s payroll increases had averaged three percent for the last five years.

**Downstream revenue.** Downstream revenue was defined as the revenue the offsite practice referrals generated to university physicians and the hospital. Nutkey Medical Services Foundation and hospital administration provided data based on location. The patient information was used to determine the financial benefit of the off-site practice to non-General Surgery physicians, non-surgery physicians and to the hospital (Appendix I - slide 7 & 8).

**Payor mix.** Payor mix was used to determine the ratio of payments. Self-pay, CMS, HMO and health insurance companies had negotiated different fees for physician services. Medicaid paid the least, while private health insurers paid more. Payor mix influenced revenue in that the more income received for a procedure; the more productive a physicians practice was (Appendix I - slide 9).
Contributions to total revenue. General Surgery's hospital revenue was obtained from hospital accounting for the past three years. Current year budget (FY04) for the hospital was obtained from the Nutkey University website.

Results

Benchmarking

Operating room turnover times. A comparison of Saint Jose East and Nutkey University's operating room turnover times revealed that the average turnover time for an operating room at Saint Jose East was eighteen minutes. The Nutkey Medical Center operating room rarely turned a room over in thirty minutes, and the wait had been as long as two hours. The turnover times were of major concern to both general Surgery and the Enterprise. In an effort to determine the reason for the delay in operating room turnover time, a consultant was hired to manage the operating room; the causes of the delays were unknown and turnover time remained a problem. This statistic was important because long waits were associated with poor patient care, satisfaction, and low physician productivity.

Hospital bed closings. On 14 separate occasions, between February 03 and February 04, NU closed the hospital to new patients for a total of 217 hours. On those occasions, no physician could admit patients to the hospital. The main reason for the closing was a shortage of nursing and support staff. Referrals were turned away, this impacted patient care and hospital and physician revenue. In addition, referring physicians had to find new venues to send patients, which decreased the likelihood of the referring physician retaining his/her patients to Nutkey Medical Center (Appendix I - slide 13). Saint Jose East had no closures during the same period.

Clinic Square Foot Comparison. General Surgery's clinic space was too small to accommodate the number of patients seen compared to other Nutkey
Clinic clinics. General Surgery saw 2.68 patients per square foot compared to 1.01 for Internal Medicine (Appendix I - slide 15).

*Payor mix.* The Payor mix for Nutkey Surgical Associates and Nutkey Hospital were compared. Data were extracted from the billings and collections database and analyzed for the past three fiscal years (Appendix I - slide 9).

Nutkey Surgical Associates’ commercial insurance rates at the Saint Jose East clinic had been between 55% and 60% of billings, while Medicaid had been less that five percent for the last three fiscal years. General Surgery commercial insurance rates at the Nutkey Medical Center decreased from 43% in fiscal year 2002 to 38% in fiscal year 04; Medicaid increased from 10% to 12% during the same period. The Medicaid rate at the University was more than twice the rate of Saint Jose payor mix (Appendix I - slide 9).

**Financial analysis**

*Break-even analysis.* Break-even analysis was calculated to determine when the venture would cover startup costs (Appendix II & III).

The ten-year lease was projected to break even in month 39 after 16,580 patients had been seen at the new facility; projections were based on revenue of $1,014,012 with variable costs of $58,030 and total fixed costs of $956,000. Return on investment for the ten-year plan was 30% (Appendix III).

The five-year lease was projected to break even in month 51 after 29,258 patients had been seen at the new facility; projections were based on revenue of $1,789,421.10 with variable costs of $102,403 and total fixed costs of $1,687,018. The five-year analysis projected a return on investment of 8% (Appendix III).

*Downstream revenue.* Total hospital downstream revenue billings that resulted from NSA were $1,994,094. New revenue to the hospital was $624,394 and outpatient revenue was $393,101, for a total collection of $1,017,495. The collection rate for these patients was 51% (Appendix I - slide 8).
General Surgery collected $143,505 in additional charges, not included in the outreach clinic revenue and other Nutkey physicians obtained $659,916 from the referrals.

