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HOSPITALS: Buying, Selling, and Valuing

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HEALTH CARE IS A MAJOR COMPONENT OF THE U.S. ECONOMY—AN ESTIMATED 18% IN 2013, WHICH EQUATES TO ABOUT $2.9 TRILLION, WITH A PROJECTED GROWTH RATE OF 6.4% A YEAR. Health-care providers are seeing, in particular, that unit costs and demographic trends are creating stress for businesses and governmental payers.

Today, many of those payers are finding savings, through efficiencies, that they estimate to be as high as $750 billion—much of that through consolidation of the provider sector. The trends and pressures facing the hospitals sector have to do with CMS, for example, promoting delivery system reform that is focused more than ever on population health and new reimbursement models. Reimbursement reductions are taking place in every market and by every payer. Patient volumes are also declining in many markets, as they are moving to outpatient settings. Inpatient volume is projected to be down 4 percentage points by 2022; outpatient volume will be up by 15 percentage points in that same period. A sector shift is definitely occurring.

Hospitals, therefore, will need to operate at current and proposed Medicare rate levels if they are to earn any profit. In addition, global payments and integrated population-based structures require the integration of information technology (IT), clinicians at various levels, and the facilities themselves. IT, or "big data," requires scale, so many providers and payers are pursuing enterprise data warehouses and similar strategies.

As a result of all this movement, M&A activity has been on a fairly steady increase over the last couple of years, with greater levels of activity projected for the near future. Those who deliver health care are moving into the health-plan space, while health plans are moving into the health-care delivery space. And various players are moving into the IT space.

Who's buying what?

Andrew Labovitz, Senior Vice President at **Cain Brothers**, —an investment banking and financial advisory firm that, over the last 10 years, has completed more than 120 hospital sales and mergers, encompassing every combination of for-profit and not-for-profit transactions—sees three primary drivers for the current wave of industry consolidation.

1. Reimbursement pressure. **DECADES OF SIGNIFICANT HEALTH-CARE INFLATION HAVE CREATED AN UNSUSTAINABLY HIGH COST OF HEALTH CARE.** The Affordable Care Act will extend insurance coverage to many currently uninsured people, but public payers, both federal and state, are dealing with budget pressures. At the same time, private payers (both employers and individuals) are reaching the limits of what they can afford to pay for commercial insurance. Low GDP growth has exacerbated those challenges.

2. The need to reorganize the delivery of care. Historically, health-care delivery has been largely fragmented or uncoordinated, resulting in inefficient delivery and lower quality care. The revolution in medical IT has created an expectation that systems can produce higher quality outcomes at lower cost and with greater transparency for both payers and patients; however, those IT systems and quality measurement systems require substantial capital investment. The deployment of major electronic medical records system such as Cerner or Epic could cost more than $100 million for a large health-care system. Therefore, hospitals will have to change their approach to care management and increase their productivity by coordinating more closely with physicians and other providers across the acute, sub-acute, and post-acute spectrum. The reorganization of delivery models and changes to how and for what the industry reimburses providers may be the most fundamental factor driving the consolidation today.

3. Reorientation of the economic models. Systemic cost reductions will require a shift from fee-for-service to new payment models. The delivery of health-care services will become an increasingly commoditized service, and the value-added element will be care coordination or care management to improve outcomes and lower costs. Most of the profitability in health-care services will be achieved through risk-based economic models. As providers assume more risk and consolidate into larger delivery groups, the economic value of pure payers will come under greater pressure.

These drivers today are a bit different from those that the industry experienced in the consolidation wave during the 1990s, when most of the consolidation was driven by the need for hospitals to achieve greater negotiating clout with large payers—which were also consolidating. That was more of a revenue strategy than today's drivers.

Historically, private equity investments were made through hospital companies. Recently, there has been more interest in direct investments. Physician-sponsored models are less prevalent following the CMS moratorium, but some examples still

exist. **EVEN WITH THE ACCELERATING PACE OF RECENT CONSOLIDATION, THE HOSPITAL INDUSTRY REMAINS RELATIVELY FRAGMENTED, SO THE CHANGES EXPECTED IN THE ECONOMIC AND CARE-DELIVERY MODELS WILL CONTINUE TO DRIVE CONSOLIDATION FOR THE NEXT SEVERAL YEARS.**

What influences the valuation of hospital systems/LTACs?

