

## Establishing an Ambulatory Surgery Center: A Primer from A to Z

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### **I. Financial planning issues**

**1. Financial feasibility; a comprehensive feasibility study.** A group of physicians (or physicians and management company or hospital) must first examine their outpatient case numbers to determine whether an ASC will be financially feasible. ASC revenue is equal to the number of procedures the group can perform at its own ASC multiplied by the expected reimbursement for these expected procedures. **As a general rule, in a reasonable reimbursement market, a center focusing on higher reimbursement procedures can be profitable with as little as 2,000 procedures per year. With lower reimbursement cases, this number can jump to 3,000 to 3,500 procedures. Further, in low reimbursement markets, a center may struggle to become profitable in some specialties at almost any case level.** Financial prudence dictates that one should only begin a project with a case level that is substantially higher than the threshold or break-even amount.

A first step to take prior to establishing an ASC is to prepare a pro forma income statement as part of performing a feasibility study.

A pro forma analysis and feasibility study should rely on sound physician data regarding projected case volumes, case mix, scheduling preferences and their expected reimbursement rates. Physician involvement will not only ensure sound data but accomplishes two other important tasks. First, it provides a chance to inform potential partners about the expectations, risks and profits. Second, it gives you a real opportunity to assess each physician's commitment to the project.

The case volume and reimbursement rate data collected are the key assumptions upon which the revenue part of pro formas are built. The greater the accuracy and certainty of these two types of information, the greater the accuracy and reliability of the final pro forma projections. In one center we helped to develop, the viability of the project itself was threatened when one or two of the key assumptions changed, thus resulting in the prospective loss of several hundred cases per year. A corollary to the statement that case volume projections should be reliable and accurate is the concept that the physician partners involved in the project should be fully committed to the project from the outset. There are few changes that will negatively impact the financial outlook for a new center as much as the departure of a core physician during the later stages of development. While a project can recover from a minor setback or challenge during the early planning stages, it is more difficult to correct severe problems that occur later in development.

In one example where the pro forma results were very different than actual results, "The pro formas that supported the decision of the lead physician to develop a three OR surgery center were not close to reality," says Tom Yerden, CEO of TRY Healthcare Solutions. "The revenues per case were overstated by 35 percent, volumes based on phone conversations with potential physician utilizers were too high, construction costs \$155 per square foot were below real costs. Then, when operational, the results were far different than the pro forma."

Counting cases is a crucial component of the development process. “Regardless of which specialties you develop the center around, it’s critical to understand the surgical case volume represented by each,” says Catherine Kowalski, executive vice president and chief operating officer of Meridian Surgical Partners. “Determine the universe of surgical case by physician and always calculate the net case transfer to the ASC, factoring in issues that discount volume including: insurance contracts, regulatory, politics, convenience, scheduling, surgeon behavior, etc. A good rule of thumb is about 50 percent of the surgical case universe for a conservative analysis.”

Attendance at meetings to discuss development of your new facility is another good indicator of the likelihood of the project’s success. “If after two meetings to investigate and develop a project your key physician members’ attendance remains strong, then it is time to get excited,” says William Southwick, CEO of Healthmark Partners. “Every surgeon likes the concept of developing a center; it is the core group that remains after two initial meetings that tells you whether the excitement is real or not.”

**2. Reimbursement by market differs significantly; CMS reimbursement system; out-of-network concerns.** Throughout the country, centers have had difficulty contracting with certain insurance companies. Thus, in assessing case volumes, one should discount the number of cases to a certain extent to reflect the possibility that certain insurance plans may not contract with the ASC. Moreover, certain insurance plans (and geographic regions) reimburse at levels below national standards. Hence, the center may find it financially impractical to provide services to these patients covered by such plans or in such regions. For example, a mediocre ASC located in an area with strong third-party reimbursement may do better than a great ASC in a bad reimbursement market. There is almost no way to fix a center that is built in a market with poor reimbursement from third-party payors.

In the planning stage, the center should attempt to discuss contracting with payors and obtain a real sense of whether contracts will be available and at what price. Payors have increasing power in many markets and are becoming harder to work with on an out-of-network basis. Payors and state regulatory agencies are increasingly scrutinizing out-of-network reimbursement strategies. In recent months we have seen more insurers attempting to recoup amounts they have paid on an out-of-network basis. Similarly, state agencies have been more aggressively policing this area. For example, in one recent case in New York, state auditors alleged that several surgery centers improperly waived patients’ out-of-pocket payments in connection with the care they received at the centers. In all, the state alleged that about \$8,000,000 was overpaid by the state employee insurance plan, the Empire Plan, and United HealthCare, the state’s insurance administrator.

