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How to Save a Dying Hospital

HFMA Lone Star Chapter

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How to Save a Dying Hospital

Presentation Outline

- Industry Dynamics Contributing to Distress
- Key Factors and Potential Warning Signs
- Situational Assessment
- Potential Turnaround Levers
 - ✓ Operational
 - ✓ Financial
 - ✓ Strategic / M&A
 - ✓ Management and Governance
- External Professional Assistance
- Q&A

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Opening Salvo ...

Each distressed hospital case is market-specific
and situational-specific

Not all distressed hospitals can (or should) be
turned around to achieve long-term viability

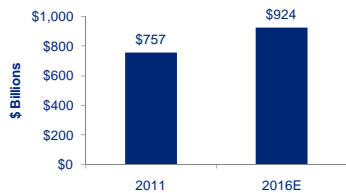
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Key Factors and Warning Signs

U.S. Hospital Market Highly Fragmented and Growing

Hospital Revenue (2011-2016E)



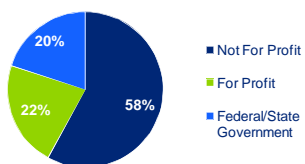
Source: IBIS (March, 2011)

Top 5 Largest Hospital Chains (2009)

Company	Revenue (Millions)	Market Share
U.S. Veterans Affairs Department	\$46.5	6.1%
Health Corporation of America	\$30.0	4.0%
Ascension Health	\$13.6	1.8%
Community Health Systems	\$12.1	1.6%
Health Management Associates	\$9.0	1.2%

Source: American Hospital Association (AHA) Hospital Statistics 2011 Edition

Hospital Ownership (2009)



Source: Credit Suisse, 2011

- The U.S. hospital industry is a localized industry consisting of almost 6,000 hospitals. The top five players account for less than 15 percent of revenue. The majority of hospitals are not-for-profit.
- IBIS World projects the \$757 billion industry will grow 4.9 percent annually between 2011 and 2016, driven by a growing senior population and insured customer base. CMS¹ projects the PPACA¹ individual mandate will expand insurance coverage to 32 million additional patients by 2014, bolstering revenue. Shrinking reimbursement and increased capital requirements, however, may limit profits.

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Source: Primer (February 2011), S&P Healthcare Facilities Industry Survey (May 2010), IBIS (March 2011), Credit Suisse (February 2011)

1) "CMS" refers to the Centers for Medicare & Medicaid Services; "PPACA" refers to the Patient Protection and Affordable Care Act.

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Key Factors and Warning Signs

Regulatory & Reimbursement Environment to Limit Margins, Drive M&A

- IBIS World predicts that hospital profits declined from 6 percent in 2006 to 2.4 percent in 2011, driven by a weak U.S. economy and cuts to both government and commercial reimbursement. High unemployment has led to increased uncompensated care. Commercial insured utilization fell due to increased out of pocket costs. In addition, there was a shift in payer mix towards increased government enrollment. In 2011, states cut Medicaid budgets and Congress decreased Medicare inpatient reimbursement levels and implemented audits to recover Medicare overpayments.
- Although the individual mandate and Medicaid expansion stipulated in PPACA may increase the number of insured, PPACA contains several provisions to further reduce payments to providers. PPACA lowers Medicare reimbursement for inpatient hospital services and services at other facility types. PPACA also decreases Medicare and Medicaid reimbursement to Disproportionate Share Hospitals (DSH) and links reimbursement to quality and performance outcomes.
- Provider operating costs continue to rise, impacted by higher wage costs and increased regulatory compliance requirements. To attract and retain staff, providers are increasing wage costs. The Association of American Medical Colleges forecasts the current physician shortage will double to 50,000 by 2015. IBIS World projects wages as a percentage of revenue for the provider sector will rise to 38.1 percent in 2015, from 37.6 percent in 2010. PPACA also mandates increased reporting, audit, and transparency requirements, further impacting operations.
- ARRA¹ and PPACA regulations requiring providers to meet meaningful use or Electronic Health Records (EHR) and ICD-10 requirements are driving increased capital spend. Providers have until 2014 to demonstrate certified EHR technology use in "ways that can be measured significantly in quality and in quantity." Providers that do not meet this deadline face reimbursement cuts. U.S. hospitals must fully transition from the ICD-9 to the ICD-10 system of disease and treatment documentation classification by October 2013. Claims not based on ICD-10 after the deadline will be rejected.
- Consolidation is increasing, as smaller and underperforming providers seek partners to meet capital requirements and larger providers pursue market share and scale. The provider environment is increasingly an industry of "haves" and "have nots." Acquiring providers are currently able to purchase struggling not-for-profit hospitals at multiples lower than historical averages. Community Health Systems (CHS) and Health Management Associates are two of the most acquisitive companies currently.