From the early 1980s through the 1990s, many mergers, acquisitions and affiliations occurred in the hospitals sector without much attention to any kind of rigorous evaluation. That certainly has changed, according to Stephen Gelineau, Senior Vice President of **The Camden Group**, a national health-care consulting and advisory firm based in Boston. **THE VALUATION PROCESS HAS BECOME MORE COMPLEX THROUGH THE USE OF VARIOUS TRANSACTION MODELS, MORE JOINT VENTURES, AND MORE TRANSACTIONS IN WHICH THE VALUE EXCHANGE IS CASH PLUS FUTURE PLEDGES OF CAPITAL INFUSIONS OR INVESTMENTS IN THE ORGANIZATION.** There are also more multi-party arrangements where faith-based organizations, not-for-profits, and other entities—in some cases, for-profits—create a rather complicated architecture in an attempt to build out a regional system, or a "super system," in a given area.

The Federal Trade Commission in 2012 publicly indicated its intention to "re-double" its focus on health-care transactions—and is evidently living up to that pledge. State attorneys general have also become much more involved in transactions and, in some cases, require independent third-party valuation to be carried out prior to approving a transaction. State departments of health and "certificate of need" regulatory bodies in certain states are also asking for information about the valuation, recognizing that many of these transactions are perceived as a once-in-a-lifetime event for the hospital and wanting to assure that whatever is being paid, whatever value is being exchanged, and/or whatever capital pledges are being made are consistent with the value of the organization—especially when it is a not-for-profit hospital under the jurisdiction of the charitable trust divisions of the offices of attorneys general.

The Internal Revenue Service is weighing in on many of these transactions, as well. In the last half-dozen years, a number of updates and refinements have been made in the generally-accepted accounting principles (GAAP) associated with transactions, along with how the exchanges are accounted for post-transaction

and how fair-market value is established. Having the rigor of a valuation has proven to be more valuable in those circumstances, as well.

THE FINANCIAL PAST IS NO LONGER PROLOGUE TO THE FUTURE, GELLINEAU EXPLAINED. THE PAYMENT MODELS ARE EVOLVING MORE QUICKLY AND ACQUIRERS ARE A BIT MORE CAUTIOUS ABOUT EVALUATING THE FUTURE REVENUE POTENTIAL, THE FUTURE GROWTH POTENTIAL, THE FUTURE CAPITAL NEEDS, THE NEED TO BUILD OUT REFORM READINESS AND PHYSICIAN INTEGRATION PLATFORMS, CLINICAL INTEGRATION, ACCOUNTABLE CARE, AND THE SPEED WITH WHICH NEW PAYMENT MODELS WILL EVOLVE IN ANY GIVEN MARKET WHERE THEY'RE CONSIDERING AN ACQUISITION. As acquirers evaluate many of those items, they certainly have an impact on the price paid and the multiples for those transactions. Obviously, an organization looking to sell, find a partner, be acquired, or join a system will find valuations to be helpful in supporting its negotiations. Many a trustee across this country has little sense of the value of their organization as they begin to move into a transaction mode. Valuations provide guidance in those circumstances.

There are several traditional approaches to conducting valuations:

- Income-based considers the future financial benefits of an organization at a current value (an internal perspective);
- Market based considers recent transactions of similar types of entities in similar markets, in similar conditions (an external perspective); and
- Cost based considers the fair-market value of an entity's assets, including intangible assets, reduced by its liabilities (a real estate perspective).

A number of factors influence valuations and will move the price or value exchanged up or down. For example: What is the condition of the hospital? Is the physical plant up to date? Is it operating with a private-room inpatient platform? Does it have sufficient ambulatory space? What is its footprint in the local neighborhood? Does it have expansion opportunity or is it landlocked? Have all routine maintenance needs of the organization been consistently addressed, or is there a large portfolio of deferred maintenance that an acquiring or affiliated entity would have to address immediately?

The typical transaction process from the hospital side often involves organizational self-assessment, as well. Is the facility sustainable in its current configuration into the future? If not, why not? What are its current needs, and can those needs be

fulfilled through an affiliation with another entity? Often, this organizational self-assessment comes about as a product of a strategic planning exercise, an element of which is a financial pro forma for the organization that looks forward to determine the impact of any reimbursement changes, of the new health-care exchanges, of new forms of payment through commercial carriers, and the net impact of the expansion of insurance coverage under the Affordable Care Act. All of those assumptions are factored into the pro forma to determine the organization's future needs, and the valuation then provides a benchmark for future evaluation.