Deutsche Bank, in its 2008 annual report on ASCs (dated Feb. 4, 2008), report that, for ASCs, “out of network situations typically result in greater overall costs to the system because both the patient and the third party payer have higher outlays” and “over the long term we believe that any ASC that builds its business model around unsustainable out-of-network reimbursement levels is bound to fail.”

One benefit a hospital partner may add to surgery center development is the ability to jointly negotiate reimbursement rates or to include the center on the hospital’s own payor agreements. However, the ability to jointly negotiate reimbursement rates in this context is often legally restricted in that it is subject to certain antitrust rules and regulations that require the hospital to have a sufficient amount of control over the venture on whose behalf it is negotiating. In many situations, the hospital will be unable to force the payors to negotiate with them on a joint basis.

To further complicate matters, some hospitals fear that by seeking to negotiate the ASC's rates with a particular payor, they will expose themselves to renegotiation of their current hospital outpatient department rates for that payor.

Another alternative to consider is hiring a third-party contracting consultant who can provide insight and advice with respect to the planning stages of reimbursement contracts. In addition, the center can ultimately use these consultants to negotiate the contracts on behalf of the center. Some management company partners employ their own in-house contract negotiators, while others outsource this function.

The new Medicare rates for surgery centers are generally more negative than positive. They essentially set reimbursement at an amount equal to 65 percent of the price paid for the same surgical procedures at hospital outpatient departments. Under the rates, of the top 20 procedures performed in surgery centers, approximately 17 will suffer a decrease in reimbursement. For many procedures, the decreases will be significant. For example, reimbursement for many gastroenterology and pain management procedures will decrease nearly 20 percent to 30 percent. Many ophthalmology procedures will experience a 5 percent to 10 percent reduction in reimbursement. Ultimately, many high-volume procedures are becoming less profitable to perform. In contrast, many higher acuity procedures, such as orthopedic procedures, will receive improved reimbursement under the new rates.

Commercial payors often follow the Medicare reimbursement trends. Some payors define their rates in terms of a percentage of the Medicare rate. The recent reimbursement changes remind us that, overall, one way to limit the risk associated with rate cuts is to operate a multi-specialty center so that cuts to any one single specialty will not be fatal to the center as a whole. While diversification of specialties can limit losses, it can also be less efficient to operate and equip, and can limit the upside potential if one specialty enjoys especially high rates.

**3. Capital requirements.** The typical development of a stand-alone ASC, with tenant improvement, requires a cost of approximately \$220 to \$250 or more per square foot to become operational. Additionally, money is also needed for equipment. Of the total budget amount, a substantial portion of the money can be provided through debt financing without guarantees. However, a certain portion of the debt may require personal guarantees (such as tenant improvements and working capital). Moreover, a cash capital contribution of a substantial amount must also usually be contributed to an ASC venture. Typically, anywhere from \$500,000 (on the low side) to \$1,500,000 is required as an equity cash contribution in total by the owners.

An ASC will typically initially issue one hundred ownership units. These units will be issued to members based on the amount of capital that each member contributes to the ASC. For example, if each unit costs \$10,000 and a member will own 15 units, he or she will contribute \$150,000. The amount of capital required depends upon the size of the project, whether the ASC will be a "tenant" or own and develop the real estate, and the amount of debt to be secured. The equity plus the debt borrowed from lenders equals the total amount of money needed to develop the project. Where a single-specialty ASC, such as an endoscopy ASC, will lease the space in which it operates, total initial equity capital contributions are often in the area of \$400,000 to \$800,000; however, the members may be able to contribute less money up front if a more substantial working capital line of credit is obtained. For a multi-specialty ASC that leases space rather than owns the building, initial equity capital contributions are often in the range of \$700,000 to \$1,200,000. One option, even where all of the investors want to invest in both the surgery center and the real estate, is to have the ownership of the real estate and the ownership of the surgery center held in separate entities. This allows for additional investors to own a portion of the real

estate holding company, thus making it less expensive for the investors in the surgery center entity. By separating the real estate from the operating entity that will run the ASC, investors can choose whether they would like to invest in the surgery center, the real estate or both. There are, however, significant benefits to fully congruent ownership.

