LIST OF 20

TITLE: WHAT HAVE WE LEARNED FROM HALIFAX, TUOMEY, NORTH BROWARD, ADVENTIST, AND COLUMBUS REGIONAL

1. Real Estate: Valuation of tenant improvements.
2. Time Share Creep: Agreement and all expenses must be attributed to the time share tenant and expenses divided based upon usage of time, not number of physicians occupying time shared space.
3. Real Estate: Value of parking for physician owned medical office building must be allocated to physician owners.
4. Real Estate: Valet services must be valued and allocated to physician owned medical office building.
5. Paid services (i.e. medical directorships) should use tracking mechanism to validate services rendered.
6. Bonus arrangements in productivity compensation that allocates a split of technical revenue (primary case - Halifax Health).
7. Full-time equivalency validation in compensation arrangement (ensuring physician is providing 1.0 FTE services if the physician is compensated as 1.0 FTE physician)
8. Documenting reason employed physician arrangement may generate a loss based on the physicians' professional services instead of downstream technical revenue.
9. Compensation stacking.
10. Validate usefulness of assets in asset purchase agreement (do not value obsolete equipment as if obsolete equipment had a useful value).
11. Not using contribution margin report to "take into account the volume and value of referrals" when establishing physician compensation arrangements.
12. Not exceeding contractual compensation maximum in independent contractor compensation arrangements.
13. Part-time employment for outpatient surgeries only.
14. Legal opinion shopping.
15. Misalignment of compensation in comparison with productivity (i.e. compensating physician at 90th percentile with 25th percentile productivity [assuming 1.0 FTE clinical allocation]).
16. Use of income approach apart from asset and market valuation approaches.
17. Meeting the "group practice" definition under the Stark Law if the in-office ancillary services exception is to be used in a physician compensation arrangement.
18. Non-physician practitioner services performed "incident to" or as a shared service in a physician productivity compensation model.
19. Free stuff.
20. Medical necessity (i.e., billing for unsupervised services when supervision is required, and non-medically necessary hospital admissions in order to re-establish skilled nursing facility coverage).

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