AGENDA

- WHAT IS DRIVING CONSOLIDATION?
- WHAT TO LOOK FOR IN A PARTNER?
- ONE HOSPITAL’S STORY
- AFFILIATIONS CLOSE, BUT FAR FROM COMPLETE
88% of provider executives plan to pursue M&A within the next 12 months

GE Capital Survey of provider Executives
Advisory Board – M&A - To What End?
Current National Hospital M&A

National Hospital M&A Transaction Count

<table>
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</tr>
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<tbody>
<tr>
<td>2011</td>
<td>85</td>
<td>100</td>
<td>87</td>
<td>98</td>
<td>25</td>
<td>23</td>
</tr>
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</table>

National Hospital M&A Transactions

Average Price per Bed

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td>Price</td>
<td>$540,492</td>
<td>$475,667</td>
<td>$551,994</td>
<td>$493,219</td>
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</table>

Based on 36 Transactions  Based on 17 Transactions  Based on 18 Transactions  Based on 13 Transactions

Average price per bed for YTD ’14 and ’15 are not meaningful.
WHAT IS DRIVING CONSOLIDATION

• Downward pressure from Medicare on already narrow margins
• Lack of Medicaid expansion?
• Declines in inpatient volumes across the nation
• Transition from FFS to alternative payment models
• Restrictions on cashflows, capital needs, cost of physicians
• General fear of unknown and uncertainties about the environment
Recent Medicare spending

Medicare spending is 14% of the federal budget

**Total Federal Spending in 2013: $3.5 Trillion**

- Social Security: 23%
- Defense: 18%
- Nondefense discretionary: 17%
- Other: 14%
- Medicaid: 6%
- Net interest: 8%

MEDICARE: 14%

**Nearly one-fourth of Medicare spending is for hospital inpatient services**

**Total Medicare Benefit Payments in 2013: $583 billion**

- Hospital inpatient: 24%
- Medicare Advantage: 25%
- Physician payments: 12%
- Outpatient prescription drugs: 11%
- Post-acute care: 8%
- Other outpatient: 6%

**Other services:** consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services, also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.

**SOURCE:** Congressional Budget Office, 2014 Medicare Baseline (April 2014).
Financial Effect of Aging US Population on Healthcare Costs

Healthcare Costs by Age

U.S. is spending much more for older ages

Annual per capita healthcare costs

Age

UK
Germany
Sweden
US
Spain
Public Payer Reimbursement is a Prime Target

ACA’s Medicare Fee-for-Service Payment Cuts

Reductions to Annual Payment Rate Increases\(^1\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital Payment Rate Cuts ($B)</th>
<th>Reduced Medicare and Medicaid DSH(^2) Payments ($B)</th>
<th>Reduced Medicare Payments due to Sequestration and 2013 Budget Bill ($B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>(4)</td>
<td>$260</td>
<td>$151</td>
</tr>
<tr>
<td>2014</td>
<td>(14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>(21)</td>
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<tr>
<td>2016</td>
<td>(25)</td>
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<td>2017</td>
<td>(32)</td>
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<tr>
<td>2018</td>
<td>(42)</td>
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<tr>
<td>2019</td>
<td>(53)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>(64)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>(75)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>(86)</td>
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</table>

$415B in total fee-for-service cuts, 2013-2022


\(^1\) Includes hospital, skilled nursing facility, hospice, and home health services; excludes physician services.

\(^2\) Disproportionate Share Hospital.
Volume trends per Moody's

EXHIBIT 3
All utilization growth slowed showing decline in demand

Source: Moody's Investors Service
Industry Thoughts from Rating Agencies - 2014

• Second year of overall weaker performance after three years of stability
• Balance sheets improved on strong investment return
  – Requires the ability to invest in stocks
• The reappearance of expense growth outpacing revenue growth
• Looking forward:
  – Anticipate weak financial performance
  – All rating categories will be affected
  – No overriding factors to drive up admissions in 2014/15
  – Anticipate the transition to value based purchasing will be highly disruptive
  – Rate increases are under pressure (Medicare 1.4% in 2015!) Estimated inflation was 2.9%
  – Effective boards will aggressively attack expenses and **CULTURAL** change will be required. Benefits will have likely have delayed recognition
Transition of health care payment methods over time

- **Cost Reimbursement** (1960s – 1980s)
- **Transition period to Prospective Payment System (1990s)**
- **Prospective Payment System (Late 1990s to 2009)**
- **Transition Period (Current)**
  - Payment Demonstration
  - ACOs
  - Bundled Payments
- **Value-Based Purchasing System**
- **Population Management**
Is Bigger Really Better?
"The largest hospitals are getting stronger, while the smaller hospitals get weaker," says Moody's VP -- Senior Analyst Daniel Steingart. "The largest hospitals have long generated stronger operating margins and revenue growth owing to factors such as their economies of scale and ability to drive revenue growth through expanded services."
Is Bigger Better?

