Health Care
Quarterly Update

Introduction

Welcome to the Winter 2008 edition of SRR's Health Care Quarterly Update. In this issue, we provide updates as to trends in Long-Term Care Facilities, Medical Devices & Supplies, Drug Stores and Related Services, and Outpatient Service Providers. Due to the fluctuations of the public markets, multiples are down across each of these sectors compared to the 3rd quarter of 2008.

Also, included in this edition is a guest article authored by Adrienne Dresevic, Esq. and Carey F. Kalmowitz, Esq. of Wachler & Associates, P.C. discussing the 2009 Medicare Physician Fee Schedule and its impact on Medicare's Anti-Markup Rule and IDTF Enrollment Requirements for Mobile Imaging.

SRR is a financial advisory firm focused on Valuation & Financial Opinions ("VFO"), Dispute Advisory & Forensic Services ("DAFS"), and Investment Banking ("IB"). Within our VFO group, we perform enterprise, intangible asset and real and personal property valuations for a variety of purposes, including acquisition/divestiture, compliance and financial reporting. Our DAFS practice provides consulting services and/or expert testimony in practice areas such as reimbursement disputes/investigations, antitrust, commercial disputes and intellectual property disputes. Lastly, our IB practice specializes in providing mergers and acquisitions advice, private capital raising services and other financial advisory services to companies.

SRR's Health Care Industry Practice is divided into following segments:

Health Care Equipment & Technology

- Health Care Equipment
- Health Care Supplies
- Health Care Technology

Health Care Providers & Services

- Assisted Living and Long-Term Care Facilities
- Health Care Distributors
- Health Systems
- Home Health Care Providers
- Managed Health Care
- Outpatient Services (Diagnostic Imaging, Ambulatory, and Dialysis Centers)
- Physician Groups

Pharmaceuticals, Biotechnology & Life Sciences

- Biotechnology
- Life Sciences Tools & Services
- Pharmaceuticals

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Outpatient Services Industry

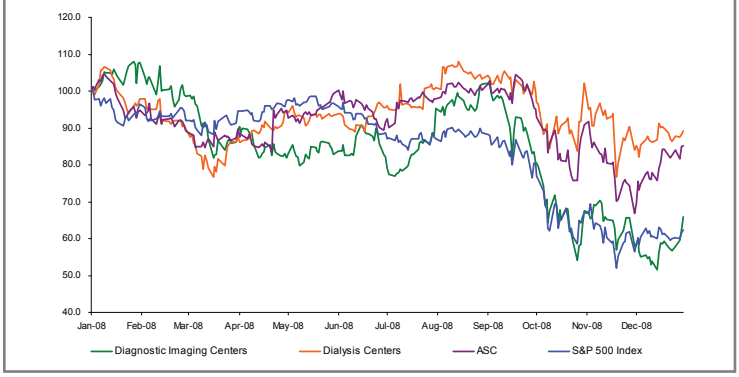
4Q08 Industry Snapshot

Overview

In recent years, there has been a shift from the delivery of health care services in a traditional inpatient hospital setting to an outpatient setting. Outpatient services can incorporate many different sectors in health care and we focus on three: ambulatory surgical centers ("ASC"), kidney dialysis centers, and diagnostic imaging centers. The sectors are comprised of approximately 3,500 ASCs with combined annual revenue of about $9 billion, 3,200 dialysis centers with combined revenue of about $10 billion, and 5,000 diagnostic imaging centers with combined revenue of $3 billion.

Outpatient centers are often viewed as being more cost effective, more efficient, and more desirable facilities at which to receive testing or treatment than competing hospitals. These benefits have led to significant growth in outpatient health care centers. With this growth has come reimbursement rate pressure. The Deficit Reduction Act ("DRA") significantly reduced reimbursement rates to diagnostic imaging centers and CMS's revisions to the payment system under which ASCs are reimbursed accomplished the same. Additional challenges include state and federal licensing requirements and regulation. The future success of outpatient centers depends upon the ability to increase patient flow through acquisitions, consolidation, or the addition of physician partners.