The operating agreement will set forth the dates on which the capital must be contributed. Typically, all or a significant portion is contributed at the signing of the operating agreement. In some situations, part of the capital will be due at a later date, such as upon receipt of a certificate of need or perhaps six months after the initial signing. Additional capital contributions may be required of the members upon the vote of the board of managers and often a vote of the holders of a certain percentage of the units. The group will need to assess the total equity to be contributed.

Working with experienced lenders will facilitate the financing of an ASC. It can be tempting to work with a friend or a local bank, but this could be a mistake. Often with ASCs, time is of the essence and problems occur which are normally much better handled by an experienced lender than by a friend. For the best result, look for a lender with specific ASC financing experience. There are some general costs you can use to help estimate the approximate investment necessary to build a facility.

“Although it varies based on location, the cost to develop a new ASC is approximately \$1 million dollars per operating room,” says Kenny Hancock, president and chief development officer of Meridian Surgical Partners. “This figure captures the costs associated with tenant improvements, equipment and working capital. A small center with two surgical suites will range from \$2 to \$3 million and a larger multi-specialty ASC \$4 to \$6 million. Typically, the majority of the investment, including the construction cost and surgical equipment, is leveraged with debt financing. The members should plan on raising a minimum of 20 percent of the capital needed in cash to invest in the partnership. The investment typically ranges from \$10,000 to \$15,000 for a 1 percent ownership interest plus pro-rata guarantees of debt. The typical timeline is 18 to 24 months from initial discussion to opening of the center.”

**4. Expense management.** Surgery centers tend to have a level of fixed costs that generally require at least \$3 to \$5 million in revenue to become significantly profitable and still cover the necessary expenses.<sup>1</sup> Centers with \$5 million to \$10 million in annual revenues can, on average, expect to have an EBITDA of around 30 percent, or earn about a 30 percent operating margin before deducting interest, taxes and depreciation.<sup>2</sup> The three biggest costs for an ASC typically include staffing costs (about 20 percent to 30 percent of revenue), supply costs (about 20 percent of revenue) and facility costs (about 10 percent of revenue).<sup>3</sup> With staffing costs making up the majority of an ASC’s expenses, it is critical to benchmark the hours per case to those at other similar centers to ensure your staff is working efficiently. Generally, multi-specialty cases will entail between 13 to 15 hours per case and single-specialty cases will entail six to eight hours per case. This number is often translated in simple terms to approximately five full-time equivalents per 1,000 patients. To control staffing costs, it is imperative to use staff efficiently by cross-training where appropriate, being open only as many hours as cases require and, if possible, by sending staff home when they are not needed.

Supply costs, to a degree, may be reduced by use of a group purchasing organization or, in some cases, a hospital or management company partner that is able to aggregate expenses over a number of facilities and, as a result, benefit from volume pricing with vendors. Another common way to reduce supply costs is to implement standardization of certain common surgical supplies and reduce the use of non-essential supplies. These are both areas where a seasoned management company can help a surgery center to achieve greater operational efficiency. While staffing and

supply costs can be modified over time, facility costs, once a lease has been signed or construction has commenced, are much more difficult to change. It is very important to obtain expert advice relative to these three cost items early and often.

## **Equity ownership, physician partner issues, and hospitals and management companies as partners**

**1. Management and equity ownership.** A group must determine whether or not it will have a management company as an equity partner. An experienced manager can help with myriad aspects of the project, such as financing, financial planning and analysis, Medicare certification, equipment planning, construction planning and physician recruitment. A good management company can significantly reduce the likelihood of problems in completing the project, operating the center, financing the project and ultimately prospering from the project.

The key downside to having a management company as a long-term equity partner relates to the disparate quality of companies that provide services to ASCs, and the profits that are shared when bringing in a management company. As a general rule, physician ownership alone, under the right circumstances, can be very attractive. However, having an experienced management team substantially lowers the risks, and, in the overwhelming majority of situations, can provide substantial benefits and actually improve profitability. Further, an equity owner/advisor often will have a much greater level of concern regarding the project's success, even when it owns only 15 percent to 30 percent of the center.

Deutsche Bank, in its 2008 ASC Report, reports that the 25 largest management companies own interests in aggregate in about 1,000 of the country's 4,700 Medicare-certified ASCs. (Contact Darren Lehigh at 212-250-2629 for more information).

Key items to negotiate with the management company include the percent of ownership, the management fee, the services provided, the personnel employed or provided, the length of the management contract, the board rights and the reserve or veto rights of the management company. A group should interview three to five management companies and talk extensively to other centers managed by the companies.