Contributions to total revenue

General Surgery’s hospital revenue increased from $54 million in 2002 to $75 million in 2004, an increase of $20 million. Case volume increased from 2402 to 2652, an increase of 25 inpatient cases. The number of cases at the Nutkey Medical Center hospital increased by 250. This was especially important in terms of the initial agreement between General Surgery and the Nutkey Medical Center. The condition of continuing the off site practice predicated upon continued Nutkey Medical Center expansion by General Surgery. General Surgery increased its contribution to hospital revenue by 27.5% (Appendix I - slide 10).

Evaluation of General Surgery contribution to Nutkey Medical Center total revenue General Surgery Hospital Income Statements were compared to Hospital total revenue (Appendix 6). Data were obtained from the performance budgets posted on the board of trustee’s web site and from information provided by the hospital to General Surgery, stating total income to the hospital (Appendix I - slide 11).

Discussion and conclusions

The primary purpose of this case study is to demonstrate the costs and benefits to the Nutkey Medical Center and Division of General Surgery of a lease to purchase agreement for clinic space and the continuation of privileges at Saint Jose East.

A problem the hospital currently faces is a shortage of operating room time. Because of the long delays between patients, the operating room is inefficient. The consultant hired to correct the problem 18 months ago has

---

4 Hospital Revenue was extracted from the Board of Trustees Budget information posted on the University’s Website
not yet resolved the wait time. Allowing outpatient procedures to be performed at Saint Jose East and in off site locations will ameliorate the operating room time shortage. Further, a patient who is operated on at Saint Jose East will have follow up care at the Nutkey Medical Center. An example is Surgical Oncology, multiple operations are performed at Saint Jose East (timely operating room space is not available at Nutkey University operating room and patients request Saint Jose East), but follow up specialty care is referred to the Nutkey Medical Center.

The Downstream revenue for this project will clearly benefit the hospital and the physicians. The hospital already collects an additional $1,994,094 in revenue for inpatient and outpatient payments because of the off-site clinic pilot.

From a financial standpoint, the third option for a lease to purchase will benefit the hospital and the general surgeons. Breakeven analysis demonstrates that the ten-year lease will break even in three years, six months. The cost to the hospital is minimal, as the Division will finance all startup costs. Downstream revenue will continue to increase enterprise revenue, and provide funding for strategic initiatives. In all areas benchmarked, Saint Jose East and the space are superior.

The research question asks what the benefits are to the Nutkey Surgical Associates by expanding their practice and continuing privileges at Saint Jose. The results indicate that the project is, and will continue to be beneficial to General Surgery by all measurements evaluated as discussed above. Improvement in these measurements will also allow the surgeons to provide better patient care because of increased access to the clinics and increased operating time.

Hospital administration changed in the spring of 2004, in the middle of the negotiations to lease/purchase space. Because the players changed, decision makers (university lawyers, Nutkey Services Foundation
Administrators hedged on the proposal and refrained from making a recommendation about the new practice.

New leaders frequently step in and discontinue an organization's organic processes (Collins, 2001) as is happening here. For most hospitals, the largest revenue generators are orthopedics and cardiology. However, at the Nutkey Medical Center there is repeated faculty member turnover in these two divisions, leaving the enterprise without coverage. Hence, the stable Divisions, such as General Surgery, that generates 23% of the Nutkey Medical Center revenue, repeatedly bear the load of physician recruitment to recover and rebuild divisions with high turnover. General Surgery bears this burden because the Division's overhead taxes remain high for two reasons. First, if these divisions are stable, their overhead tax dollars will support the Enterprise, allowing taxes to be lower. Second, replaced physicians receive guaranteed salaries for up to three years which the enterprise supports through the overhead tax structure; therefore, less turnover means the enterprise will not have to support these startup salaries.

Jim Collins, writing in Good to Great, states "The only way to deliver to the people who are achieving is to not burden them with the people what are not achieving" (Collins, 2001, p. 53). General Surgery is repeatedly burdened with the costs of rebuilding other divisions. Collins also encourages putting the best people on the biggest opportunities, not the biggest problems. The Enterprises' strategic plan includes the creation of a Cardiology and Orthopedic product line. Unfortunately, previous administrations invested repeatedly in these divisions, while failing to meet the requests of outstanding General Surgeons; as a result, many superior surgeons left the Nutkey Medical Center, often for top five universities.