Stock Price Performance vs. S&P 500
Last 12 Months



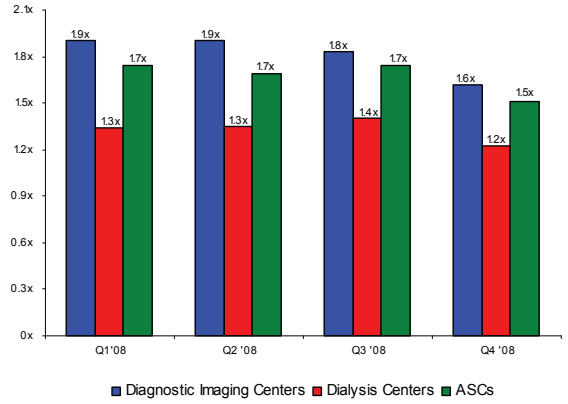
News and Trends

- CMS issued the Physician Fee Schedule 2009 final rule on October 30, 2008. The final rule softened some of the language in the proposed version related to ASCs, specifically the proposal that would have defined an ASC as an entity providing surgical services that do not require an overnight stay. The final rule refined the definition to state that ASCs may provide surgical services that do not exceed 24 hours following admission. This language provides more flexibility for ASCs in the treatment of patients. Consistent with the final rule, as CMS transitions to its revised payment system, ASCs are expected to be paid on average only 61% of hospital reimbursement for the same services.

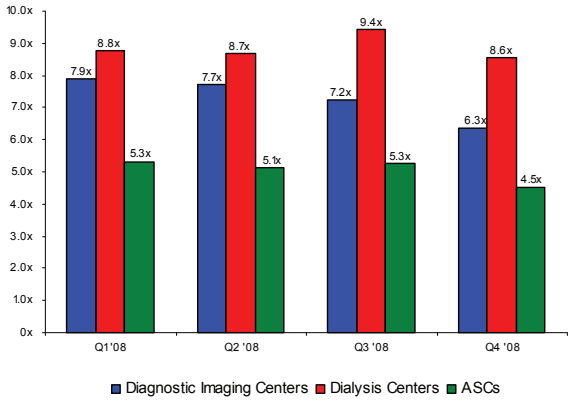
Merger & Acquisition Summary

- On December 16, 2008, Alliance Imaging Inc. acquired Shared PET Imaging LLC ("SPI") for $43.0 million. SPI operates in 13 states with approximately 90 clients providing mobile and fixed-site positron emission tomography and computed tomography.
- NovaMed Inc. acquired a 65% interest in Physicians Surgical Center ("PSC") on December 2, 2008. PSC performs orthopedic, ophthalmology, pain management, urology, and general surgery procedures.
- Renal Advantage finalized its purchase of National Renal Alliance, LLC ("NRA") on December 28, 2008. NRA is a $100 million operator of dialysis facilities in the U.S.

SRR Composite Revenue Multiples



SRR Composite EBITDA Multiples



Index Composition

Diagnostic Imaging Centers	AIQ, RDNT
Dialysis Centers	DVA, DCAI
ASCs	AMSG, NOVA

Guest Article: The 2009 Medicare Physician Fee Schedule – Medicare's Anti-Markup Rule and IDTF Enrollment Requirements for Mobile Imaging

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In recent years, diagnostic imaging services have been intensively scrutinized by the federal government. This article will summarize some of the more significant recent federal regulatory changes included in the 2009 Medicare Final Physician Fee Schedule ("2009 MFPFS") and their impact on diagnostic imaging arrangements. Industry stakeholders should anticipate, and be attentive to, future regulatory changes, as the Centers for Medicare and Medicaid Services ("CMS") is expected to continue to focus on areas, such as diagnostic imaging, which it believes are vulnerable to patient and program abuse, and which are among the fastest-growing set of services paid for under Medicare Part B physician fee schedule.

Medicare's Anti-Markup Rule – CMS Finalizes Two Alternatives

On October 30, 2008, CMS released the 2009 MFPFS. In the 2009 MFPFS, with respect to the application of the anti-markup rule to the provision of certain diagnostic testing services, effective January 1, 2009, CMS adopted two alternative tests for determining the applicability of the anti-markup rule.

The Final Anti-Markup Rule

Specifically, the following principles determine the applicability of the anti-markup rule:

(1) Alternative 1 – "Substantially All Test."
Arrangements should first be analyzed under this Alternative. If the performing physician (i.e., the physician who supervises the TC or performs the PC, or both) performs substantially all (at least 75 percent) of his or her professional services for the billing physician or other supplier, the services will not be subject to the anti-markup rule payment limitations. If the "substantially all" services requirement is not satisfied, an analysis under Alternative 2 may be applied.