In addition to a management fee, the leading management companies are increasingly requiring equity in the surgery center. Before rejecting such an arrangement, evaluate how that management company compares to other management companies.

A solid management company partner can also substantially improve the financing prospects of a center. Some finance companies will not finance an entity without an experienced management company being involved.

John Marasco, CEO of Marasco Associates, notes that understanding recent partnership trends can help you gauge the direction other ASCs are choosing for their development.

"In the last few years our business has seen an increase in joint venture ASC's and physician-hospital ASCs, as compared to individually developed projects," says Mr. Marasco, "They range from physician/hospital to physician/management company to physician/hospital/management company joint ventures. We have helped develop an almost equal number of single-specialty/single-group joint ventures as we have multi-specialty/multi-group joint ventures, which is also a shift in direction. It appears that groups are shifting towards going it alone, surgically speaking, but having a partner to share in the risk as well as bring expertise and insurance contract stabilization to the table. We haven't seen a huge rise in the overall number of operating

or procedure rooms in our average ASC — just a shift in who owns them and who they serve. “

**2. An ASC can have too many physician investors.** You can have too many physician partners. With too many physician investors, there is often a dilution of individual physician responsibility and ownership interests. With too little ownership, physician investors often lose their commitment to the ASC and look for other alternatives. Further, a great deal of resentment can develop between productive and less productive parties. Of course, with too few physician investors, the price of buying in will be greater, there will be more risk of case volume losses, and the overall case volume of the center can suffer. The number of investors is a delicate balance that requires significant forethought and planning. The average number of physician-owners in an ASC is approximately 15:1 according to Deutsche Bank’s 2008 ASC report.

**3. Single- or multi-specialty center.** Single-specialty centers can be more efficiently staffed and built than multi-specialty centers. Moreover, a single-specialty center avoids the turf wars and the level of concern regarding sharing profits and revenues with other specialties that are often present with multi-specialty centers. However, changes in reimbursement can affect single-specialty centers more dramatically than multi-specialty centers. For example, Medicare has instituted significant cuts in ASC reimbursement for gastroenterology, pain management and, to an extent, ophthalmologic procedures. These cuts can disproportionately impact a single-specialty GI or pain management ASC’s overall revenue and financial health.

On the other hand, a multi-specialty center can help reduce reimbursement reduction risk through a diversification of reimbursement sources and a mix of physicians. In addition, a multi-specialty center can provide for greater staff and physical plant economics of scale, which may be needed if single-specialty volumes are insufficient. In many cases, the operating margins in single-specialty ASCs are much higher than multi-specialty ASCs.

Specialty net revenues per case, according to the VMG Health 2007 Intellimarker, can be seen for several specialties in the following chart:

Specialty	Net Revenue
ENT	\$1,776
GI/Endoscopy	\$825
General Surgery	\$1,572
OB/GYN	\$1,864
Ophthalmology	\$1,276
Oral Surgery	\$1,056
Orthopedics	\$2,435
Pain Management	\$915
Plastic Surgery	\$1,548
Podiatry	\$2,664
Urology	\$1,802

The number can be heavily influenced by sample size, and several factors such as out-of-network considerations.

**4. Hospitals as partners.** Approximately 25 percent of the surgery centers in the country have a hospital partner. In many situations, a hospital can add value through either helping with managed care contracting, making it easier to recruit physicians or otherwise reducing physician concerns regarding being excluded from privileges or having other types of retaliatory action taken against them by the hospital. On the other hand, it is critical in surgery centers that physicians own a significant amount of the equity and that they remain interested and excited about the venture. We

have seen hospital partners own from 10 percent to 30 percent of the venture on the low end to 60 percent to 70 percent on the high end. There are a number of lawyers representing hospitals who believe that they must own 51 percent or more. In contrast, many lawyers believe that hospitals can own a smaller interest and either agree to treat the income as taxable income or otherwise have separate special powers to help assure that the venture serves exempt purposes. From a business perspective, having a hospital partner in many circumstances can prove helpful. However, it is not a panacea for surgery centers and there are a great number of surgery centers that have hospital partners that still underperform.

“Some hospital-physician joint ventures never survive the transition from a ‘spirit of negotiation’ to a ‘spirit of partnership,’” says Mr. Yerden. “Regardless of the strength of the projections (business plan), those joint ventures that I have seen fail (do so) due to lack of trust among the parties.”

**5. Ophthalmology procedures can still be profitable.** Do not make a blanket decision to exclude ophthalmology as a specialty. ASCs can still profit from ophthalmology procedures if the ASC has significant volumes and effective internal cost control; in other words, the ASC must run very efficiently.

