CHAPTER 5

EVALUATING HOSPITAL BUSINESS FUNDAMENTALS

Economic Value: The Common Denominator of Hospital Valuation

As we have seen, the specialized nature of hospital facilities limits the value of such facilities outside the context of an operating hospital. Hospitals and medical centers acquire real economic value primarily by virtue of their ability to generate net cash flow (sometimes called "free cash flow"), regardless of whether they are operated as for-profit or not-for-profit organizations. Although other perceptions of "value" may influence a decision by a purchaser or financier of a hospital, the concept of economic value by necessity provides a common denominator by which to analyze hospitals as operating organizations, and the ability to generate future net cash flow is the primary determinant of hospital economic value.

But how does a hospital generate net cash flow? What are the business and operating fundamentals which create net cash flow?

Since a hospital's value as an operating concern is so dependent upon projected net cash flows, the reasonableness of a hospital valuation will depend largely upon the reasonableness of the underlying cash flow projections. And, the quality of the cash flow projections themselves will
depend upon how thoroughly various hospital business fundamentals are analyzed, for cash flow is not a discreet business event but is, rather, the reflection of numerous business dynamics and events. Cash flow is an effect of what is happening in an operating business; to accurately project cash flow, one must examine the causes of what is happening, and in hospital valuation this means examining certain key business fundamentals.

The Elements of Hospital Viability

There are certain very basic conditions underlying the financial viability of hospitals. Several conditions, in particular, would seem to be essential, and the absence of any one of these could cause a hospital to be financially troubled. These conditions for hospital viability are:

- Acquiring patients.
- Providing services effectively and efficiently.
- Maintaining adequate facilities and equipment.
- Receiving timely and adequate payments.

The purpose of evaluating hospital business fundamentals is to identify those elements which affect cash flow, for anything which affects hospital cash flow can also affect hospital value. Factors which enhance the ability to accomplish the above three objectives also enhance cash flow and value. Factors which impair or limit the ability to accomplish any of the above objectives tend to limit cash flow and, therefore, value. In order to gain insight into a hospital's business fundamentals and their effect upon cash flow, we can identify five key areas of business performance which should be examined in any complete hospital valuation assignment:
Market Position:

A hospital’s relative market status, the quality of its medical staff, the hospital’s scope of services, and its past and projected utilization by type of patient.

Regulatory Position:

The degree of regulation of facilities and operations, the regulatory history of the organization, and the expected relationships with third party payors and other regulators.

Operations:

The effectiveness and efficiency of operations, the quality and adequacy of staffing, and the overall quality of management.

Physical Facilities:

The quality, capacity, and condition of physical facilities and equipment and the projected requirements for the future.

Financial Position:

The condition of the hospital’s balance sheet, its liquidity, its receivables position, its projected assets and liabilities, and the projected timing and adequacy of revenues.

Let us deal separately with each of the five areas above to determine how these key areas of hospital businesses affect cash flow and value. For each area we will suggest the most important factors to be examined during the hospital valuation process.
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THE MARKET POTENTIAL OF A HEALTH CARE ORGANIZATION IS A FUNCTION OF...

The Industry Market Forecast:

How large is the overall market?
Is the market expect to grow?
What are the growth projections?

The Competition within the Market:

The present number of market participants.
The size, market share, and viability of existing market participants.
Expected entry of new participants.

The Expected Market Share of the Specific Organization:

How much market share is there presently?
What is a realistic growth rate, given the organization’s resources?
What is a realistic market penetration, given market potential and existing competition?
Changes in the Market Position of Hospitals

Of all the forces underlying the changes in the market position of hospitals, one of the most important has been the increased freedom of choice by patients of health care providers. This greater freedom of choice has been caused by both technological improvements in health care delivery and by pressures from third party payors encouraging "alternative care"—meaning care outside the acute inpatient hospital setting.

As more treatment options and services have become available to the public, health care businesses are increasingly competing with one another for the same patients. The technology of health care delivery now permits physician offices and specialty outpatient clinics to perform many of the same procedures which hospitals perform, and procedures which just a few years ago required hospitalization can now be performed on an outpatient basis—sometimes more effectively and at a lower cost to patients and insurers. Even in the field of long term care, many patients who used to require care in a nursing home can now be taken care of at home through home health agencies.

As various types of health care businesses are able to perform many of the same services, they face double-edged competition for patients:

- Competition among like providers (i.e., hospital to hospital competition).
- Competition across industry lines (hospital-physician, hospital-clinic, hospital-home health competition).

