KEN CONNER

Ken Conner has over 30 years of experience in the financial aspects of the healthcare industry.

Leading Decosimo's healthcare practice, Ken coordinates assurance, tax, due diligence compliance and valuation activities involving healthcare clients. He provides clients with objective and practical financial advice. Healthcare clients take advantage of Ken's experience in preparing forecasts, advising mergers, acquisitions and divestitures. Clients benefit from his knowledge of facilitating problem resolutions within joint ventures and from his ability to arrange financing for established entities and startup companies alike.

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TIM BROWN

Tim Brown serves as the Chief Administrative Officer of the Claiborne Medical Center, which is part of the Covenant Health hospital system. Holding the position of Administrator for Claiborne County Hospital, Mr. Brown joined Covenant in 2014 when the Tazewell, Tennessee, facility became the most recent addition to the Covenant family. Experienced in both the sales and acquisitions of hospitals, Mr. Brown is a respected authority on transactions within the healthcare field.

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Hospital Transactions – Ups and Downs

February 18, 2015

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Overview: Start to Finish

- Why are you doing it?
- Framework of the Letter of Intent/Purchase Agreement
- Due Diligence
- Holding it all together
- Getting it to close

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Background

Background

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- Claiborne County is about an hour north of Knoxville, Tenn., on the Kentucky border with a population of 32,450 growing at the rate of 0.5 percent
- Service area included Claiborne County and parts of four other counties in Tenn. and Ky.
- Hospital was owned by Claiborne County, but was overseen by an appointed board
- Hospital had adjusted EBITDA of $633,000 and $703,000 in 2011 and 2012, but had turned negative in 2013
- Generally, the hospital was in good condition, though in need of a facelift and new computer system

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Background

- County was reluctant to provide any new funds or support additional debt
- Supportive medical staff composed of aging primary care, two good general surgeons, one non-invasive cardiologist, part-time specialists from Knoxville, including urology, GI, Ophthalmology, ENT, Cardiology
- Pressure to add hospitalists
- Osteopathic Medical School 10 miles from the hospital, contributed to the access to physicians through the teaching faculty
- Significant pressure of outmigration to Knoxville

Background

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- Employers including England Furniture, DeRoyal Industries, Giles Manufactured Homes, Lincoln Memorial University
- Has a nursing home in a separate, fairly new building attached by a bridge
- Operated the county ambulance with a subsidy from the county

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Why Sell

- Ever-growing threats to small rural hospitals
- Need for capital
- County concern over bond rating

Priorities

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- Maintain hospital and emergency services
- Employees of the hospital
- Resolve County Bonds
- Provide for ambulance subsidy

Retention of Advisory Team

- Financial - Elliott Davis Decosimo to advise and manage the sale process
- Legal – Healthcare Transaction Counsel to manage legal and attorney general filings, support from local counsel on governmental, real estate and board governance
- Hospital Execs

Define Goals and Objectives

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- Possible Goals and Objectives:
  - Hospital presence
  - Expanded service
  - Financial strength
  - New facilities or equipment
  - Expanded medical staff
  - Dollars for community benefit and use of proceeds

Why Sell/Buy? Does It Make Sense?

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- Financial, Strategic and Defensive Transactions
- Obstacles to Selling:
  - Financing
  - Regulatory (licensing, CON)
  - Anti-trust
  - Political
  - Uncertainty (e.g. Obamacare)
  - Culture/mission
  - Willing Buyer/Willing Seller

Community Hospital Vs. Prospects

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Local Hospital

- Sees value to citizens
- Limited access to capital
- Currently, not able to reach full potential
- Wants to treat patients in the community
- Must buy external resource
- Limited ability to create efficiencies

Good Prospects

- Sees value of the local market
- Access to capital
- Invest to meet demand or attract patients
- Wants to treat patients in their respective facilities
- Access to internal experienced resources
- Able to leverage certain efficiencies

Understand the Prospective Buyer

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- Both for-profits and not-for-profits are trying to expand their businesses
- Make money by operating successfully in the community – meaning the treatment of more patients in a cost-effective manner
- What is the market niche of each prospective buyer?

What is My Hospital Worth?

- Current operations
- Scope of services
- Age and quality of building and equipment
- Current and future community population and economy
- Capital structure and access to capital
- Working capital status (accounts receivables)
- Competitors
- Non-hospital services
- Alternative services and hidden assets

What is it worth?

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- Do you need a valuation?
- Do you want a valuation? – FMV does not equal price
- Seller – a sense of the value and the components impacting value
- Buyer – a confirmation, particularly if a physician is involved
- Regulatory requirement – AG, Not-for-profit

Finding a Buyer

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- Direct contact with preferred party
- RFP
- Networking/prospecting
  - Financial buyer
  - Strategic buyer
- Auction?
- Nondisclosure Agreement (NDA)

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Structure Alternatives

- Sale of Assets
- Lease of property, including rights to CON and licenses
- Merger
- Stock sale (for-profit only)
- Replace Board of Directors (nonprofit)

Lease Arrangements

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- Any long-term lease arrangement should be considered an effective sale
- Prepaid
- All expenses borne by lessee
- Allows for limited control on the use of the property
  - Charity obligation
  - Continued use as an acute care hospital

Tax Issues

- Federal
  - Income tax
  - UBIT
  - Obligations under 501(c)(3)
- State (income and property tax)

So how did it play out?