Here is what Luke Lambert, the CEO of Ambulatory Surgical Centers of America says about the specialty: “Most mature eye practices are already participating in surgery centers. When ophthalmologists start working in an ASC they never want to go back to the hospital, because the fast nature of eye cases plays to ASC strengths.”

**6. Pain management and anesthesiologists.** Pain management services are often provided in an office setting. Centers are increasingly concerned that physician investors will perform their pain management procedures in their own offices rather than in the ASC. Medicare’s site-of-service differentials, which often pay more for in-office procedures, along with other incentives, may very well encourage physician investors to perform these procedures in their own offices. ASCs should plan accordingly and diversify services to accommodate a potential loss of pain management revenue. CMS has also implemented relatively large reductions in pain management reimbursement for ASCs. In order to control the flight of pain cases from the surgery center to physician offices, it is necessary to engage in a frank conversation with pain physicians fairly early in the planning process to clarify which procedures will likely be performed in their offices versus those that will likely be performed in the surgery center. For financial planning, it is critical that both parties fully understand the expectations for these types of cases.

Notwithstanding these concerns, “Efficient pain specialists can be a pillar of strength in a successful ASC,” says Mr. Lambert. However, “ASCOA recommends against inviting anesthesiologists to be owners in ASCs. We feel it is better to be the consumer and contractor of anesthesia services than to be partnered with them.”

**7. Gastroenterology can still be profitable.** In a 2006 study, gastroenterology was the largest surgical specialty, representing 25 percent of all surgical cases performed at ASCs.<sup>4</sup> Medicare has implemented decreased reimbursement for gastroenterology procedures performed in an ASC. This can hurt an ASC because gastroenterology-endoscopy centers typically rely on Medicare for about 20 percent to 40 percent of their cases. Fortunately, because these centers still generate from 60 percent to 80 percent of their gastroenterology business from outside Medicare, the specialty can still be profitable if they have significant volumes and the non-Medicare business continues to grow.

“This is a specialty characterized by high volumes,” says Mr. Lambert. “ASCs are important to enhancing productivity. Profits per case are low and declining but given sufficient volume it can be attractive.”

Gastroenterologists will increasingly have to minor in anesthesiology. Increasingly, payors will not pay physicians separately for anesthesia procedures provided in connection with gastroenterology procedures. Thus, increasingly gastroenterologists must be competent at offering all types of anesthesia procedures.<sup>8</sup> Plastics. In multi-specialty surgery centers, plastics, particularly cosmetic procedures, often are very challenging. Here, the physician often bills globally, and the ASC and the physician are adverse to each other in that the ASC must negotiate its rates with the surgeon as opposed to charging a third-party payor.

“Cosmetic plastic surgery is not of benefit to most surgery centers as the facility fees paid tend to be too low for these lengthy cases,” says Mr. Lambert.

**9. Bariatrics is booming, but don’t count on it as a long-term profit center.** Bariatric procedures are growing rapidly and increasingly being performed in ASCs. Initially, ASCs will earn outsized profits from these procedures. However, as the number of bariatric providers increases and price competition evolves, the prices on these procedures will eventually normalize and become less profitable. For this reason, and because substantial concerns remain regarding the safety and risks related to bariatric programs, ASCs should use caution and proceed conservatively when developing bariatric programs.

**10. Lasik.** Lasik surgery, for reasons akin to why plastic surgery is problematic, is often best left to physician practices.

**11. Neurosurgery and orthopedics remain strong specialties.** Orthopedic procedures remain great procedures for ASCs.

“How well you do with orthopedics depends a great deal on how successful you are in negotiating payer contracts,” says Mr. Lambert. “Medicare’s new fee schedule phase-in is making it possible to cover costs and setting a reference point that is helpful when negotiating with other payors.”

Spine procedures are also increasingly performed at ASCs as well; they remain popular and are growing in importance. Orthopedics profits from the new CMS surgery center rates. Spine procedures can be increasingly performed in ASCs and are likely to remain good specialties for ASCs for a substantial period of time to come. In the best situation, the center has a base of cases from both specialties.

Despite the promise it offers, before you invest in spine services, it is important to consider the costs involved.