Although physicians remain influential in controlling patient care and in directing patients to hospitals and other health care providers, patients today have a variety of choices for both elective and nonelective health care services. In many areas, for example, a person who has an injury can drive to the nearest 24-hour emergency clinic and be competently treated by nurses and physicians he or she has never met and may never see again. Someone desiring to lose fat around the waist can watch a television advertisement for out-patient liposuction surgery, then make the
appointment, check in, and have the surgery performed by a physician he or she has never met. A person who likes the look of a hospital brochure sent through the mail may telephone the hospital and be referred to a physician on the spot.

In recognition of the greater role of patients in choosing where and from whom they will receive health care services, the health care industry has entered the world of advertising and promotion—something which would have been unheard of even as recently as the mid-1970s. From television ads to billboards to direct mail campaigns, health care providers and insurers are competing head on for the attention of the consumer. Whereas in 1980 the concept of “hospital marketing” was virtually unheard of, today if a hospital does not have a marketing department or a marketing plan it is viewed as backward and out of touch with the realities of today’s “market driven” health care industry.

In addition to the high level of sophistication of health consumers, employers are now exerting considerable influence upon the type of health care benefits they give their employees. Most employers are now required by law to offer HMOs and other types of managed care benefits to their employees. Instead of turning to a huge insurance company for employee health benefits and then relying upon the insurance company to negotiate with health care providers, many employers are taking such negotiations into their own hands—either as individual companies or as groups of companies in the form of “health business coalitions”—and are determining where and on what basis their employees will obtain medical care based upon what kinds of managed care contracts the employers can secure with hospitals, physicians, HMOs, PPOs, and other providers.

Thus, we can point to a number of factors which have broadened the health care market and created intense competition among health care providers and which markedly influence the market position of most hospitals:

- Advanced medical technology permitting quality medical treatment to be given in a variety of settings.

- An increasing number of physicians, including a large number of medical specialists who have their own clinics.
The advent of "alternative" health care providers such as HMOs and PPOs.

The trend toward "managed care", which has stimulated intense price competition among health care providers.

Public and private insurance regulations which encourage or require second medical opinions and which limit inpatient hospital utilization.

The increasingly aggressive role of companies in defining employee health benefits and in contracting with providers.

The Diversification of Health Care Services

The diversification of health care services among many types of providers has hurt hospitals more than any other kind of health care business. Hospitals have faced pressures to curtail patient lengths of stay and pressures to curtail costs, while at the same time the technological revolution in medical equipment has given physicians, dentists, and other health professionals the ability to compete directly for many hospital patients. These dynamics have now forced hospitals to scale back some of their unused beds while simultaneously attempting to closely affiliate with successful physicians. Hospitals now compete with one another to have successful physicians on their medical staffs who have permanent loyalties and shared vested interests, spawning a new field of activity known as "physician bonding".

At the same time that hospitals are taking defensive measures to capture physicians and their patients, many hospitals are taking offensive measures such as buying physician practices, buying or building outpatient clinics, and buying high-tech equipment to more effectively compete. Many hospitals are also attempting to "vertically integrate" their businesses by purchasing or starting businesses in other health care sub-industries such as nursing homes.
Some hospitals have grown into large, multi-faceted organizations owning outpatient clinics, emergency clinics, nursing homes, retirement centers, HMOs, and numerous other health care businesses. These "health care corporations" can be formidable competitors by offering patients the full range of health care under one umbrella organization. However, merely branching out into a diversified business does not guarantee success, for new businesses must be properly capitalized and properly managed. Thus, although the existence of non-acute care businesses under the hospital corporate umbrella can be an encouraging sign, these businesses--like other health care enterprises--add value mainly by virtue of their ability to generate net cash flow to the overall organization.

Analyzing a Hospital’s Market Area

In analyzing the patient flow of a hospital, it is important to determine how much competition for patients exists among like providers and how much, if any, competition exists from other types of health care providers within the particular market area. It is not uncommon for the majority of a hospital’s competition for patients to come from non-hospital health providers within a given market area. Attempting to determine the relative market position of a given hospital involves examining all of its competitors and potential competitors whether they are hospitals, clinics, HMOs, home health agencies, specialized physician practices, nursing homes or other types of providers.