Jim Collins (2001, p. 43) details the actions that delineate good companies from great companies and emphasizes hiring and retaining the right players; this is not merely a function of executive compensation, it is about
attracting individuals with innate capabilities and sterling character. The general surgeons who left are the right players and they will be difficult and costly to replace. The expense of recruiting a new surgeon at Nutkey Medical Center is well over $1 million. New surgeons have up to a three-year salary guaranteed between $190 and 300K. When benefits and tax overhead is included, the salary guarantees are equal to $352K to $469, over the three years these costs will be between $1 - $1.4 Million excluding new equipment and divisions expenses.

In addition to the strategic plan investments, the Division is soliciting the Enterprise administration to invest proportionally in General Surgery programs and facilities.

Relationships between hospitals and physicians are complex. Hospitals need physicians to survive, yet hospitals often treat physicians poorly. By their actions, one may assume that both division physicians and enterprise administration are aware of the best practices detailed in A Bristol Group Mitretek White Paper (Bristol, 2003). For example, the enterprise essentially follows the best practice methodology, outlined in the white paper, by creating an executive committee of physician leadership to oversee enterprise activities. The question is why if General Surgery’s physician efforts generate close to 24% of the hospitals total revenue is there not a General Surgery physician represented on the executive committee. In the preceding three years, six talented, productive, revenue-generating physicians have been recruited to other universities. None of the physicians left willingly, their minimal requests to stay are seemingly unheard by enterprise administration.

Collins further states (2001, p. 42) "Great vision without great people is irrelevant." To retain general surgeons, in order to achieve enterprise visions, enterprise administration should include a general
surgeon on the executive committee and fund programs for existing productive physicians at the same level as incoming physicians.

Brand name dilution is cited by the enterprise as one of the major reasons for denying the off-site practice. When the hospital's brand name is well established, Ambulatory Surgical Centers do poorer.

The enterprise is controlling General Surgery's outreach by denying malpractice insurance. The enterprise's insurance is self-funded by the hospital and physician practices. Anti-competition conduct may be occurring and the legal repercussions of the enterprises actions are unknown. Further, the legal implication of controlling physicians through withdrawal of benefits is an area that needs additional investigation.

The analysis indicates the lease to purchase of the space will be beneficial to the Nutkey Medical Center and General Surgery. General Surgery is the only unit requesting permission for entrepreneurial expansion that prepared a formal presentation for the Executive Committee's review. Appendix I contains a copy of the presentation given to the Nutkey Medical Center Executive Committee in June of 2004. The EVPHA is allowing the group to continue the practice, a fact gleaned via the Executive Vice President for Health Affair's monthly newsletter; no formal notification has yet been received.

Communication between the Enterprise and the Division is revealed by both the way the division discovered it will no longer have malpractice (certificates are not provided) and the announcement that the group will be able to continue a lease in the current space via a newsletter, months after the fact.

Although General Surgery may continue the lease at Saint Jose East office park, the group is denied permission to build an office park and procedure room.
Cohn and Colleagues in "Gaining hospital administrator's attention: Ways to improve physician-hospital management dialogue" (2004) note the necessity of physicians and hospitals developing shared organizational goals. Nutkey Surgical Associates' efforts show a significant return on investment for the surgeons and an increase of Nutkey University Hospital revenues because of the new practice. The idea is to refer the patients back to the MC. Because of administrations focus on Nutkey University's brand name the two units are unable to develop shared organizational goals with the long-term goal of increasing Nutkey University's market share.

The Saint Jose East lease to purchase is not part of the enterprise's strategic initiative and may not be in the best interest of the organization. For the Division's physicians malpractice insurance to perform operations at Saint Jose is essential because this allows the group to service patients that will not come to the University Hospital. The hospital will gain because of the downstream revenue generated. Cohn and colleagues (2005) believe that by working together the enterprise and physicians should create goals that allow the hospital and division to achieve growth and stability.