Prime Healthcare Services is in the business of buying, turning around, and operating distressed hospitals. The company looks for hospitals in on-rural areas with a busy ER ("The busier the better," according to
Arnie Kimmel, Senior Vice President for Development) and with an operator that's looking to sell. Prime sees many instances of systems that operate under a philosophy of "Show me the profitability, and we'll show you the capital." Without the profitability (as a result of a lack of program development or declining volume), there is no capital and, therefore, red ink. One of the things that an operator may do well and differently, though, is to pledge and spend capital up front. They would do this for two reasons: 1) to fix what's broken; and 2) to send a message to the community that this distressed hospital is there to stay and serious about the long run.

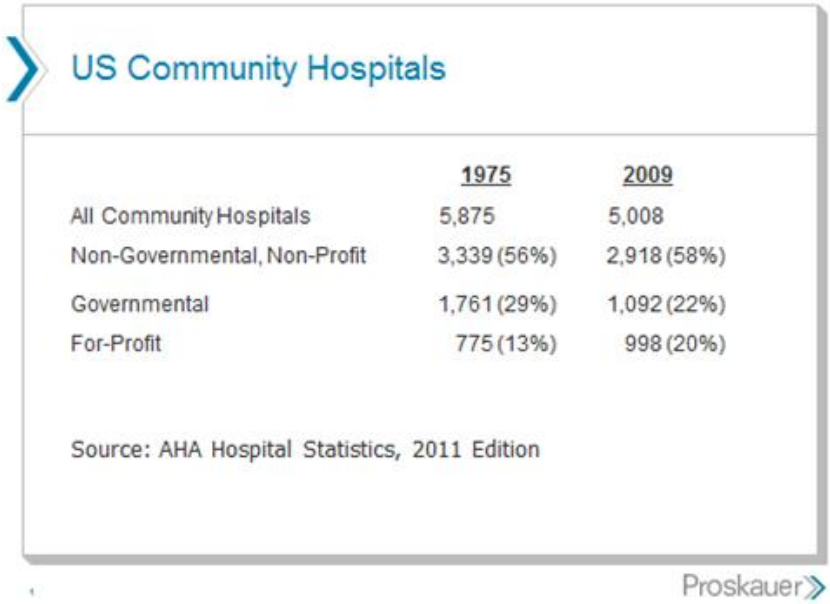
The sellers' objectives vary widely. Many view the distressed facility as the community hospital, and they're are not sure that becoming part of a system will help much. Others are looking to maximize the foundation resulting from a sale that will enable them to continue their charitable mission but in ways other than owning and operating an acute-care hospital. Still others are looking to escape—i.e., buy some time—with regards to health reform, bundled payments, ACOs, etc.

PAYERS ARE LOOKING FOR HOSPITALS THAT CAN QUANTITATIVELY DEMONSTRATE VALUE. Prime's view of the way to demonstrate value is to demonstrate compliance with the same payment and penalty metrics that are applied to Medicare, Blue Cross, and other payers. The average length of stay at a Prime hospital is half a day less than the national average, which is how Prime makes money. And moving people through the system quickly and documenting the quality of care provided is what ACOs will find valuable and what is also important to a board member of a not-for-profit community hospital.

How do you make the deal work?

TODAY, THERE ARE 700 OR SO FEWER GOVERNMENTAL HOSPITALS (CITY-, COUNTY-, DISTRICT-, AUTHORITY-, STATE-OWNED) THAN THERE WERE 30 YEARS AGO, ACCORDING TO MONTE DUBE, A LAWYER WHO SPECIALIZES IN HEALTH-CARE M&A FOR PROSKAUER ROSE. Most of those that didn't survive failed to keep up with technological improvements. Others have become privatized. Conversely, there are more for-profit hospitals than there were 30 years ago, as for-profits bought up those governmental hospitals that became privatized; other not-for-profits have been increasingly willing to sell to a proprietary operator, as well.

