Strategies in Capital Finance

Volume 62

COPING WITH THE NEW NORMAL

Capitalizing Hidden Value in Non-core Hospital Assets

Tax-exempt hospital operators have four primary sources of funding: 1) income from operations, 2) income from investments, 3) philanthropy, and 4) tax-exempt debt. Just as the phrase "new normal" is applied to the inevitable restructuring taking place as a result of the U.S. and global financial crises and related economic downturns, hospitals and health systems are entering a "new normal" period where all four sources of funding are constrained. We do not yet fully know what the "new normal" will be or mean for hospitals and health systems, but some of its outlines are already clear: pressure on operating and non-operating cash flows and more restrictive and expensive tax-exempt debt. The "new normal" in this regard means a much more difficult environment in which to fund capital expenditures for all but an exceptional few.

The nascent "new normal" in health care is already forcing hospitals and health systems to consider nontraditional sources of capital. This *Strategies in Capital Finance* white paper discusses alternatives for increasing liquidity and accessing capital with a particular emphasis on capitalizing on the value in non-core hospital service lines and assets.

CAIN BROTHERS

INVESTMENT BANKERS & CAPITAL ADVISORS TO THE HEALTH CARE INDUSTRY

STRATEGIES IN CAPITAL FINANCE, Volume 62
COPING WITH THE NEW NORMAL:
CAPITALIZING HIDDEN VALUE IN NON-CORE HOSPITAL ASSETS

TABLE OF CONTENTS

IMPACT OF THE "NEW NORMAL" ON FUNDING CAPITAL EXPENDITURES 1

- Hospital Operations 1
- Philanthropy 1
- Debt Markets 2
- Operational Strategies to Improve Liquidity and Generate Capital 4

MONETIZATION OF NON-CORE ASSETS AND BUSINESSES 5

- Medical Office Buildings and Real Estate 5
- Candidates for Non-core Asset Monetization 5
- Potential Value 6
- Reasons for Assets to be Classified as Non-core 7
- Attractiveness of Hospital-oriented Businesses to Strategic Acquirers 7
- Experienced Strategic Acquirers Understand Key Hospital Issues 8
- Benefits for the Hospital Seller or Joint Venture Partner 8
- Transaction Structure Alternatives 9
- Evaluating Monetization Opportunities 10

CONCLUSION 11

FIGURES

1 Hospital Development Performance, 2009 vs. 2008 YTD 2

2 Illustration of Interest Rates Spike Following Lehman Bankruptcy and Flight to Quality With Widening Credit Spreads 3

3 Selected Non-core Valuation Metrics 6

4 Monetization Transaction Structure Alternatives 9

IMPACT OF THE "NEW NORMAL" ON FUNDING CAPITAL EXPENDITURES

HOSPITAL OPERATIONS

Current conditions are all too familiar to hospital operators.[1] Operating and non-operating earnings necessary to generate liquidity and support existing and new borrowings are under pressure and have been declining for many hospitals. The Healthcare Financial Management Association (HFMA) reported recently that hospitals are experiencing negative margins, declines in non-operating income (with the largest hospitals suffering the most), decreases in days cash on hand, and reductions in patient revenue.[2] In its report, HFMA's findings indicated that 54% of the hospitals surveyed had negative total margins, and 80% of the hospitals with more than 500 beds had negative total margins. Non-operating revenue declined at 78% of the hospitals, and 64% of the hospitals reported declines in non-operating income of more than 20%. In terms of liquidity, HFMA reported that 73% of responding hospitals had decreases in days cash on hand; and 96% of the hospitals with more than 500 beds suffered decreases in days cash of more than 20%. Finally, net patient revenue was down at 43% of the hospitals. Although a recent Thomson Reuters report found that hospital margins may be improving,[3] Moody's issued a negative outlook report for the for-profit hospital sector at about the same time.[4] In that same report Moody's reaffirmed its negative outlook for the not-for-profit hospital sector and said, "We continue to see weakening operating performance from soft to declining volumes, as patients defer healthcare needs, and bad debt expenses and charity care rise. We have also seen deteriorating liquidity and balance sheet strength…"

The major reasons for these negative results are widely known. Primary among these are the general financial maelstrom that commenced in 2007[5] and accelerated in 2008 and the resulting tight conditions in the debt markets and realized and unrealized investment portfolio losses. As the value of donors' portfolios declined, their philanthropy also declined and contributed to lower non-operating income. Indirect causes include widespread job losses and layoffs and increases in the number of uninsured, which have led to reductions in patient-elective volume and increasing charity care and bad debts. Health care reform is likely to put further pressure on hospitals as reductions in Medicare and Medicaid reimbursement is expected to help fund reform efforts.