Source: Patient Protection and Affordable Care Act, Thomson M&A, Factiva, Pillsbury, The Effect of Health Care Reform on Hospitals (June 2010)

1) "ARRA" refers to the American Recovery and Reinvestment Act of 2009

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Key Factors and Warning Signs

Impact of Health Reform

- Likely increase in consolidation activity.
 - Strong players will seek to expand market share; weaker players more vulnerable
- With continued pressure on reimbursement rates, higher quality requirements, and an increased access to care, margins will likely be challenged.
- Current health care costs are not sustainable.¹
- The implementation of the Patient Protection and Affordable Care Act (PPACA) will be framed in the broader context of economic recovery, deficit reduction, and fiscal discipline.¹
- Health care organizations must innovate, scale operations, and optimize efficiency to survive.¹

1. Paul Keckley, Monday Memo, November 15, 2010.

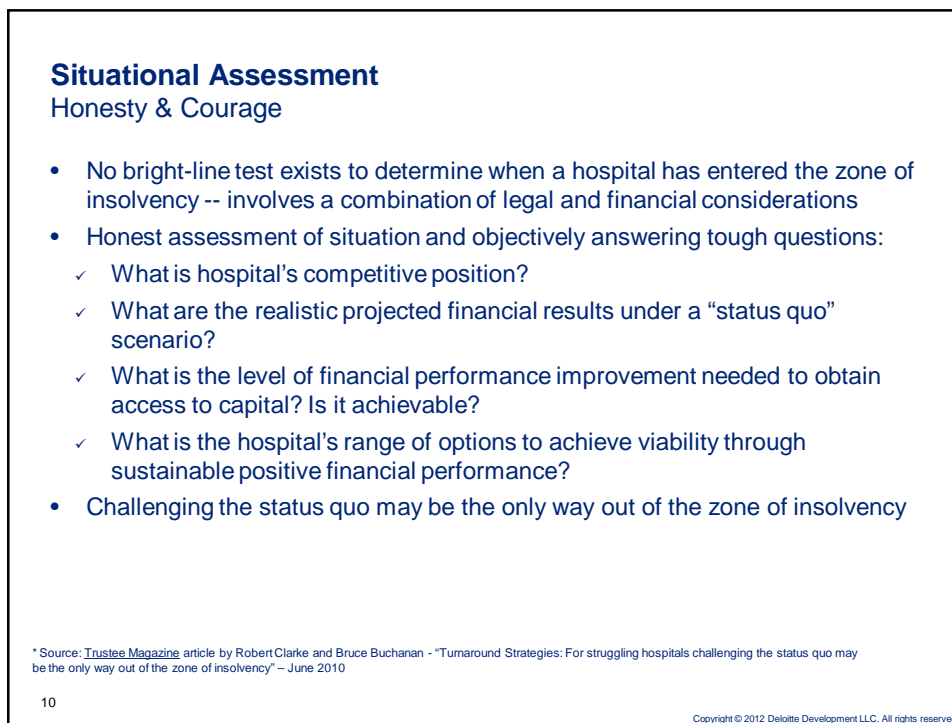
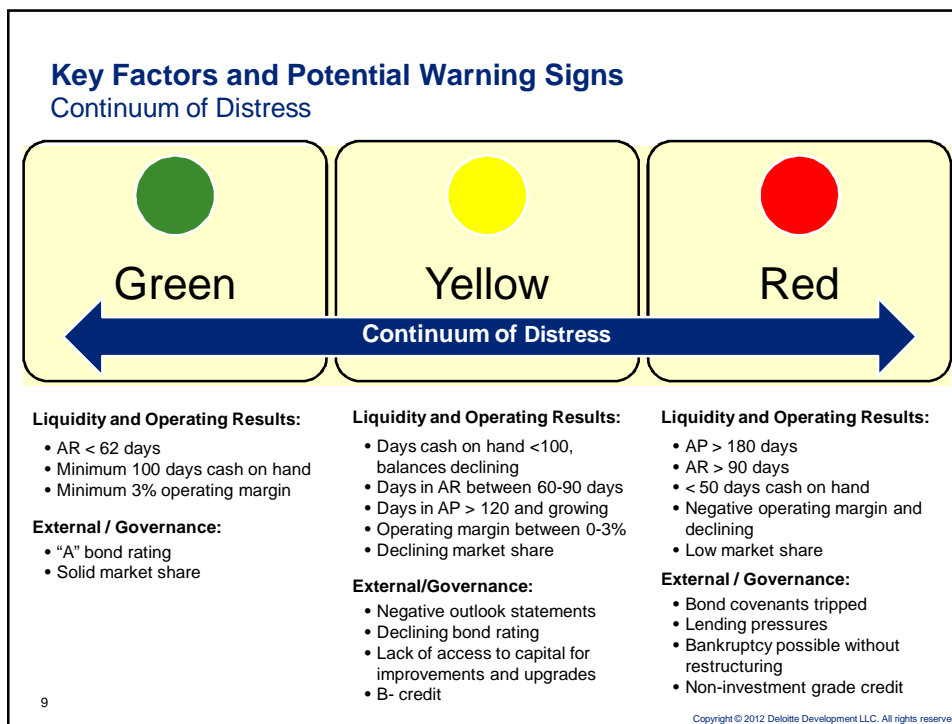
Key Factors and Warning Signs