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- Twenty potential buyers contacted
- Twelve discussed the deal
  - Two who dropped hurt pricing
  - Revenue too low for key players, LifePoint, Capella, etc.
- Eight signed non-disclosures
- Four visited the facility
  - One bid on the required lease format
  - One offered a management contract
  - One passed based on financing
  - One passed based on internal limitations

Along the way

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- CHS buys HMA
- A lot of interest in carving out the nursing home
  - Would have increased value by two to four million
  - Challenges with shared services
- 21 county commissioners and one county finance administrator
- Concern over Appalachian Health and unionization
- Medical staff rumors and preferences

Along the Way

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- Contracts/Documents – 54 years to cover
- Maintaining Operations until Deal Closes
  - Costs and Declining volumes
  - Cash Flow
  - Retaining Staff
  - Contract Renewals
- Due Diligence Reveals/Resolves to Preserve Deal
- Third Party – working community for "turnaround engagement"

And the Deal is…

- $10 million in the form of prepaid lease
- Required County reserve $700,000 in specific CAPX
  - Pharmacy
  - Surgery
  - Hospital beds
- Paid bonds and expense of the sale
- Balance in Escrow – including use for ambulance subsidy
- All the employees were retained for 90 days, subject to dismissal for cause

Letter of Intent

- Do you have a deal?
- How much detail to include, or leave for later negotiations?
  - You are not negotiating every detail, but you are setting framework (e.g., what was promised verbally)
  - Any deal-breakers that should be resolved now?

Letter of Intent (continued)

- Price and adjustments (e.g., working capital)
- Excluded assets (AR, real estate)
- Liabilities/contracts assumed
- Seller’s employees

Letter of Intent (continued)

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- Mostly non-binding, but…
  - Exclusivity/no-shop
  - Confidentiality (NDA) – Extension of an earlier NDA
  - Ordinary course
  - Expenses

Letter of Intent (continued)

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- Subject to:
  - Buyer and Seller board approval
  - Approval of lender(s), landlord, others?
  - Use of closing proceeds (pay debts, tail-ins, contingent liabilities/Medicare)
  - Claims escrow (5-10% of price)
  - Regulatory (assume/reject existing MPN, AG approval, licensing)
  - Post-closing Buyer requirements (continuity of services, CAPX, advisory board, etc.)
  - Healthcare fund or foundation for net proceeds

Communications Plan

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- Media is in the Board meetings
- How and when to roll it out?
- Who communicates and how?
- People are the most important component to any healthcare entity – they need honest answers

Execution of Communications Plan

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- An ongoing process
- Multiple constituents
  - Board
  - Medical staff
  - Employees
  - Community leadership
  - Prospects
  - Media
  - Attorney General's Office
- Establish process for who, where, when and how much, being mindful of the legal obligations of a governmental entity

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Communication

- Public process begins by initially informing medical staff, employees, county officials, board members and local paper
- Public Hearing
- Multiple Board/Commissioner Approvals
- Communication effective in all parties realizing this was best thing for the hospital
- Timely communication from THA with Claiborne on list of hospitals to potentially close

Due Diligence

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- More than you ever thought you could know
- Both parties should be prepared

Seller Representations & Warranties

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- Financial statements
- Taxes
- Recent material events
- Employee benefit plans
- Licenses
- Medicare, etc.

Seller Representations & Warranties (continued)

- Compliance with Laws
- Contracts/leases in force
- Environmental
- Maintenance/CAPX (no deferral)
- Employees

Seller Representations & Warranties (continued)

- Materiality & Knowledge qualifiers
- “Sandbagging”

Buyer's Reps and Warranties

- Typically minimal absent significant Seller financing
  - Duly organized and licensed
  - No conflict with charter, bylaws, etc.
  - Financial ability to close
  - No broker

Post Closing

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- Escrow Structure
- Caps and Buckets
- Working capital settlement
- Buyer agreement to provide access to records for Seller obligations (i.e. taxes, audit, cost report)

Escrow

- Amount – varies by size and circumstances – major compliance issue or other contingent liability could raise the amount but typically between 5% and 10% of the deal consideration
- Duration two to five years
- Burn off – Escrow released incrementally (e.g., 20% per year) based on remaining balance less known claims

Working Capital

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- Working capital (current assets less current liabilities – as defined) required to operate the business (“peg”)
- Buyer’s expectation of reasonable receivables, payables, inventory, etc.
- Suggest modeling the number and including in LOI
- True-up at 90 or 120 days, subject to use of an auditor
- Protects Buyer and Seller if properly drafted

Caps and Buckets

- Sets Seller's maximum future liability
- May use more than one cap
  - Major risk – larger (e.g., Medicare, environmental)
  - Normal business risk - smaller and shorter; typically 10%-30% of the deal consideration
- Deductible = minimum amount of $ claims before a claim can be made against Seller – prevents nickel and dime claims; typically 1%
- Excluded liabilities are not covered by deductible or caps

Buyers - Now the Real Work Begins

- Putting Buyer’s name on the acquired business alone will not change the culture
- Buyer needs buy-in from the people treating patients
- Setting the right expectations for process, time, change

Your Questions or Comments

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