In short, for most hospitals, operations are producing lower earnings, less cash flow, and reduced liquidity to support borrowings for new capital projects.

PHILANTHROPY

Given the tremendous loss of wealth in the equity markets in 2008 and even despite equities' improved performance in the second and third quarters of 2009, philanthropy and hospital development offices cannot be expected to supplement revenues to the degree they might have in the past. Key findings by the Foundation Center in a recent study "…suggest that 2009 foundation giving will decrease in the range of the high single

[1] For simplicity, hospitals and health systems are both referred to in this paper as hospitals.

[2] How Hospitals Are Combating the Financial Downturn, HFMA's Healthcare Financial Pulse, April 2009.

[3] David Koepke and Gary Pickens, "Hospital Operational and Financial Performance Improving," Center for Healthcare Improvement, Thomson Reuters, August, 2009.

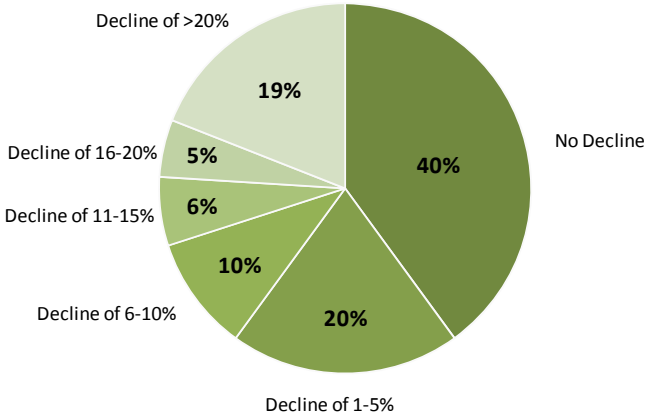
[4] "U.S. For-Profit Hospitals Face Further Uncertainty," Moody's Investors Service, August 2009.

[5] Municipal bond insurance company credit rating downgrades, for example.

digits to low double digits."[6] Although foundations slightly increased giving in 2008, with asset declines of nearly 22% in 2008, the Foundation Center found that more than two-thirds of foundations will decrease funding in 2009; and the outlook is for further decreases in funding in 2010.

Similarly, in a recent survey of 88 hospitals, the Advisory Board Company concluded that 2009 would be a difficult year for philanthropy and development, as shown in Figure 1.

FIGURE 1. Hospital Development Performance, 2009 vs. 2008 YTD



Source: Health Care Advisory Board, "Leadership Through the Downturn,"2009, p. 40.

Philanthropy and development, therefore, in the short term cannot be counted on to provide capital expenditure support to the degree it has in the past.

The harsh lesson of 2008 and 2009 in the debt markets for tax-exempt health care borrowers is that easy access to the tax-exempt debt market has ended and can no longer be taken for granted.

DEBT MARKETS

The harsh lesson of 2008 and 2009 in the debt markets for tax-exempt health care borrowers is that easy access to the tax-exempt debt market has ended and can no longer be taken for granted. The days of multiple borrowing options and flexibility are now greatly curtailed, especially for lower rated and non-rated credits.

▶ *Tax-exempt Fixed Rate Debt Markets*

General financial markets turmoil accelerated during 2008, and the fixed income markets essentially seized up in the immediate aftermath of Lehman Brothers' September 2008 bankruptcy. This was especially true in the tax-exempt fixed income health care market that saw no new long-term tax-exempt health care hospital bonds issued for a five-week period in September and October 2008.

An important factor in the dislocation of the tax-exempt market was that non-traditional investors, such as hedge funds, deserted the municipal market, because leveraged municipal bond arbitrage strategies failed. These kinds of investors had been major drivers of the market from 1998 to 2008.

[6] Foundation Center, Foundation Growth and Giving Estimates, 2009 Edition.