(2) Alternative 2 – "Site of Service Test."
TCs conducted and supervised in, and PCs performed in, the "office of the billing physician", which includes the "same building", by an employee or independent contractor physician avoid the anti-markup payment limitation.

These alternative tests measure whether or not a performing or supervising physician "shares a practice" with the billing physician or other supplier. A physician is no longer required to exclusively work for one physician practice; rather, a physician need only "share a practice" with a physician or physician organization. This change aligns certain provisions of the Stark group practice definition with the anti-markup provisions.

Additionally, the 2009 MFPFS provides that a billing physician or other supplier satisfies Alternative 1 if he or she has a reasonable belief, at the time he or she submits a claim, that either: (1) the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier for the period of 12 months prior to and including the month in which the service was performed; or (2) the performing physician is expected to furnish substantially all of his or her professional services through the billing physician or other supplier during the following 12 months (including the month the service is performed).

With respect to Alternative 2, CMS aligns the location test with the Stark Law "same building" test by clarifying that a physician or other supplier may have more than one "office of the billing physician or other supplier". Such space is one in which the ordering physician or ordering supplier regularly furnishes patient care (and with respect to physician organizations or group practices, the space in which the ordering physician performs substantially the full range of patient care services that the ordering physician provides generally). Additionally, CMS requires the physician supervising the TC to be an owner, employee, or independent contractor of the billing physician or other supplier. With respect to the PC, the performing physician must be an employee or independent contractor of the billing physician or supplier.

As a practical matter, the final anti-markup provisions permit the use of shared space imaging arrangements between physicians that occur in the "same building". Nevertheless, CMS notes that centralized building locations raise concerns for over-utilization and are not permitted for the provision of diagnostic tests. CMS further cautions that despite its flexibility, it has concerns with the present use of the IOAS exception under Stark and may issue future changes.

Of particular significance for those physicians providing imaging services in reliance on Alternative 2, the TC must be both conducted and supervised in the "office of the billing physician or other supplier" ("the Same Office Requirement"). While Stark Law generally applies the Medicare coverage and payment regulations governing supervision of tests ("Medicare Coverage Requirements"), providers seeking to rely on Alternative 2 must meet the Same Office Requirement. This is due to CMS's belief that the Same Office Requirement is necessary to minimize the potential for overutilization and program abuse.

Arrangements that fall within the ambit of the anti-markup provisions are subject to restrictive payment limitations, such that payment to the billing entity will be limited to the lowest of the following: (1) the performing physician's or other supplier's net charge to the billing entity; (2) the billing entity's actual charge; or (3) the fee schedule amount for the test that would be allowed if the performing physician or supplier billed directly.

Significantly, the net charge amount must be determined without reference to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier. Therefore, the billing physician, or other supplier may only recover costs for the salary and benefits it paid to the performing supplier of the TC or PC. As a result, billing physicians or other suppliers who implicate the anti-markup rule will likely receive reimbursement that fails to even cover the costs of providing the services.

Below are two examples of the final anti-markup provisions and their application to common imaging services arrangements:

(1) Group Practice Independent Radiologist Arrangement.

A physician in a multi-specialty group practice orders an x-ray and the part-time technician employee performs the x-ray in the group's office. The ordering physician works exclusively for the multi-specialty group and supervises the test in the group's office. A radiologist, who is an independent contractor with the multi-specialty group practice, performs the PC of the test in the group's office and reassigns his right to payment to the group. The radiologist provides professional services to several groups and hospitals in the area. He performs approximately 20 percent of his professional services for the multi-specialty group practice. The anti-markup rule does not apply to the group's billing of the TC because the supervising physician (i.e., the performing physician) "shares a practice" with the billing group insofar as he performs at least 75 percent of his professional services for the group. With respect to the PC of the test, the independent contractor (i.e., the performing physician) does not perform substantially all of his professional services to the group (he performs approximately 20 percent). Thus, an analysis under Alternative 2 applies. Under the "site of service" test, the anti-markup rule does not apply because the performing radiologist provided the interpretation on-site in the group's office.

(2) IDTF Arrangement.

A physician orders a diagnostic test from an IDTF. The IDTF bills globally for the test (TC and PC). The anti-markup rule does not apply because the IDTF did not order the test; rather, it was ordered by an outside physician.