They further note this inability to formulate mutual goals between the hospital and university, and participate in shared governance lead to "self-fulfilling prophecies of distrust and alienation" (Cohn et al., 2005). Mastering of communication, conflict resolution, and negotiation techniques are recommended to improve physician/hospital administration relationships.

A structured dialog process implemented by health care organizations in partnership with physicians allows physicians to resume leadership for clinical direction and allows an innovative approach for operational and strategic planning. Nutkey University will benefit by implementing a structured dialog process in addition to the committee structures currently used in hospital decision making. Further, participating in a structured dialog process broadens a physician's focus beyond his/her specialties.
The second research question is more difficult. Financially the expansion will benefit the hospital and the physicians that work with the hospital. The expansion should also improve the hospital’s payor mix as the surgeons refer cases to their colleges at Nutkey. The expansion conflicts with the Executive Vice President strategic goal of emphasizing the enterprise’s brand name. Therefore, from a strategic standpoint the expansion is not in the best interest of the enterprise.

An aside to the case study is the competitiveness displayed within the Nutkey Medical Center and externally from outside physician groups, many of whom are trained by Nutkey Medical Center general surgeons. Internally, General Surgery is competing with cardio-thoracic, cardiology, and other divisions. Future research on the impact of physician competition and the benefits of this competition to hospitals might help physicians understand the consequences of not cooperating with their colleagues.

After receiving indirect permission to continue the original lease, all but one of the general surgeons abandoned the proposal when their colleagues at Saint Jose East insisted the Nutkey General Surgery take night call during December of 2004 and again in January 2005. Night call during consecutive months is challenging, as the Nutkey Surgical Associates physicians are already responsible for Nutkey trauma call and the Veterans Administration Hospital call. Hence, physicians from a competing group devised a way to eliminate the Nutkey General Surgery competition by demanding two months of back-to-back night call.

Although the study’s results are not generalizable to other entities, the case study presents a microcosm of the struggles between physicians and hospitals, and physicians and physicians as they compete for constrained resources and for power. For the Nutkey Medical Center hospital administration, failure to master the lessons documented in the study will promote the continued changeover in physicians, a changeover that comes at a
huge cost financially and strategically. For the physician if he/she cannot end the conflict he/she will be powerless to affect the dominance of hospital administration.
References


NU Healthcare Enterprise

- **General Surgery Goals:**
  - Increase referrals for the enterprise.
  - Improve payor mix and revenue stream.
  - Enter the local and (surrounding counties) market.
  - Provide excellent, cutting-edge, cost-effective patient care.

Appendix 1 - slide 1

Scope of Practice

Establish an outpatient office/ASC with the intent to enter the local market to improve payor mix and referrals for the enterprise.

Appendix 1 - slide 2

- Initial agreement with Enterprise
  - Expansion off-site General Surgical Services
  - Non-compete clause
  - As access to University resources improve, such as clinic facilities, OR, inpatient beds, GS will utilize these resources.
  - If surgical volume declines at the NUMC the agreement may be altered and/or terminated.
  - Clinic site is to be owned or leased at a site where the contract is approved by the Enterprise.
  - Program will be reviewed at six-month intervals to ensure common financial success.
  - Exceptions to practice agreement
    - Patients with contractual exclusion for NUMC
    - Elective booking wait time > 2 weeks
    - Patients who decline NUMC
    - Referring physicians requests admission/treatment to the hospital for which they have staff privileges.

Currently entering year three of a four year agreement.

Appendix 1 - slide 3

SJE Practice Overview

- Referral source
  - New source of referrals
  - Enter the local market
- Revenue generation
  - Physicians
  - Hospital
- Payor mix
- General Surgery Activity at NU
- Barriers to care
  - Clinic Capacity
  - OR Turnover

Appendix 1 - slide 4
Referral Sources

- Overview
  - Referral based business

New NU Cases Referred by SJE to NU
April 2002 – March 2004

- Inpatient Cases - 52
- Outpatient cases - 472

Physician Downstream Revenue
04/2002 – 03/2004

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General Surgery: $448,165.00, $143,556.00
All Other UK Physicians: $599,916.00, $265,926.00