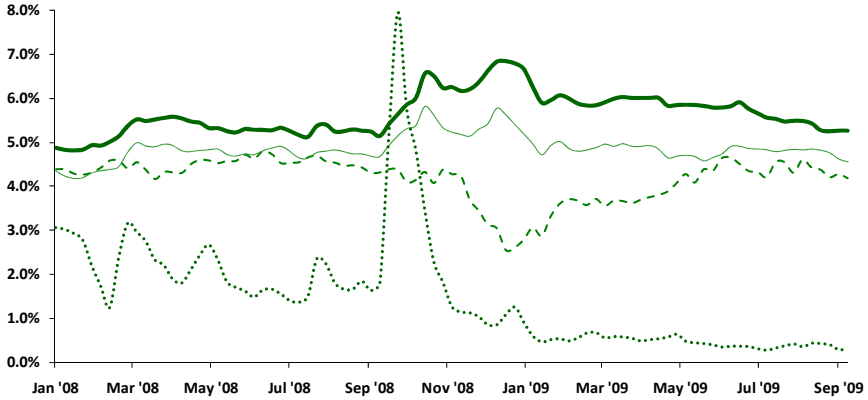
Since the beginning of 2009, liquidity has returned to most markets including the tax-exempt health care market, although the pace has been slow. The participation of traditional institutional bond funds and individual retail investors has been primarily responsible for the improvement. By the end of the second quarter of 2009, new tax-exempt health care bond issuance had returned to near normal levels, at least for single-A and double-A quality credits, although credit spreads to comparable maturity U.S. Treasuries remain wide by historical measures. Issuance of triple-B quality hospital bonds has been sporadic, but, as with higher quality issuers, credit spreads for triple-Bs have been improving. New bond issuance of non-rated tax-exempt health care credits has remained very difficult.

► *Tax-exempt Variable Rate Debt Markets*

When the auction rate securities (ARS) market failed in February 2008, many tax-exempt health care issuers discovered that they had transaction structures that didn't work and had to scramble to refinance. Today, the ARS market remains dormant. Most of the high maximum rate ARS transactions have been refunded, and outstanding low maximum rate deals are illiquid and a concern to investors. The reduced numbers of variable rate demand bonds (VRDBs) with devalued bond insurance that remain outstanding are still experiencing higher rates and will eventually need to be refunded. In the current market environment, VRDBs are limited to direct-pay letter of credit (LOC) structures, transactions that have Assured Guaranty insurance and bank liquidity facility back up, or double-A credits with substantial cash positions providing self-liquidity. "Put bonds," which are a variation on VRDBs, are not finding wide acceptance. The number of banks providing credit facilities, including LOCs, has declined, and their capacity has been greatly reduced. These banks are usually limiting any new commitments to existing customers and often require cash management and other non-credit bank business as part of any new commitments.

FIGURE 2. Illustration of Interest Rates Spike Following Lehman Bankruptcy and Flight to Quality with Widening Credit Spreads

Figure 2 illustrates the spike in interest rates following the Lehman bankruptcy and the flight to quality that caused spreads between Treasuries and municipals, including health care debt issuers, to widen substantially. Although credit spreads have been improving, they still remain relatively wide.



	9/11/09	MAX	MIN	AVG
30-YR AA Health Care	5.26%	6.85%	4.81%	5.65%
30-YR AAA GO Benchmark	4.56%	5.81%	4.19%	0.27%
30-YR Treasury	4.18%	4.79%	2.55%	4.15%
SIFMA*	0.31%	7.96%	0.27%	1.50%

*The Securities Industry and Financial Markets Association Municipal Swap Index (SIFMA) is a short-term index that reflects tax-exempt interest rates in the VRDB market.

Source: Cain Brothers

The wake up that hospitals have experienced in recent quarters is that they may no longer be able to generate enough internal cash flow and borrowed money to pay for all of their capital programs. Consequently, they are investigating and pursuing alternatives for restoring/improving liquidity and generating capital through other means.

OPERATIONAL STRATEGIES TO IMPROVE LIQUIDITY AND GENERATE CAPITAL

Hospitals are moving on many fronts to improve liquidity. Included among some of these tactics are the following:

- Revenue cycle improvements to collect more cash: collection of charges and co-pays at the points of patient access; installation of discount policies to increase self-pay collections; analysis of patient accounts receivable to identify best tiers of collection likelihood to pursue; review of coding and third party payments and denials; extension of favorable managed care contracts; and identification and enhancement of high revenue/ high margin services.
- Expense reductions through staff layoffs, attrition, and reduced hours; limitations on purchasing; and reduced investments in non-essential assets and operations.
- Programs to increase operational efficiencies: capacity throughput analyses to increase patient flow through emergency and imaging departments and operating suites; initiatives to better manage supply chains and control supply costs; and staffing studies aimed at reducing headcount without allowing quality of care to suffer.
- Use of nontraditional and alternative financing sources: project financing using federal guaranty programs, such as those offered by the Federal Housing Administration;[7] capital facility and capital equipment leasing programs through third parties such as banks and real estate investment trusts and equipment vendors; sale/leaseback transactions using operating leases; and outsourcing through management agreements that include capital contributions.
- Implementation of financial discipline using hurdle rate, economic value added, and return on investments concepts to evaluate and approve new capital projects.
- Strategic planning adjustments: slowing down and reducing capital expenditures on low return projects and accelerating spending on projects with higher and quicker expected returns; prioritization of projects related to core businesses; and placing more emphasis on profitable and high-growth services lines, such as cardiology and neurosurgery, and cutting or outsourcing low margin service lines like pediatrics.
- Sale and/or joint ventures of non-acute and non-core assets and operations: discussed in detail in the following section; monetization of non-core hospital assets and businesses has both significant financial and strategic implications.