Summary Observations

- There will be winners and losers in every sector: efficiency, scalability, a solid value proposition and innovation will be essentials.
- The legislative and judicial process will continue to unfold: strategic scenario planning based on a fact-based understanding of markets, competitors, regulations and industry pressures essential.

*The seven last words of a dying organization:
“we never did it that way before”*

Source: Health Reform: Executive Briefing, Paul H. Keckley, Ph.D., Deloitte Center for Health Solutions, January 2011.



Situational Assessment

Where is Your Organization?

“A” Rated Credit - *High quality and are subject to very low credit risk*

- Solid liquidity and ready access to capital markets on favorable terms
- Opportunistically expands market share in areas where competitors are weaker
- Expands presence by acquiring distressed assets
- Clinical and operational best practices
- Deploys capital in strategic manner to achieve long-term, enterprise-wide goals and market share
- Effectively achieves strategic and incentive alignment with physicians

“B” Rated Credits – *Obligations have speculative elements and are subject to moderate / substantial credit risk*

- Modest liquidity and challenged access to capital markets
- Modest and/or static volume growth
- Static / declining liquidity and operating cash flow
- Frequent reassessment of service lines and strategic priorities
- Renewed focused upon cash acceleration and cost reductions
- Deferring strategic capital projects

11 Note: Classification and characteristics developed by the presenters

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Situational Assessment

Where is Your Organization?

“Below Investment Grade Credits” - *Obligations judged to be of poor standing and are subject to very high credit risk with some or little prospect of recovery of principal and interest*