Hospital Downstream Revenue
04/2002 – 03/2004

- Total billings - $1,994,094
- Inpatient Cases Net Revenue - $624,394
- Outpatient Cases - $393,101
- Total Collections - $1,017,495
- Collection Rate - 51%
GS NU Hospital Activity

Barriers to Care
- Hospital
- Patient access
- Bed closure
- Operating Rooms
- At capacity
- Turnaround time
- Equipment
- Overloaded

Payor Mix

GS to Total Hospital Revenue

GS Revenue $74,490,000
- Total hospital Revenue $244,076,000
Barriers to Care: Bed Closure

Graph

- Hospital Closure

- Number of occurrences: 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20, 10, 0
- Total duration of occurrences (hours): 74, 74, 74, 74, 74, 74, 74, 74, 74, 74, 74, 74

Barriers to Care

AVERAGE ROOM TURNOVER

SJE OR Turnover – Eighteen Minutes

Barriers to Care: Clinic Space

- The General Surgery clinic space is at capacity

SJE Services

- Peri-operative process is streamlined and extremely easy for patients and physicians
- Convenient booking
- Quiet, well appointed lounge for physicians to interact with colleagues
- Areas available to privately interact with patients
- Complimentary food and beverages
- Can change equipment or O/R time, no questions asked – ease of change

= Excellent physician service
UK Services

- Professional Colleagues
  - Radiology faculty are excellent
  - Anesthesia is an asset
  - Exceptional nursing staff
- Convenience
  - Comfortable in the institution
  - Minimal travel time
- Facilities
  - Laparoscopic rooms are excellent

Appendix I - slide 17

Future Plans for Offsite Practice

- Fulfill original agreement – Four year pilot
- Increase referrals and revenue for Enterprise
  - 50% of new SJE cases returned to NU
  - Improved payor mix and revenue stream
  - Increased revenue
    - Hospital
    - Direct
      - Direct referral
    - Downstream revenue to physicians
- Establish ourselves in the local market
- Provide excellent, cutting-edge, cost-effective patient care.

Appendix I - slide 18

We ask to continue the existing pilot program at Saint Jose East Hospital under the terms of the original agreement.

Appendix I - slide 19
### Kentucky Surgical Associates
#### Revenue/Expense Five Year Plan

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<th>Year</th>
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#### Expenses

**Salaries**

- Physicians .75 FTE
  - $161,250  $166,088  $171,070  $176,202  $181,488
- Clinical Manager/Nurse
  - $34,091  $35,114  $36,167  $37,252  $38,370
- CMA / Billing / Registration
  - $28,000  $28,840  $59,410  $61,193
- Part time
  - $7,500  $7,725  $7,957
- Business Manager
  - $4,100  $4,223  $4,350  $4,480  $4,615
- Fellow
  - $-  $-  $-  $-  $-
- **Total Salaries** | $234,941  $241,989  $249,249  $256,726  $264,428

**Fringe Benefits**  $46,988  $48,398  $49,850  $51,345  $52,888

**Personnel Bonuses**  $11,747  $12,099  $12,462  $12,836  $13,221

**Total Salaries & Benefits**  $293,676  $302,487  $311,651  $320,988  $330,635

#### Operating Expenses

- Startup Costs (See Appendix 1) * $65,725
- Fit-up @ $50 sq ft ($45 Allowance)  $35,040
- **Rental Expense (see Appendix 2) (a)** $28,280  $40,603  $41,820  $43,075  $44,367
- **Operating Expense (see Appendix 2)** $12,150  $12,514  $12,890  $13,277  $13,675
- **Office Supplies** $3,600  $3,708  $3,819  $3,934  $4,052
- **Telephone Service** $2,400  $2,472  $2,546  $2,623  $2,701
- **Long Distance Service** $1,200  $1,236  $1,273  $1,311  $1,351
- **Service Contracts for Equip.** $960  $989  $1,018  $1,049  $1,080
- **Copying** $2,400  $2,472  $2,546  $2,623  $2,701
- **Postage** $2,400  $2,472  $2,546  $2,623  $2,701
- **Total Operating Expenses Fixed**  $51,390  $66,466  $68,460  $70,514  $72,629