[7] See Cain Brothers' *Strategies in Capital Finance* Vol. 61 "Financing and Debt Restructuring Solutions for the Senior Living Industry Financial Crisis," available at www.cainbrothers.com.

MONETIZATION OF NON-CORE ASSETS AND BUSINESSES

Many hospitals have considered and executed non-core asset sale and joint venture transactions.

MEDICAL OFFICE BUILDINGS AND MEDICAL REAL ESTATE

In recent years a common asset class targeted for monetization has been hospital-owned medical office buildings (MOBs) and other medical real estate.[8] Because hospital MOBs often have predictable cash generating characteristics from stable physician and hospital tenancies, they possess strong fundamental qualities that make them attractive to institutional real estate investors. As these investors have become more familiar with some of the unique characteristics of MOBs and other medical real estate they are increasingly seeking this asset class for inclusion in their investment portfolios. Many providers have taken advantage of these favorable market conditions by either selling existing real estate assets or by using third-party developers to develop and own new medical properties. Much of the focus on this "third-party" model has been on maximizing sale proceeds relating to existing properties, the comparison of the cost of capital between direct ownership and the third-party ownership, and the benefits of accessing alternate pools of capital. In addition to the financial benefit from MOB monetizations, hospitals have found that they can preserve much of the strategic value from MOB ownership through ground lease structures that require the buyers to ensure MOB space in the sold property is leased only to those tenants that have strategic value to the selling hospital. Much of the growth in medical real estate monetizations has been in non-acute properties. These properties are often on-campus MOBs or ambulatory properties, but in recent years transactions have increasingly included a variety of other off-campus properties, as well.

CANDIDATES FOR NON-CORE ASSET MONETIZATION

What a given hospital considers non-core assets or businesses and, therefore, candidates for monetization transactions, will vary depending on each particular hospital's level of operational integration with the non-core business, the business' legal characteristics, and the overall operating philosophy of the hospital. Assets and businesses that are frequently considered to be potential monetization candidates include the following:

- Affiliated hospitals in non-core markets or with significant, sustained operating losses
- Ambulatory surgery centers
- Behavioral health facilities and operations
- Diagnostic imaging centers
- Dialysis centers
- Home health agencies
- Hospice facilities
- Laboratories
- Managed care organizations
- Medical transportation services
- MOBs
- Physician practice management infrastructure
- Rehabilitation facilities
- Senior living and housing, including skilled nursing, assisted living, and dementia services

[8] See Cain Brothers' *Strategies in Capital Finance* Vol. 41 "From Strategic Assets to Tactical Investments – Changing Attitudes Toward Medical Office Building Ownership," Vol. 46. "Medical Real Estate – Trends in Third Party Development," and Vol. 51. "Physician Ownership Participation in Medical Office Buildings," available at www.cainbrothers.com.