IDTF Performance Standards for Mobile Imaging Providers

In the 2009 MFPFS, CMS finalized its earlier proposal by requiring mobile IDTFs to enroll and bill Medicare directly for the provision of TC services. However, CMS does not require mobile testing entities to bill directly for their services when such services are furnished "under arrangements" with hospitals. This final rule prohibits many common arrangements in which mobile entities lease diagnostic testing equipment and technicians to physicians who conduct and bill for such tests in their offices. To summarize, effective January 1, 2009, all mobile entities furnishing diagnostic testing services must enroll in the Medicare program and bill directly for the services, unless they are billing "under arrangements" with a hospital.

Conclusion

Through a series of regulatory actions, CMS has been targeting diagnostic imaging arrangements. Diagnostic imaging providers and suppliers should be attentive to developments with future rulemakings, which may significantly affect the structure of many current imaging arrangements. As a result, we advise providers to incorporate mechanisms into their current contractual arrangements that will permit these arrangements to adopt a more stringent regulatory framework. Finally, the regulatory changes discussed in this article likely will not be CMS's final word on diagnostic imaging. Providers should be mindful of this before entering into structures that cannot be unwound or modified.

Adrienne Dresevic graduated Magna Cum Laude from Wayne State University Law School in 2002 where she was elected as a member of the Order of the Coif. Ms. Dresevic is a member of the American Bar Association, State Bar of Michigan, Health Law Section, American Health Lawyers Association and serves as an editorial board member for the ABA's e-Source. Ms. Dresevic concentrates her practice on Stark; Fraud and Abuse; healthcare compliance; and Medicare, Medicaid, Blue Cross Blue Shield and other third party payor audits. She can be reached at 248.444.2512.

Carey F. Kalmowitz is a 1994 graduate of New York University Law School, is a member of the Michigan Society of Hospital Attorneys, American Health Lawyer's Association, and the American Bar Association Health Law Section. Mr. Kalmowitz represents providers across the health care spectrum, including physician groups, hospitals, nursing homes and surgery centers, with transactional and compliance health care matters. Areas of Mr. Kalmowitz's expertise include structuring health care delivery contractual arrangements, formation of physician groups, joint ventures, and surgery & imaging centers, certificate of need, fraud and abuse and Stark Law analysis, and compliance program design and restructuring. Mr. Kalmowitz can be reached at 248.790.6225.

Long-Term Care Facilities

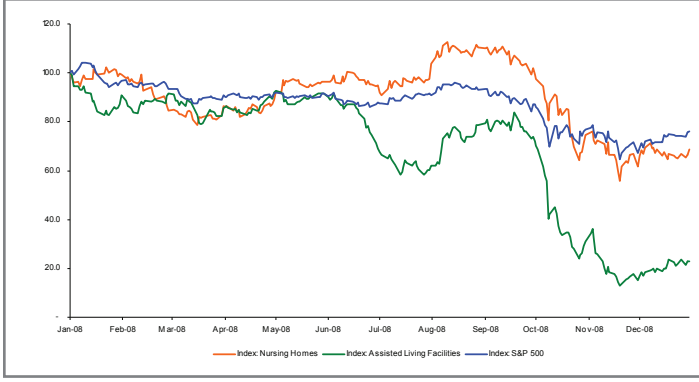
4Q08 Industry Snapshot

Overview

The long-term care industry consists of a various levels of service and care options, including independent living, assisted living and skilled nursing. The $130 billion industry is highly fragmented with 35,000 companies managing 70,000 facilities. Major players within this space include Sunrise Senior Living, Kindred Healthcare, Skilled Healthcare, and Brookdale Senior Living.

Favorable demographic trends – namely an aging population will benefit providers; however, the industry is fraught with challenges. Long-term care providers offering greater levels of care (i.e., assisted living and skilled nursing facilities) are subject to significant regulation by federal, state, and local authorities. Labor issues are a substantial concern since these expenses account for one-half of a provider's costs. Staff turnover is often high due to low pay and difficult labor conditions. Additional challenges include declining reimbursement rates from Medicare and Medicaid, competition from home health care providers and health systems, and potential lawsuits related to neglect and abuse.