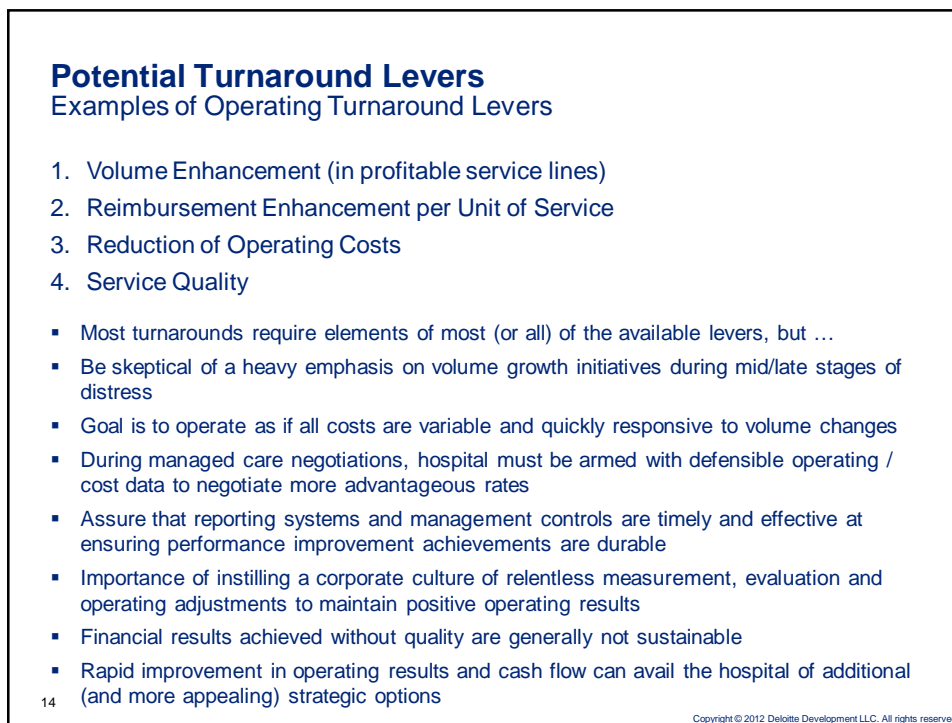
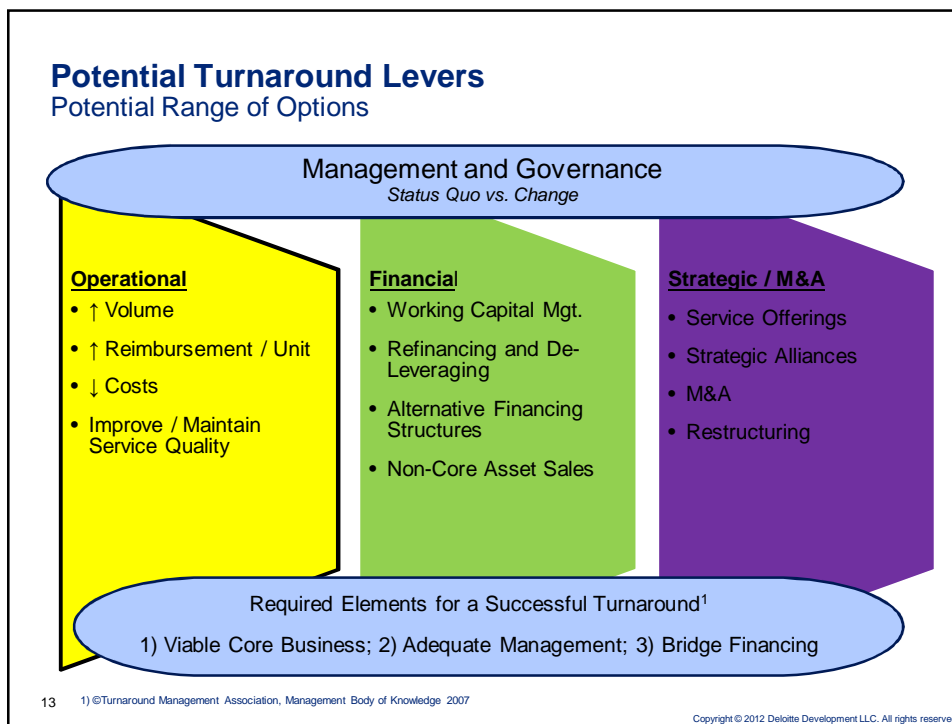
- Minimal liquidity and extremely limited access to capital markets
- Substandard and/or declining operating performance measures
- Potential for, or history of, covenant breaches
- Evaluating management and governance changes
- Reassessing and/or disposition of non-core assets
- Search for “game changing” strategic shift, including new capital partner (may not exist)
- Retention of third-party turnaround experts

•Defaulted / Insolvent

- No liquidity and no access to capital
- Evaluating out-of-court temporary and permanent debt modifications
- Potential distressed out-of-court M&A alternatives
- Consideration of bankruptcy scenarios (restructuring, §363 sale or liquidation)
- Potential management change -- need for crisis manager / Chief Restructuring Officer

12 Note: Classification and characteristics developed by the presenters

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Potential Turnaround Levers

Examples of Financial Turnaround Levers

1. Working Capital Improvement / Management
 2. Refinancing and De-leveraging Strategies
 3. Alternative Financing Approaches
 4. Non-Core Asset Sales
- Many financial turnaround strategies result in one-time liquidity and/or leverage improvements
 - Certain ones, such as divestiture of non-core assets, may also have recurring positive cash flow results
 - Refinancing and de-leveraging is generally more difficult (or not feasible) during later stages of distress
 - Alternative financing approaches include sale-leaseback transactions, operating leases
 - Non-core asset sales can be an important source of liquidity combined with a potential benefit of eliminating costs and/or operating cash flow losses