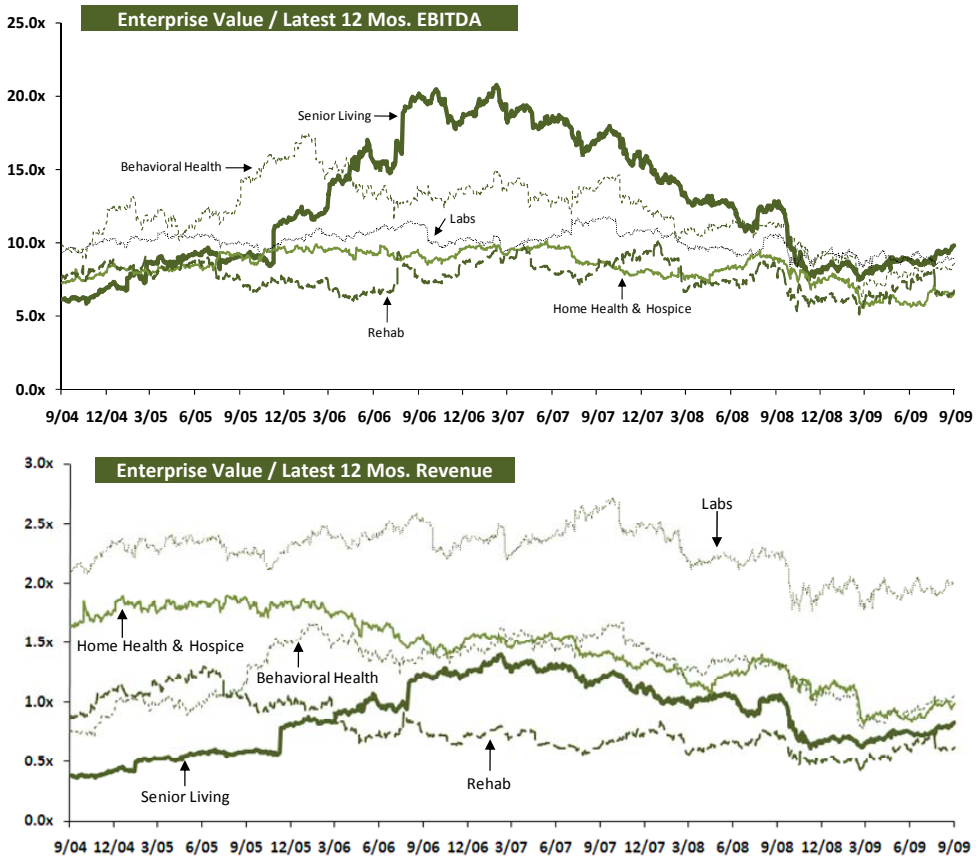
The relative attractiveness of monetizing any of these assets and operations will depend on two primary considerations: i) the strategic implication to the organization of selling an operating activity, and ii) the potential value to be generated from a monetization transactions. Hospitals should not consider monetization of non core assets purely from a financial impact standpoint. The strategic benefit or disadvantage of selling an operation should be factored into any decision to pursue a monetization opportunity.

POTENTIAL VALUE

There are a number of different methods for determining the potential value of a non-core asset. The clearest but most resource intensive is to solicit offers from potential buyers. Absent actually marketing a non-core asset, other proxies for potential value include values of publicly traded companies focused on a specific sector and values associated with transactions that have been completed.

FIGURE 3. Selected Non-core Valuation Metrics

These charts summarize valuation indices for a number of health care businesses that are attractive acquisition targets for financial and strategic investors. The sectors selected for illustration are senior living, clinical labs, home health and hospice, behavioral health, and rehabilitation. The selected valuation indices are total enterprise value (equal to the market value of total debt and equity) compared to latest 12-month earnings before interest, taxes, depreciation and amortization (EBITDA) and total enterprise value compared to latest 12-month revenue. As can be observed from the charts, sectors and their valuation metrics will move in and out of favor over time depending on sector dynamics and investor interest. For example, in the senior living sector, enterprise value to LTM EBITDA rose from about 6 times in 2004 to about 20 times in 2007 and back down to about 10 times today.



The charts include the following companies:

Senior Living: National Healthcare, Sunrise Senior Living, Emeritus, Kindred Healthcare, Sun Healthcare, Assisted Living Concepts, Capital Senior Living, Five Star Quality Care, and Brookdale Senior Living.

Labs: Clarient, Laboratory Corp. of America, MEDTOX Scientific, Myriad Genetics, Orchid Cellmark, Bio-Reference Laboratories, Enzo Biochem, Psychemedics, Quest Diagnostics and Genomic Health.

Home Health & Hospice: Lincare, Odyssey Healthcare, Gentiva Health Services, Chemed, American Homepatient, Almost Family, Amedisys, Arcadia Resources, LHC Group and Rotech Healthcare.

Behavioral Health: Psychiatric Solutions, Res-Care and PHC.

Rehab: Rehabcare Group and US Physical Therapy.

Source: Capital IQ.

REASONS FOR ASSETS TO BE CLASSIFIED AS NON-CORE

There are many reasons that a hospital might have for classifying an asset or business line as non-core in nature. A primary reason often relates to lack of economies of scale and resulting high, noncompetitive cost structure. A laboratory serving a small to medium sized hospital or system, for example, may not have enough volume to generate low per-accession and test costs, and attracting skillful technicians and pathologists is often difficult.

The allocation process for scarce capital resources is often another contributing factor. Following the lab example, a hospital might be more compelled to allocate capital to upgrading operating rooms or clinical information technologies than it would to the purchase of state-of-the-art lab equipment. Hence, a business line like laboratory may become orphan-like and starved for capital. Selling or joint venturing with an independent lab company can solve issues like these and generate capital for redeployment in core acute care assets.

…in some cases third parties or third parties in the form of joint venture entities, in which the hospital continues to participate, can operate businesses more efficiently and profitably without degrading quality.