Stock Price Performance vs. S&P 500
Last 12 Months



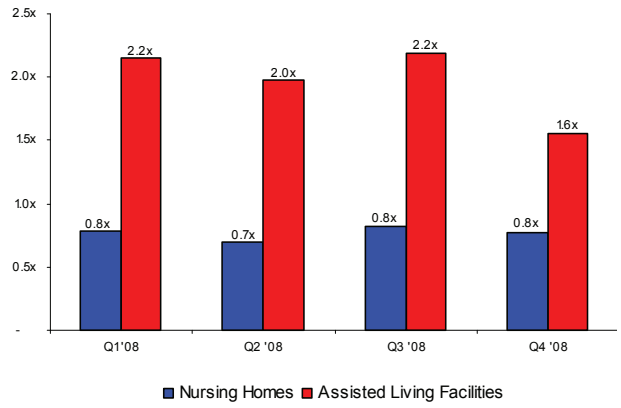
News and Trends

- Launched on December 18, 2008, the CMS sponsored five-star rating system has already created controversy. Critics state that the survey system is flawed and were upset that CMS shared survey results with the media and state agencies prior to the individual facilities. In the initial ratings, non-profit facilities scored better than their for-profit counterparts. 19% of non-profit facilities received the highest rating of five stars while only 9% of for-profit facilities achieved this mark.
- On December 10, 2008, Wisconsin Senator Herb Kohl introduced the "Retooling the Health Care Workforce for an Aging America Act of 2008." This bill would provide funding for training in geriatrics and studies on workforce needs for long-term care.

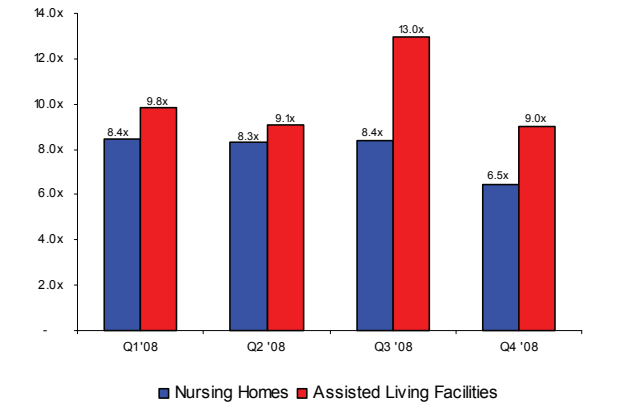
Merger & Acquisition Summary

- Effective October 28, 2008, The Ensign Group, Inc. acquired Four Skilled Nursing Facilities in Texas and California for $10.4 million. The three Texas facilities and one California location had 426 licensed skilled nursing beds. The Ensign Group also acquired a nursing home from Infinia Health Care Cos. on December 4, 2008.
- On December 3, 2008, Five Star Quality Care, Inc. acquired Carolina 7, LLC, a holding company owning seven retirement communities located in North and South Carolina. Post transaction, operations will continue under the Carolina 7 name as a subsidiary of Five Star Quality Care.

SRR Composite Revenue Multiples



SRR Composite EBITDA Multiples



Index Composition

Nursing Homes	ENSG, KND, NHC, SKH, SUNH
Assisted Living Facilities	ALC, BKD, ESC, FVE, SRZ

Drugstores, Pharmacy Benefit Managers, and Mail-Order Pharmacy Industry

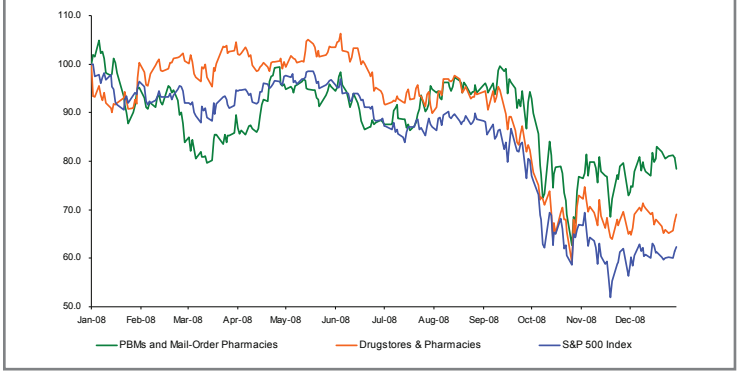
4Q08 Industry Snapshot

Overview

In the US, there are about 45,300 drugstores with combined annual revenue of about $198 billion. PBMs effectively influence the supply and demand for prescription drugs through the implementation of aggressive cost controls. PBMs are able to provide cost-effective medications to patients to combat the rise in healthcare costs. The industry is highly competitive with growth in new store openings, mail-order and internet pharmacies. Competition is based on location, client service, brand offerings, and price. The industry continues to experience industry consolidation as the smaller pharmacies and pharmacy chains are acquired by the major industry players which include Walgreens, Rite Aid, CVS Pharmacy, MedcoHealth Solutions and Express Scripts.