**Total Fixed Costs**  $346,067  $366,862  $380,021  $391,422  $403,164

**Total Variable Cost Operations $3.5 per RVU**  $20,900  $21,527  $22,173  $22,838  $23,523

**Total Estimated Costs Five Plan**  $365,967  $390,479  $402,194  $414,260  $426,687

**Project Net Income**  $ (100,765)  $ (740)  $11,270  $39,730  $40,922  $42,160

- **Return on Invest (ROI) IRR** 8%
- **Operating Margin** 0% 3% 9% 9%
- **Option 2: If Option to terminate occurs at end of Year 3** 9%
- **Total Estimate Costs Three Year Plan**  $365,967  $390,479  $451,239  $444,776  $438,365

**Projected Net Income Three Year Plan**  $ (100,765)  $ (740)  $11,269.58  $9,314.76  $10,408.02  $30,471.64

- **ROI Option 2** 17%
- **Operating Margin** 0% 3% 9% 9%

**Assumes 3% Costs Increase per Year**

(a) **First Year Allows for 4 Month Rent Abatement**

* Start UP costs ranged between $46495 - $65725, upper limit

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*Appendix II*
### Kentucky Surgical Associates

#### Expense Assumptions Ten Year Plan

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#### Expenses

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#### Operating Expenses

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<td>Service Contracts for Equip.</td>
<td>960</td>
<td>989</td>
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<tr>
<td>Coping</td>
<td>2,400</td>
<td>2,472</td>
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<tr>
<td>Postage</td>
<td>2,400</td>
<td>2,472</td>
</tr>
<tr>
<td><strong>Total Operating Expenses Fixed</strong></td>
<td>47,126</td>
<td>61,469</td>
</tr>
<tr>
<td><strong>Total Fixed Costs</strong></td>
<td>340,803</td>
<td>363,955</td>
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</tbody>
</table>

Total Variable Cost Operations $3.5 per RVU $ 20,900 $ 21,527 $ 22,173 $ 22,838 $ 23,523 $ 24,229 $ 24,956 $ 25,704 $ 26,476 $ 27,270
Total Costs $ 361,703 $ 385,462 $ 396,440 $ 407,722 $ 419,340 $ 431,324 $ 443,641 $ 456,326 $ 469,386 $ 482,834

Project Net Income -100,765 $ 3,824 $ 16,267 $ 45,484 $ 47,460 $ 49,497 $ 51,579 $ 53,748 $ 55,985 $ 58,294 $ 60,678

Return on Invest 30%
Operating margin 1% 4% 10% 10% 11% 11% 11% 11% 11%
Cost per square foot

Assumes 3% Cost Increase per Year
(a) First Year Allows for 4 Month Rent Abatement
* Start UP costs ranged between $46495 - $65725, upper limit

Appendix III
# Kentucky Surgical Associates

## Expense Assumptions

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Cost Structure</th>
<th>Number of persons</th>
<th>% Time</th>
<th>Salary/FTE</th>
<th>Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salaries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>Fixed</td>
<td>1</td>
<td>75%</td>
<td>215,000</td>
<td>13,438</td>
</tr>
<tr>
<td>Two Clinical Manager/Nurse</td>
<td>Fixed</td>
<td>1</td>
<td>100%</td>
<td>34,081</td>
<td>2,841</td>
</tr>
<tr>
<td>CMA / Billing / Registration</td>
<td>Fixed</td>
<td>1</td>
<td>100%</td>
<td>28,000</td>
<td>2,333</td>
</tr>
<tr>
<td>Part time</td>
<td>Fixed</td>
<td>1</td>
<td>50%</td>
<td>15,000</td>
<td>625</td>
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<tr>
<td>Business Manager</td>
<td>Fixed</td>
<td>1</td>
<td>10%</td>
<td>41,000</td>
<td>342</td>
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<tr>
<td>Fellow</td>
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<tr>
<td><strong>Total Salaries</strong></td>
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<td></td>
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<td></td>
<td>19,578</td>
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<tr>
<td>Fringe Benefits</td>
<td>Fixed</td>
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<td>20% Salary</td>
<td></td>
<td>3,916</td>
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<tr>
<td>Personnel Bonuses</td>
<td>Fixed Allowable</td>
<td></td>
<td>5% Salary</td>
<td></td>
<td>979</td>
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<tr>
<td><strong>Total Salaries &amp; Benefits</strong></td>
<td>Fixed</td>
<td></td>
<td></td>
<td></td>
<td><strong>$24,473</strong></td>
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## Operating Expenses