Another important reason for an asset or operation to be considered non-core is that hospitals recognize in some cases third parties or third parties in the form of joint venture entities, in which the hospital continues to participate, can operate businesses more efficiently and profitably without degrading quality. Nonprofit and for-profit organizations that specialize in operating senior living facilities, for example, can often bring lower cost structures to these businesses, because personnel policies and salaries and benefits packages do not need to match the levels often necessary for hospitals to attract and retain staff or due to collective bargaining arrangements. Different benchmarking also can be applied to the business. In addition, focused operators often have more expertise to better manage operational and development risks, both of which are often outside a hospital staff's areas of expertise.

Clinical expertise is often a key factor in concluding whether a service line is core or non-core. For example, specialty operators of free standing rehabilitation facilities or even units within hospitals have often been able to demonstrate better clinical outcomes at lower costs than general acute care hospitals operating these units on their own.

After years of excess bed capacity in many markets, many hospitals are beginning to encounter significant capacity constraints. By selling or joint venturing non-core operations such as skilled nursing and rehabilitation units, hospitals can free up hospital bed capacity for more profitable use. Similarly, by joint venturing with outpatient surgery companies, hospitals can free up operating room capacity to accommodate higher intensity inpatient procedures.

ATTRACTIVENESS OF HOSPITAL-ORIENTED BUSINESSES TO STRATEGIC ACQUIRERS

Strategic acquirers[9] are attracted to hospital-oriented businesses for many reasons. The ability to increase and diversify revenue is a key motivator for acquirers, of course. Acquisition of hospital-run businesses can often provide operational and bottom line improvement possibilities to specialty operators, as well. Hospital-oriented businesses are also highly attractive because they will have a continuing referral stream of business, which can be further leveraged by the acquirer. The built-in nature of the

[9] We refer to strategic acquirers as companies that already operate in the subject space. They can be nonprofit or for-profit companies, have independent status or be part of a larger company, and have private equity sponsorship and/or public financing resources.

hospital's business line work force with its clinical knowledge and technical experience is usually another attractive ingredient. The hospital's "halo effect," in terms of local or regional name recognition and community standing, can be attractive and can lead to marketing and co-branding opportunities for the acquirer. Acquirers are also attracted to nonprofit transaction parties, whether as a seller or joint venture partner, because accounting improprieties and potential fraud situations are extremely rare.

EXPERIENCED STRATEGIC ACQUIRERS UNDERSTAND KEY HOSPITAL ISSUES

As either a seller of a line of business or a joint venture partner, a hospital will naturally have significant concerns about the strategic implications of divesting clinical operations. Experienced strategic acquirers have faced such issues before and understand them. Before entering into a transaction, a hospital will need to be convinced that the purchaser or joint venture partner can and will maintain the hospital's high standards of care and ethical principles. The hospital cannot afford to have its reputation diminished by the subsequent owner and operator of the business. The hospital will also need to be assured that strong community ties can be maintained. Further, it is critical for the hospital that strong physician relationships be maintained and enhanced and that business referral sources continue to be cultivated. Another consideration is that the hospital's employees involved in the sold or partnered business be treated fairly during the transition and after the transaction closes.

BENEFITS FOR THE HOSPITAL SELLER OR JOINT VENTURE PARTNER

Capital generation and unlocked management resources are the two most obvious benefits…

Capital generation and unlocked management resources are the two most obvious benefits to a hospital that sells a non-core asset or business line or enters into a joint venture partnership relating to a non-core asset or business line. Cash proceeds from a monetization transaction can augment scarce capital resources and be redeployed into core acute care hospital operations and higher and better uses. Freeing up management resources from having to operate the sold or joint ventured business, while perhaps somewhat difficult to quantify, is another frequent benefit. The ability to focus on key operations and challenges without being distracted by marginal assets and businesses is often a significant benefit for overburdened management teams. The hospital can typically retain referral business from the new operator or the joint venture, and, indeed, this can usually be addressed the transaction documents. If a hospital completes a joint venture transaction or otherwise retains an equity interest in the sold business, another benefit of a monetization transaction is that the hospital will participate in future earnings distributions from the business. Due to the operating efficiencies and expertise of companies focused on a specific sector, in a number of situations the income generated from partial ownership of a non-core operation can be greater than the income generated under 100% hospital ownership.