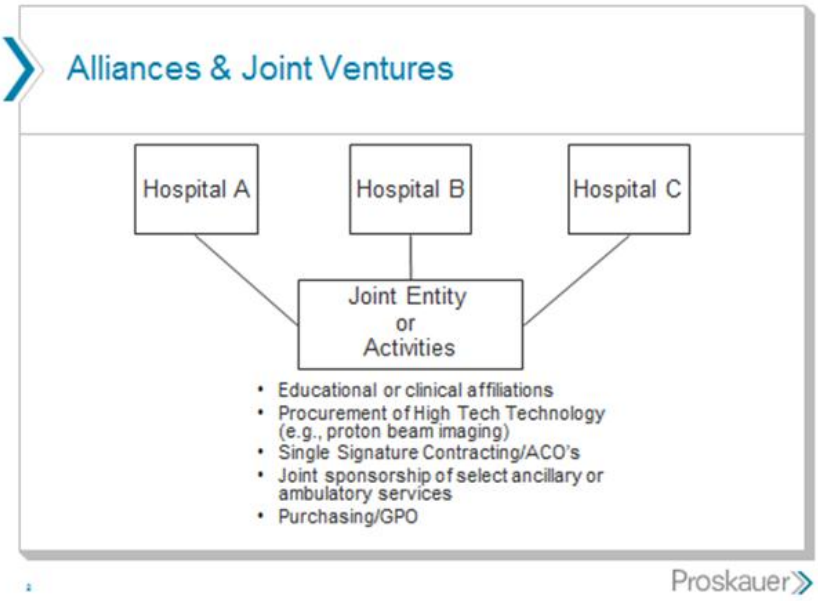
Why join a system? Why give up meaningful control? Historically, hospitals and hospital systems have been doing joint ventures between and among themselves forever. Most of those joint ventures haven't borne a lot of fruit, mainly because competitors often get together in a common undertaking to collaborate on things as minor as joint laundry services, for example. Increasingly, however, joint ventures between and among competing hospitals and health systems have legs. In lieu of handing over the keys to someone else, a hospital will seek access to a bigger system's balance sheet, expertise, population, or simply its strength. The purpose also may be to create educational or clinical affiliations, procure technology, facilitate single-signature contracting (ACOs), sponsor ancillary or ambulatory services, or allow joint purchasing.



When a for-profit takes over a not-for-profit entity, it will be an asset deal almost 100% of the time. The buyer's will have the flexibility to select among certain

assets and certain liabilities to buy or assume and omit those assets that it doesn't want. If the not-for-profit seller has a separate foundation, its assets often remain outside of the deal.

The motivation of the seller has become a really important development in the last decade or so with regard to not-for-profit sales to for-profits. Sellers often wanted to maximize the monetization by trying to get the highest possible sales price in order to fund a foundation to do good deeds. More and more, though, sellers would rather reinvest the capital in the hospital or health system that it is selling. So post-closing covenants, whether they're CapEx or programmatic or both, have become a key driver and a key form of consideration in these transactions.



In 1998, the IRS issued revenue ruling 98-15 that allows tax-exempt, not-for-profit organizations to joint venture an entire hospital facility with a for-profit and, if structured appropriately: 1) maintain the tax exemption; 2) take out dividends or pro rata profits from the joint venture and not have to pay tax on unrelated business taxable income. Lots of not-for-profit organizations are taking advantage of that alternative because, arguably, it's not a sale to a for-profit. Instead, the organization is getting a capital partner while retaining meaningful governance in the joint venture going forward. While these deals all vary, the relative splits are typically 80/20 or 70/30 for-profit to not-for-profit equity in the joint venture. But even though the not-for-profit seller is, the minority equity investor, it will have 50% of the fiduciary board—also a requirement of the 98-15 rule.

A lot of government hospitals are also doing leases, depending largely on the enabling statute of the hospital. In some states, for example, a 50-year lease is possible; in other states, it may be limited to a 20-year lease. In some states, too, a referendum or election is required in order to do a lease; in other states, it is not.

The FTC is going after consolidation, as well, according to Dube **"WHEN I ADVISE HOSPITALS THAT ARE CONSIDERING A DEAL, WE TRY TO GIVE THEM A REALISTIC PERSPECTIVE OF THE ANTITRUST RISKS. TOO MANY HOSPITALS OVERSTATE THE ANTITRUST RISK ASSOCIATED WITH A DEAL. BUT IF YOU CAN SHOW PRO-COMPETITIVE ADVANTAGES, IF YOU HAVE STRONG EFFICIENCY STUDIES, IF YOU'RE A GOVERNMENTAL HOSPITAL WITH POTENTIAL STATE ACTION, OR IF YOU'RE IN A RATE-REGULATED STATE, THERE MAY BE SOME VERY COMPELLING ARGUMENTS (DESPITE RECENT FTC SUCCESSES) IN FAVOR OF WHY THE DEAL OUGHT TO GO THROUGH."**

Attorneys general, who historically never went after not-for-profits, are lately finding them fair game. So, like any transaction planning, buyers and sellers all need to understand the potential impediments of any deal and plan accordingly.