Demand for prescription drugs is driven by the aging population, increased life expectancy, government funded health policies, and the proliferation of innovative drug therapies. The industry is in large part dependent on reimbursement rates which periodically are evaluated by CMS and third party payors to determine appropriate reimbursement levels.

Stock Price Performance vs. S&P 500
Last 12 Months



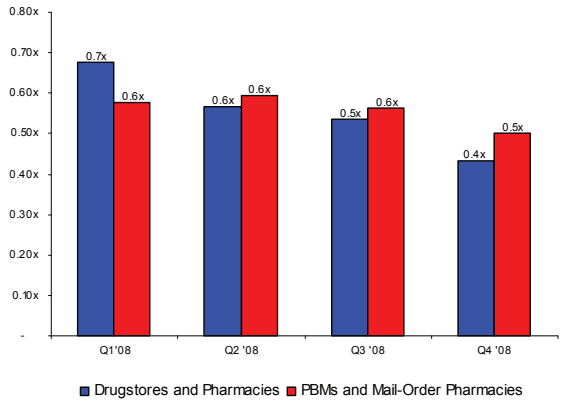
News and Trends

- The legal battle surrounding a lawsuit filed in November 2007 by the National Association of Chain Drug Stores ("NACDS") and the National Community Pharmacists Association ("NCPA") against CMS is still ongoing. The NACDS and the NCPA filed an initial complaint which sought to challenge a provision in the Deficit Reduction Act of 2005 that changed the basis of pharmacy reimbursement for generic pharmaceuticals under Medicaid to the Average Manufacturer Price (the "AMP Rule"). According to Chain Drug Review, the AMP Rule would reduce pharmacy reimbursement for generics by 78%, a $21 billion cut over 10 years. The U.S. District Court issued a preliminary injunction on December 19, 2007, which temporarily blocked the reimbursement cuts until October 2009. The court is expected to make a final decision as soon as the first quarter of 2009 about whether the AMP rule complies with federal law. If upheld, the AMP Rule has the potential to have a significant negative impact on the pharmaceutical industry.

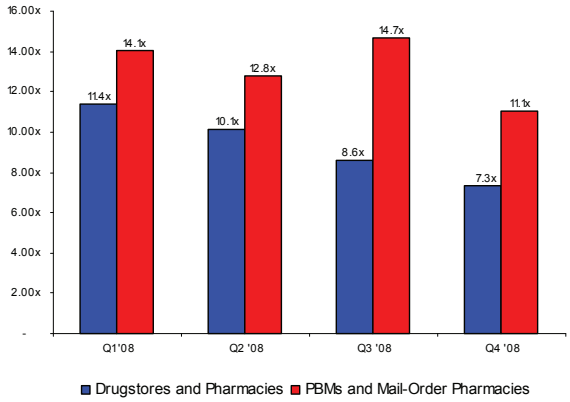
Merger & Acquisition Summary

- On December 1, 2008, Walgreens Co. signed a definitive agreement to acquire McKesson Corporation's specialty pharmacy division known as McKesson Specialty Care Solutions ("MSCS"). The terms of the agreement were not disclosed. MSCS provides specialty pharmacy services and products to patients with complex, chronic health and medical conditions. MSCS is the nation's second largest specialty pharmaceutical distributor and will provide Walgreen's with an opportunity to grow its own specialty pharmacy business with preferred payor agreements, and access to patients and clients in the areas of oncology, multiple sclerosis, rheumatoid arthritis, and reproductive health services.