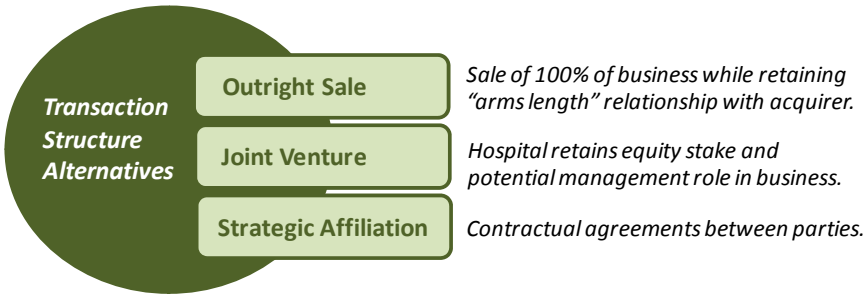
This last point bears emphasis, because important strategic benefits can sometimes be derived by monetization of non-core assets or lines of business that are in addition to the usual financial and unlocked management resources benefits. For instance, in August 2009, Caritas Christi Health Care in Massachusetts announced that it sold its outreach laboratory business to Quest Diagnostics. In addition to cash proceeds generated by the sale, Caritas Christi said that it would gain access to Quest's information technologies and be able to use Quest's online ordering and results-reporting systems to update their medical records. Caritas Christi also said that Quest will collaborate with it on a secure information exchange among the system's hospitals, network physicians, and affiliated doctors.

In addition to financial and potential strategic benefits of monetization, there may be opportunities for joint marketing and fund raising initiatives associated with the new operator or joint venture operator of the monetized business.

TRANSACTION STRUCTURE ALTERNATIVES

As illustrated in Figure 4, a hospital can pursue one of three general types of monetization transaction structures.

FIGURE 4. Monetization Transaction Structure Alternatives



The ***outright sale alternative*** is relatively straight-forward. The hospital sells the asset or business line to a new operator in return for consideration, generally cash, and the new owner takes over. Depending on the operation sold, the hospital can retain significant legal and contractual claims on the business. For example, in most MOB transactions, the hospital will retain ownership of the land underneath the MOB and enter into a ground lease with the building's buyer. The terms of the ground lease can include controls on the buyer, such as the kind of tenant that can rent space within the building (e.g., a physician on the hospital's medical staff), and in that manner the hospital can continue to protect its interests.

In cases such as home health, hospice or rehabilitation where the operation is part of the continuum of care, purchasers are often willing to provide the hospital with long-term contracts at favorable rates and with specific service and quality commitments built into the agreements. These types of arrangements allow the hospital to preserve the strategic value from the sold operation while benefiting from the monetization. To further preserve the hospital's interests, some buyers are willing to structure repurchase rights under certain circumstances and at predefined valuations.

Joint ventures with unrelated parties as well as related parties, such as physicians, can have a multitude of variations, and the ultimate legal and operating structures will depend on answers to key strategic questions like the following:

- What will be the ownership interests of the parties? 50%/50%? Minority? Majority?
- How much capital will be necessary?
- How will the venture be financed?
- What are the clinical objectives of the venture?
- What is the business case for the venture?
- How will the venture be reimbursed?
- How will the venture be managed?

- How will the venture be governed?
- How will the venture be taxed?
- What impact, if any, will it have on the hospital's tax-exempt status?
- Will there be a "halo" effect that will produce additional volume for the hospital?
- How will competitors react?
- What is the exit strategy or strategies for the parties?

Joint ventures can be structured in multiple ways depending on the objectives of the parties. Common objectives include accessing proven management expertise, enhancing hospital referrals and patient catchment areas, boosting the growth rate of the business and/or increasing market share and geographic scope beyond what one party can accomplish on its own, and generating capital for the business. If the objective of the joint venture is to attract capital to support the operation, a common transaction structure is for the hospital to contribute the operation at its fair market value and the joint venture partner to contribute cash equal to the value of the operation contributed by hospital. The joint venture partner then obtains a contract for management of the joint venture.

Strategic affiliations through the use of management contracts can also have lots of variations. Hospitals can use contracted management to provide patient care services instead of employing a manager directly as a salaried employee. Support departments such as security and dietary have a long-standing history of using this kind of contracted management service. Outpatient services such as ambulatory surgery are often conducted through management contract arrangements.

EVALUATING MONETIZATION OPPORTUNITIES

► *"Inventory" of Non-core Assets and Businesses*

As a first step in evaluating monetization alternatives, the hospital should assess what operations are potentially non-core in relation to its strategy and mission. This starts with an assessment of the subject business' strategic importance and impact on the hospital's core operations and mission.

A second part of the decision process should also include a comparison of key performance benchmarks against industry standards. If the hospital's benchmarks generally tend to fall below the industry's (i.e., the hospital performs worse than the industry average), the hospital may be more inclined to include the business in the non-core category or at least recognize that the business might perform better under a different ownership and/or management structure.