“Spine service costs up to \$360,000 to set up; \$80,000 for microscope, \$80,000 for trays, \$120,000 for c-arm and perhaps a Jackson table for \$80,000,” says Tom Mallon, CEO of Regent Surgical Health. “This should not be taken on frivolously. However, if the surgeon uses loops instead of a microscope and if you have a c-arm, the entry cost is much less: \$160,000. Spine often cannot be performed on contracted patients. So in order for you to begin even a small program (five cases per month) you need at least some out-of-network patients. However, the surgeon will love the efficiency and the patients will love the facility. This will grow over time and as payors recognize the benefits, we will be able to negotiate reasonable reimbursements.”



**12. ENT continues to be strong.** Ear, nose and throat procedures continue to be a strong specialty for surgery centers. This specialty continues to be reimbursed reasonably well in many markets.

As a result, says Mr. Lambert, “We see ENT as an attractive specialty if the cases in your area are not overly dependent on Medicaid. Special considerations for this specialty include requiring skilled pediatric anesthesia and having a private recovery area for children.”

**13. Urology.** Urology can increasingly also be a real plus for ASCs.

“Many procedures are short and can pay well on a time of utilization basis, of those that are longer some reimburse well,” says Herb Riemenschneider, MD, founder of Knightsbridge Surgical Center. He notes that the longer procedures for urinary tract stone disease (such as extracorporeal shock wave lithotripsy and ureteroscopic stone work with laser), urinary prosthetics (penile prostheses and artificial urinary sphincter), prosthetic slings for treatment of female incontinence, and the most recent addition of cryoablation for treatment of prostate cancer, have “big potential if done correctly.”

“Urology can be profitable when it involves lithotripsy and female incontinence surgery,” says Mr. Mallon. “Both are predominantly commercial populations. Serving Medicare men with prostate cancer can often be break-even at best.”

Some ASCs are finding benefits of building a center around urology.

“The surgery center has allowed our urologists to remain more efficient doing outpatient surgery than they could be by performing the same procedures in an outpatient hospital setting,” says Bill Monnig, the president of a large urology group. “The single-specialty designation allows us to gain maximum benefit of the special endoscopic equipment that urologic surgery requires and, therefore, may be more financially advantageous than a multi-specialty center where this equipment may not be used as much. Our surgery center also gives us an opportunity to dovetail other ancillary services such as CT scanning, urodynamics, pathology lab, clinical lab, research programs, office-based minimally-invasive prostate surgery and clinical research programs into adjacent facilities. The number of and type of procedures that we can perform in the surgery center continues to grow each year.”

## **II. Building issues**

**1. Do not overspend on real estate.** Physicians planning centers should purchase property that is cost-appropriate. Normally, a second or third tier commercial property that is level, safe, accessible to your physicians and patients and has easy parking will often be sufficient. Make sure that the less expensive land will not ultimately cost you more due to unknown variables. If a property has a lack of utilities, set-backs or zoning restrictions, it may ultimately cost more. A site should be evaluated by an experienced ASC architect to ensure that it can meet the ASC’s requirements. This includes performing a thorough analysis of state and municipal codes and regulations in regards to health and zoning issues prior to purchasing the land. Do not assume, for example, that a space used for an ASC in the past is automatically qualified to fit your needs. In many cases, existing structures may not meet standard coding requirements and a change in ownership or management of the facility will trigger a need to update it to current specifications.

A visible, expensive parcel is often an unnecessary cost. It is not important that the ASC be

visible in order to attract drive-by or foot traffic. This is significant because premier commercial lots can cost considerably more than otherwise equally appropriate, yet less visible, lots.

**2. Do not overbuild.** A building should meet the group's volume and specialty needs, as well as the financial parameters. The space plan should be integrated with your staffing and equipment plans. Knowing your case numbers, how many technicians, nurses, schedulers, business office and administrative staff and other staff you will need, as well as your equipment requirements, should drive your space needs.

**3. Lease or build from the ground-up; lease or own the real estate.** A center does not need more than one operating room per 1,000 to 1,500 cases. A typical two-room ASC can be built in 7,000 to 8,000 square feet. An average size ASC is approximately 13,000 square feet.<sup>5</sup> VMG Health's Intellimarker also indicates that the median ASC includes four ORs and two procedure rooms. Centers can be leased from a third party or built from the ground up. Often, it is quicker and less expensive to lease space and operate as a tenant. On average, rental rates are approximately \$27 per square foot each year.<sup>6</sup>

"We prefer to lease our ASCs' real estate because we lease without personal guarantees and avoid having to put cash/equity into real estate," says Mr. Lambert. "Surgery centers, if conceived and managed properly, can offer returns that are superior to that of the typical ASC real estate investment."