SRR Composite Revenue Multiples



SRR Composite EBITDA Multiples



Index Composition

Drug Stores and Pharmacies	RAD, CVS, WAG
PBMs and Mail-Order Pharmacies	BIOS, DSCM, ESRX, MHS, SXCI

Medical Devices and Supplies Industry

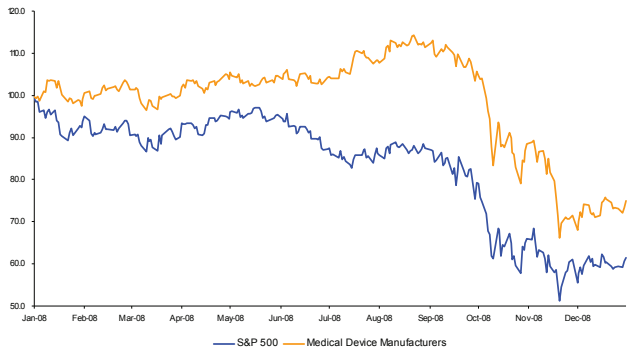
4Q08 Industry Snapshot

Overview

Medical device and supply manufacturers include producers of a wide variety of complex medical equipment such as pacemakers, stents, and neuromodulation devices as well as low-technology products like gauze and syringes. Customers consist of hospitals, distributors, government health care programs, and group purchasing organizations. While there are 12,000 companies in this industry, the largest 50 competitors comprise 60% of the $50 billion market. Larger manufacturers include Baxter, Medtronic, Boston Scientific, and St. Jude Medical.

This space is characterized by significant merger and acquisition activity as larger competitors make acquisitions to diversify their product offerings and access new technologies. Device manufacturers are subject to significant regulatory risk from the FDA and other governmental bodies and are often involved in extensive and costly patent litigation. Competitors have experienced significant pricing pressure due to declining reimbursement rates, the buying power of group purchasing organizations and other large buyers, and increasing competition from other device manufacturers and substitute treatments (e.g., pharmaceuticals). In order to combat pricing pressure, device manufacturers make significant investments in research and development to remain technologically competitive and avoid the commoditization of their products.

Stock Price Performance vs. S&P 500
Last 12 Months



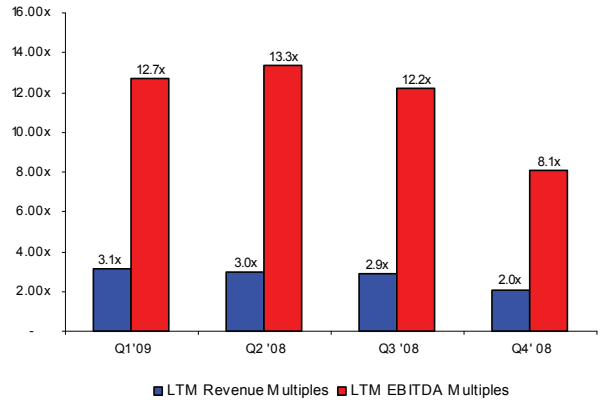
News and Trends

- A draft version of the Pharmaceutical and Medical Device Manufacturer Code of Conduct was released by the Public Health Council of the Massachusetts Department of Public Health in December 2008. This Code of Conduct essentially restricts the gifts and benefits medical device companies can provide medical practitioners in Massachusetts. The Code of Conduct sets forth guidelines and enforcement mechanisms for training staff and disclosing gifts to practitioners and facilities. Additionally, the Advanced Medical Device Association ("AdvaMed") has adopted a similar set of ethics guidelines with the goal of promoting transparency and rebuilding public trust.

Merger & Acquisition Summary

- St. Jude Medical Inc. completed the acquisition of MediGuide, Ltd. from Elbit Systems, Ltd. on December 22, 2008 for approximately $300 million. MediGuide, Ltd. develops imaging technology for cardiovascular and endovascular procedures.
- Endocare, Inc. signed a definitive agreement on November 10, 2008 to acquire Galil Medical, Ltd. in a stock deal. Galil Medical develops and manufactures cryotherapy systems to treat cancerous and non-cancerous tumors.
- St. Jude Medical, Inc. acquired Radi Medical Systems AB on December 21, 2008 for $250 million, a 3.7x implied enterprise value to revenue multiple. Radi Medical Systems AB primarily produces medical devices and systems designed for the interventional cardiology, hemostasis management, and radiology markets.

SRR Composite Multiples



Index Composition

Medical Device Manufacturers	BAX, BXS, WMGI, EYE, ARTC, BDX, COV, STJ, MDT

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Investment Banking

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