EXHIBIT 8A
Higher-rated hospitals have stronger operating margins and are better able to absorb unexpected operating challenges

- Operating Income
- Operating Margin

Source: Moody’s Investors Service
Goals of Community Hospital’s

• Maintain health care services in community long-term
  – Need to maintain local control?
• Economies of scale – vendors, payers, alternative payment methods reality.
• Access to capital (IT, Equipment, & Buildings)
• Access and stabilization of physicians (and specialists)
• Direction?
Goals of Health System’s

• Market share
• Inflow of inpatients to fill beds
• Increased utilization of outpatient services and physicians
• Solid balance sheet and strong operations
• Collaboration across ACOs, bundled payments, etc.
• More control over population served
Barriers to Affiliation?

- Local control?
- Weak performance?
- Not investing in anchors...
- Will there be a partner for everyone?
- Federal trade commission, State Attorney General – anti-trust issues
Affiliation Model to Partnership Goals Alignment

**Degree of Independence**
- High
- Medium
- Low

**Degree of Need**
- Low
- Medium
- High

- Regional Clinical Network
- Best-Practice Collaboration
- Physician Support
- Service Line Affiliation
- Consultative Support
- Joint Venture
- Management Agreement
- Lease
- Merger/Acquisition

**Goals of Partnership**
- **Financial Advantage**
  Gains financial, operational efficiencies
- **Clinical Advantage**
  Achieves quality improvements, expands acute care services
- **Continuum Advantage**
  Builds toward population management expertise, expands scope of services

Source: The Advisory Board Company / BKD, LLP

BKD National Health Care Group
ONE HOSPITAL’S STORY

- 143 Bed Hospital in Rutherfordton, NC (Rural)
- Recently Remodeled Facility
- Strong balance sheet $100M in Assets
  - 150 days cash on hand
  - Limited outstanding debt
- Net Revenue - $85M, significant operating losses past 3 years
- Local industry downturn
- High Medicaid, Medicare and self-pay population
Affiliation Close, But Far From Complete
POST-MERGER INTEGRATION CHALLENGES

#1 – Focus on Deal Closure Distracts from Integration Planning Process
#2 – Existing Leadership Lacks Capacity Necessary to Oversee Integration Process
#3 – Deal-Making Team Not Well Positioned to Oversee Integration Planning Responsibilities
#4 – Failure to Recognize Importance of Initial Successes and Failures
#5 – Barriers to IT Integration Often Underestimated
#6 – Integration Plans Not Likely to Trickle Down Naturally
#7 – Lack of Measurable Goals Reduces Evaluation to Gut Checks and Hearsay
#8 – Simple Establishment of Objectives Insufficient to Instill Accountability

BKD National Health Care Group
POST MERGER OBJECTIVES

Performance Against Wide Range of Opportunities Dependent on Successful Integration

**Deal Objectives**
- Financial Stability and Profitable Growth
  - Economies of scale, market share gains, and development of new programs

**Common Integration Activities**
- Debt restructuring
- Management and staff consolidation
- Closing underperforming facilities
- Contract renegotiation

**Service Line Regionalization and Rationalization**
- Expanded footprint and opportunities for service line rationalization

**Value-Based Care and Population Management**
- Scale and scope advantages to position both organizations differently in the market
- Cross-continuum collaboration
- Best practice sharing
- Integration of care management activities
- Centralized primary care infrastructure

www.advisory.com

BKD National Health Care Group
RURAL STRATEGY?

- Rural Designations –
  - Sole Community Hospital
  - Medicare Dependent Hospital
  - Rural Referral Center
  - Critical Access Hospital
- Bed days available vs. Licensed beds
- Rural health clinics
- Swing-beds
- Low volume payments
- 340b expansion
- Provider based clinics
- Provider based campuses
- Outpatient Centers
- Home Office Cost Report
- Wage index reclassification
- Impacts of Uncompensated Care DSH
- Others?
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