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Potential Turnaround Levers

Examples of Strategic Turnaround Levers

1. Strategic / service line overhaul (usually a focus strategy, not expansion)
 2. Public / private partnerships and ventures
 3. Competitive joint-ventures and strategic alignments, including with physicians
 4. Out-of-court or court-assisted debt restructuring
 5. Out-of-court or court-assisted M&A (change of control)
- Refocus on core, profitable activities in order to preserve existing value --- avoid the "bleeding edge"
 - Leverage a hospital's importance to the public / community
 - JVs and strategic ventures will inevitably involve ceding some control (maybe significant control)
 - M&A solutions have historically been an oft-used tool to resolve distressed situations – present industry dynamics have amplified its importance as a options for potentially resolving distressed hospitals
 - Out-of-court options usually more prevalent with mild/moderate distressed organizations with comparatively simple debt structures (less costly, but can be more time consuming)
 - Court-assisted options available across the entire spectrum of situations (more costly, but can often resolve complex situations more quickly than out-of-court options)

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Potential Turnaround Levers

Examples of Governance Issues

"To Change or Not to Change" – Definition of insanity

Some Common Board / Governance Observations Sometimes Associated with Distressed Hospitals:

- ✓ Lack of financial and governance sophistication on Board
 - ✓ Incomplete, biased or non-objective information provided to Board
 - ✓ Too little, or too much physician involvement
 - ✓ Too many Board members leading to indecision
 - ✓ Insufficient independence, including independent audit and compensation committees
 - ✓ Conflicts of interest
 - ✓ Board dominated by entrenched CEO
- The overall turnaround requires a coordinated plan consisting of fiduciary stewardship, management oversight, physician buy-in and an engaged, motivated workforce
 - Board-enhancement strategies to consider include, among other things, professional education, augmentation with skilled independent members, and establishing restructuring sub-committee

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Potential Turnaround Levers

Examples of Management Issues

The *"Who vs. What"* Dilemma – People vs. Strategy

Common Management Observations Associated with Distressed Hospitals

- ✓ Entrenched, insular & dogmatic posture
 - ✓ Denial of true condition of organization
 - ✓ Ego, fear and insecurity leading to flawed Board reporting
 - ✓ Supports a "prevent defense" strategy
 - ✓ Inability to mesh with Medical Staff
 - ✓ Inadequate monitoring and control systems
 - ✓ Does not know where organization is making / losing money
 - ✓ Does not fully appreciate extent of liquidity exhaustion
- Organization must obtain clarity of the true situation
 - Acknowledging a problem is not (and should not be) tantamount to acknowledging failure
 - Mediocrity always has an excuse / rationalization for underachievement

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External Professional Assistance

Range of Options

Interim Management

- Typically fills C-Suite roles for 12-36 month tenure
- Often performed by experienced solo practitioners, some boutique and large firms also provide such services

Performance Improvement / Turnaround Advisors

- Brings leading-practice subject matter experience and specialization
- Comprehensive operational and strategic assessments
- Experienced implementation leaders who report to management and committee of the Board
- Typically functions as “active” advisor

Crisis Manager / Chief Restructuring Officer

- Independent, third-party “change agent” reporting directly to the Board of Directors
- Often retained when stakeholders have lost confidence in management
- Interjects honest assessment and sense of urgency
- Given authority to make restructuring / turnaround decisions and oversee implementation

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External Professional Assistance

Typical Role of Chief Restructuring Officer

- Traditionally serves as a special-purpose C-suite officer reporting directly to the Board
- Functions as “change agent” who helps lead the company through crisis and toward viability and instills a sense of urgency throughout the organization
- Typically has authority to carry out Board-approved restructuring plans and make restructuring-related implementation decisions
- Credible, independent professional that objectively evaluates an organization’s situation and develops tailored restructuring options
- Provides executive restructuring leadership and advocacy while building consensus with company’s various stakeholders and their advisors (e.g., trade creditors, equity, lenders, insurers, bond trustees, government agencies and regulators, etc.)
- Leads, or participates in, presentations and negotiations with stakeholders, including governmental agencies
- Works closely with legal counsel and other C-suite members
- Can serve as company representative in a court-assisted restructuring process

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Q & A

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