The third part of inventorying non-core assets and businesses is to estimate a preliminary valuation, which will help to assess the monetization opportunity. In some cases it may be advisable to engage an advisor familiar with doing merger and acquisition transactions in the subject sector. Such an advisor can pinpoint value better and gage potential third party interest based on experience.

▶ *Identify Potential Candidates*

In virtually all hospital related sectors, there will be multiple companies seeking to participate in a monetization transaction. Sometimes, as in senior living, there will be both nonprofit and for-profit participants. The more participants in a given sector, the more likely it is that an interested transaction party or parties can be identified. Again, an outside advisor with M&A experience in the sector can provide valuable assistance to the hospital.

▶ *Solicit Interest and Proposals*

Assuming the hospital decides to move forward with a monetization, it (or its advisor) should prepare a memorandum that describes the opportunity surrounding the subject asset or business line, with its positives and any potential negatives[10], and distribute it to potentially interested parties. Enough information should be included in the memorandum so that an interested party can make a realistic assessment of the degree of its interest and be in a position to put forth a good faith preliminary proposal.

▶ *Decision*

With one or more proposals in hand that indicate the broad outlines of transaction terms and valuation, hospital management and board members will be able to make a determination about whether to proceed with the monetization transaction or be content with preserving the status quo.

CONCLUSION

Hospitals and health systems are entering a "new normal" period where the basic sources of liquidity and cash flow generation are constrained and the environment for funding capital expenditures is much more difficult for all but an exceptional few. As a result, many hospitals and health systems are considering taking advantage of non-traditional sources of capital to capture hidden values contained in non-core hospital service lines and assets through monetization transactions that can result in financial, operational, and strategic benefits.

[10] Full disclosure is very important and demonstrates good faith to potential transaction parties. Negatives will be revealed in the "due diligence" period in any case, and sellers need to avoid negative surprises.

About Cain Brothers

Cain Brothers is an employee-owned investment banking and financial advisory firm that focuses exclusively on the medical services and medical technology industries and their related businesses. Cain Brothers has one of the largest teams on Wall Street dedicated to the health care industry, with bankers and traders who possess experience in all facets of the industry.

Cain Brothers is all about ideas and direct senior banker involvement with the firm's clients. Our philosophy is to roll up our sleeves and work side by side with our clients to produce innovative, market driven solutions for the many opportunities and challenges they face.

The firm's client base is primarily composed of nonprofit and investor-owned health care service providers, third-party payors, medical technology companies, and companies that provide services to the health care industry such as information technology and real estate companies. The firm was formed in 1982 based on the belief that health care organizations have unique needs that can be best addressed by professionals with a focus on the health care delivery system as a whole. The firm has grown to become one of the nation's preeminent investment banking and advisory firms to the health care industry.

Cain Brothers research scans the health care industry environment to identify client challenges, trends, and solutions. Through our *Strategies in Capital Finance* series of white papers, the firm communicates substantive strategic perspectives to senior management teams and board members. The firm also keeps its clients up to date on industry developments, interest rate changes, and equity price trends through its two newsletters, *Industry Insights* and *Senior Health and Housing Weekly News*. These publications are available on our website.

Cain Brothers' venture capital affiliates, Health Enterprise Partners and CB Health Ventures, invest capital in fast-growing health care service and information technology companies.

Nonbroker Affiliates

Health Enterprise Partners, LLC
www.hepfund.com

CB Health Ventures, LLC
www.health-ventures.com

Robert Schulz
rschulz@hepfund.com
360 Madison Avenue, 5th Floor
New York, NY 10017
212-869-5833

Management

James E. Cain
Chief Executive Officer
jcain@cainbrothers.com

Robert J. Fraiman
Head of Corporate Finance
rfraiman@cainbrothers.com

Andrew McB. Garvey
Head of Capital Markets
agarvey@cainbrothers.com

Scott D. Smith
Head of Special Products
ssmith@cainbrothers.com

James M. Moloney
Head of Real Estate
jmoloney@cainbrothers.com

Headquarters

360 Madison Avenue, 5th Floor
New York, NY 10017
212-869-5600

Other Locations

CHICAGO

HOUSTON

SAN FRANCISCO

ATLANTA

INDIANAPOLIS

LOS ANGELES

SARASOTA

ST. LOUIS

Websites

www.cainbrothers.com
www.cbfirm.com

Member

Financial Industry Regulatory Authority

Securities Investor Protection Corporation

CAIN BROTHERS & COMPANY, LLC