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<th>Cost Structure</th>
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</thead>
<tbody>
<tr>
<td>2419 sq ft</td>
<td>Fixed</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Office Supplies</td>
<td>Fixed</td>
<td></td>
<td></td>
<td></td>
<td>300</td>
</tr>
<tr>
<td>Telephone Service</td>
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<td>200</td>
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<tr>
<td>Long Distance Service</td>
<td>Fixed</td>
<td></td>
<td></td>
<td></td>
<td>100</td>
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<tr>
<td>Service Contracts for Equip.</td>
<td>Fixed</td>
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<td>80</td>
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<tr>
<td>Copying</td>
<td>Fixed</td>
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<td></td>
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<td>200</td>
</tr>
<tr>
<td>Postage</td>
<td>Fixed</td>
<td></td>
<td></td>
<td></td>
<td>200</td>
</tr>
<tr>
<td><strong>Total Operating Expenses Fixed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,080</td>
</tr>
<tr>
<td><strong>Total Fixed Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$25,553</td>
</tr>
<tr>
<td><strong>$306,636 per year</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Cost Structure</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Medical Supplies</td>
<td>Variable</td>
<td></td>
<td></td>
<td>$3.00 per RVU</td>
<td></td>
</tr>
<tr>
<td>Linen &amp; Laundry</td>
<td>Variable</td>
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<td></td>
<td>$0.50 per RVU</td>
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<tr>
<td><strong>Total Variable Cost for Operations</strong></td>
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<td></td>
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<td>$3.60 per RVU</td>
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### Kentucky Surgical Associates
#### Start up

<table>
<thead>
<tr>
<th>Start Up or Up-Front Costs</th>
<th>Range</th>
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<tr>
<td><strong>Medical Equipment</strong></td>
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</tr>
<tr>
<td>Start up</td>
<td></td>
</tr>
<tr>
<td>Instruments diagnosis</td>
<td>High: 2,229</td>
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<tr>
<td>Instruments surgical</td>
<td>High: 2,496</td>
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<tr>
<td>Exam and Procedure room</td>
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<tr>
<td>Supplies</td>
<td>High: 2,480</td>
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<tr>
<td>Surgical</td>
<td>High: 246</td>
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<tr>
<td>Paper, misc</td>
<td>High: 3,290</td>
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<tr>
<td>Consultation Room</td>
<td>High: 3,600</td>
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<tr>
<td>Computing Equipment</td>
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</tr>
<tr>
<td>Computing Software - Appt, Clinic Central Server</td>
<td>High: 10,000</td>
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<tr>
<td>Waiting Room Furniture</td>
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<tr>
<td>Office Equipment</td>
<td>Start up</td>
</tr>
<tr>
<td>Office Furniture</td>
<td>Start up</td>
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<tr>
<td><strong>Total Start up</strong></td>
<td>High: 65,725</td>
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<tr>
<td>Admit Service</td>
<td>InOut Code</td>
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<tr>
<td>--------------</td>
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<tr>
<td>SGB</td>
<td>Inpatient</td>
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<td>Inpatient</td>
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</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th>Total Cases</th>
<th>Total Charges</th>
<th>Total Direct Cost</th>
<th>Contribution Margin</th>
<th>Total Indirect Cost</th>
<th>Net Profit</th>
<th>Contribution Margin per Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,628,365</td>
<td>5,559,985</td>
<td>3,327,297</td>
<td>37,345,087</td>
<td>3,052,436</td>
<td>3,705,565</td>
<td>5,492</td>
</tr>
</tbody>
</table>

*Appendix VI*