The disadvantage to this approach is that one does not ultimately own the real property nor completely control the project. At the same time, the long-term capital costs can be substantially lower.

Tom Irscher, President of Irscher Construction, makes two interesting observations on this subject. First, he says, the larger public companies typically do not want to own their real estate. In contrast, the private small group will often choose to own their real estate. Second, in the private projects, the group will typically form a separate entity to own the real estate.

**4. Equipment budget and planning.** When developing a center, you have to decide whether or not to use an equipment planner. The argument for using equipment planning is that it costs approximately \$200,000 to \$500,000 per OR to set up the OR. This will be one of the largest expenses you have at a surgery center. Thus, the argument is that you use an expert to help you do it, help save costs and plan more efficiently and coordinate better through design, development and construction. The counter argument is that either a center can do it itself or it could use a management or development company to do it as well. In fact, many people resent the concept of using a management or development company and then, on top of that, having to use an equipment planner. Further, there are situations where the equipment planning firm may have such close ties with industry (equipment manufacturers) that using an equipment planner might not get you some of the benefits that you expected to get from the process.

**5. Other building issues.** Early in the design process, an ASC should examine how information technology systems, fluid management systems and anesthesia systems will be incorporated into design. For example, as to fluid waste management, Bill Merkle of MD Technologies notes:

"ASC design should consider fluid waste management since disposal systems require plumbing, drains and medical gas piping most easily installed during construction or remodeling. Procedure room layout should address fluid management to assure that utilities and piping are conveniently located near the patient bed as well as near medical equipment (such as an endoscopy cart with

light source). System size and floor space requirements should be assessed, particularly if suctioned fluid must be transported to disposal sites. Today, most (about 80 percent) fluid management costs is for canisters, with remaining cost for waste disposal. Tremendous cost savings can be realized if both costs are eliminated. Advance planning can improve room efficiency, reduce turnaround time and minimize fluid management costs.”

### **III. Miscellaneous.**

**1. Accreditation and state licensure.** Many surgery centers are state-licensed, Medicare-certified and accredited. For example, in 2005, over 4,500 ASCs were Medicare-certified.<sup>7</sup> There are currently approximately 5,500 to 6,000 ASCs. Many states require ASCs to be licensed. In addition, ASCs should attempt to become accredited by the Joint Commission, the Accreditation Association for Ambulatory Healthcare or another reputable accrediting agency such as the American Association for Accreditation of Ambulatory Surgery Facilities. Accreditation often lets ASCs be deemed Medicare-certified, to serve certain payors and to measure their services and performance against national recognized standards, thereby helping them to improve the quality of their care.

Speak with your state health department early on in your development process to learn your state’s ASC licensing requirements as each state is different. In all cases, you will want to speak with them very early in the process to access state requirements and processes, and to help avoid unexpected delays in licensure requirements.

**2. Hire strong leadership; cost; timing.** High-quality management is critical to an ASC’s success. Many management companies offer superior services. However, many are of little value. All management companies are not equal. For this reason, it is important to work with an experienced management company that has a proven track record of successes. Working with a low-quality, inexperienced company will do more harm than good. You will need to start by hiring an administrator and director of nursing.

It is far better to overpay the employee a bit to hire outstanding help as a great staff is crucial to an efficient and profitable ASC. You need not necessarily employ your staff full-time. However, you are best off paying your staff well and attempting to obtain the highest quality staff — even if highly paid on an hourly basis. It is also critical that you treat the staff extremely well so that you are able to recruit and retain the best possible staff. Finding and retaining an experienced and competent staff can prove challenging.

Registered nurses can make superior administrators. Experienced RNs often make great ASC administrators. The RN must study and be interested in the business side of ASCs. Generally, RNs are trained to be disciplined and dedicated workers; a work ethic that carries over to the administrator position. As such, RNs are often vibrant and willing to contribute in many ways to improve the surgery center. An administrator should typically be hired four to six months before a center intends to become operational.

Here are some insights from Roger Manning, founder of the Manning Search Group, on the costs and timing of hiring certain leadership:

- Base salaries can, of course, vary depending on the geographic locations with California and certain areas of the Northeast (such as Boston) being the most highly paid.
- On average, an owner can expect to pay an ASC Administrator from \$70,000 per year to

\$110,000 for more experience. “We occasionally will find an administrator who is paid far higher than this, but I think it is because of close long-term relationships with the physicians and/or the physicians made a strong deal to get them to help open up their ASC,” says Mr. Manning. “Multi-site management positions will start paying in the \$110,000 range to \$125,000 as their low range and can go up to a high average of \$150,000 to \$175,000. Most of my [multi-site]-type positions are paying in the higher end due to the competitive pressures to gain experience.”

- The opening of an ASC by a surgery center management company is usually done with the assistance of a key development manager until 30 days within the opening date. Between 30 to 60 days, “I am usually given a call to find the new administrator,” says Mr. Manning. “If a private group of physician investors is opening the center without the assistance of a national management company, they should consider hiring an administrator who has had prior ASC development experience that will stay on as the administrator. In this case, the hire should be done at the conception of the deal.”

- Again, base salaries can vary depending on the geographic areas of the United States. “I have seen directors of clinical services (director of nursing) salaries vary from \$55,000 in small ASCs or single-specialty ASCs to \$100,000 per year,” he says. “I would say that owners should expect to pay on the average \$75,000 to \$88,000. Recruiting a doctor with experience from a national competitor will probably cost you \$90,000-plus because of the highly competitive nature of the ASC industry coupled with the nursing shortage (especially in California).”

**3. Typical problems for surgery centers.** The No. 1 problem for most ASCs is the inability to effectively recruit the right number of physicians and cases or the inability to obtain appropriate commitments from their physician partners. The most successful centers are increasingly built around a core group of physicians. This approach lessens certain risks related to the center and clarifies the level of physician commitment. Over time, an evolving risk in many markets relates to the actual number of independent physicians available for recruitment.

A second set of core risks includes overstaffing an ASC and building a facility that is too big. The desire of partners to have the latest and greatest technology and equipment can quickly kill a budget. It is often useful to have third-party input in these decisions to help inject some rational, efficiency-minded thought into the process.

Despite their growth throughout the country (nearly 5,500 to 6,000 ASCs), a substantial number of ASCs still fail. The failures occur mostly due to bad management, low-volume of cases, poor reimbursement or overbuilding. Knowing the risks involved in developing an ASC can help to ensure that your ASC will prosper and not fail. Working with experienced managers in developing a center can also help prevent failures.

Many centers also face significant risks related to reimbursement, managed care exclusion, poor billing and collection practices and failing to contain supply and equipment costs. In essence, because the reimbursement for procedures is becoming less predictable, there is an extensive need to assure that the project is well-managed and well-thought out. A failure to do either of these can lead to significant financial problems for the entity.

Turning around struggling ASCs requires many changes.

“You must change the thinking of the partners and staff,” says Mr. Mallon. “They need to be open to doing things differently. True insanity is doing the same thing over and over and expecting different results. We must understand how we make money and how we lose it. Every

center has losing cases, but they must be performed judiciously. Do a losing case in a lineup of profitable cases — that is OK. Do losing cases that have small supply costs and no implant — that is OK. Avoid high-cost implants and surgeons who only bring losing cases based on fully loaded cost analysis.”

**4. Advisors, management, architects, builders and lawyers.** Given that more than 5,500 ASCs now exist, we strongly advise that ASCs utilize experienced advisors. Should you need recommendations, please contact Scott Becker at (312) 750-6016 or at [sbecker@mcguirewoods.com](mailto:sbecker@mcguirewoods.com) .

**5. Establish MIS and billing systems early.** An ASC should establish its management information system and other operational systems, such as billing, materials management and marketing. You should set up your MIS as early as three months prior to your ASC’s opening. The MIS is a critical part of an ASC’s organizational backbone and can support the effective management of the ASC. If established early and populated with appropriate information, upon opening, your clinicians, front office and management will have immediate efficiencies scheduling surgeries, billing, performing collections, case-costing and taking inventory, among many other tasks.

Caryl Serbin, CEO of Serbin Surgery Center Billing, implores those planning ASCs to decide early whether to outsource billing or handle billing internally — an ASC should decide at least four to six months prior to becoming operational. Further, she says, an ASC should also set up its billing office early so that it can start billing (and collecting) reimbursements from day one. Another option is to outsource billing and collections services. If you choose to use an outside provider, it is advisable to also get them involved early in the development stage in order to expedite implementation of their systems.

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1 Intellimarker, Ambulatory Surgical Centers Financial & Operational Benchmarking Study (2d Ed. May 2007) (“2007 ASC Study”) at p. 30.

2 Id.

3 2007 ASC Study at p. 15

4 2007 ASC Study at p. 7

5 2007 ASC Study at p. 35

6 Id.

7 2007 ASC Study at p. 7