Properly defining the "market area" itself can be important, and a hospital organization may draw upon different market areas for different types of services. For example, the normal acute care services may draw patients from a fairly confined geographic area, whereas some highly specialized service in which the hospital has a reputation may draw patients from a wide region. There is a growing tendency by hospitals in major cities to become known for certain specific kinds of care such as alcohol treatment, substance abuse, pediatric care, obstetrics and eye care. Knowing how patients are acquired, how they are retained, and what kind of competition exists--these and other related factors are critical to health care valuation. Methods of acquiring patients vary among the types of health care businesses. Although physicians generally rely upon referrals, many are now advertising either blatantly or through direct mail health education brochures. Hospitals advertise blatantly as well as through community
outreach programs. Hospital-affiliated clinics rely upon referrals and upon advertising, as well as upon their relationships with physicians. Many hospitals have established specialized types of outpatient clinics such as surgicenters, executive health screening clinics, cardiovascular clinics and other clinics which are operated apart and distinct from the "main hospital", sometimes in entirely different locations.

Cross-referrals among the different types of health businesses are common everywhere, for health care is a highly interdependent industry. It is important in determining hospital market position to identify the sources of cross-referrals to the hospital in question aside from the hospital's own medical staff and extended "family". Such sources can include nursing homes, outpatient clinics, home health agencies and even other hospitals who may not offer a particular specialized service.

Image and Reputation

The issue of hospital image and reputation can significantly affect market share and future market position. A hospital's image can be a difficult element to identify and quantify, but it is worth attempting to do so during a valuation assignment because of the potential impact upon future utilization. Although it is wise to rely upon outside marketing experts who specialize in evaluating hospital image, there are some obvious indicators of market image:

- News coverage, both positive and negative.
- The introduction of new, publicized services.
- The condition and appearance of physical facilities.
- Patient surveys and "focus group" interviews.
- Surveys which may have been conducted assessing the interest in new products or services.
- The reputation of certain key physicians who may be providing a specialized, regionally-oriented service.
• Lawsuits which attract media attention.

• Support of or problems with community groups.

• Attitudes of interrelated health professionals, especially referral sources.

• Accreditation status with the Joint Commission on Accreditation of Healthcare Organizations.

• State or federal survey status.

Analyzing and Projecting Patient Utilization

When it comes to evaluating past patient utilization and attempting to project future utilization, several factors are important:

• The absolute trend of patient utilization of the hospital in question.

• The competitive position of the hospital relative to other health care providers.

• The type of patients who are served by the business in terms of the relative profit margins of their case types (e.g., obstetrics, medical-surgical, psychiatric, orthopaedic, pediatric, emergency).

• The patients’ type of payment (e.g., private pay, private insurance, managed care plan, Medicare, Medicaid).

As many administrators of inner city hospitals know, it is one thing to have a high occupancy rate and quite another thing to have beds occupied by patients who are reimbursed at a positive cash flow to the hospital. In fact,
the whole issue of "uncompensated care" is affecting not only Medicaid and publicly-owned hospitals but also a number of hospitals with high Medicare populations--especially those whose DRG costs are higher than the norm.

The objectives of studying a hospital's market position are twofold:

- What has been the past patient utilization and patient mix, and what factors have contributed to this past and present status?

and...

- What is the reasonably projected patient utilization and patient mix based upon the institution's recent trends, its relative market share, its medical staff, its new services, its plans for the future, its overall image, and the competitive trends in the area?

In a hospital valuation or feasibility study it is customary to bring in outside experts familiar with analyzing hospital markets and the dynamics underlying those markets. Some of the information to be examined includes:

- History of the business and its growth patterns.

- Occupancy and utilization statistics by major category of service--inpatient and outpatient and, if appropriate, by subsidiary--for at least the prior three years.

- Occupancy and utilization statistics by type of payor for at least the prior three years.

- Analysis of rates and charges for major units of service, and a comparison of these with competitors. Rates and charges per unit of service in comparison with competitors can be useful in certain situations and highly misleading in other situations. Knowing how the rates of a given health care business compare to other businesses in its market can provide insight into why
certain utilization trends can be expected to occur. Rates and charges, however, are related to the types of payors and to service intensity, and caution should be exercised when reviewing comparative pricing of services.

- Identification of competing hospitals, their services, their utilization, and their overall financial condition.

- Identification of major competing non-hospital health care providers and their growth trends and impact, if any, upon the hospital in question.

- Identification of planned new entrants into the local health care market.

- Geographic patient origin studies performed over the past five years, comparing trends and changes in patient origin.

- Identification of secondary patient origin sources for specific specialized hospital services which may have a "regional draw".

Medical Staff Evaluation

The analysis of a hospital's medical staff can be as important as studying patient origin and type, for the medical staff of a hospital is its primary "feeder" of patients. Following are some of the factors to be studied in evaluating the impact of the medical staff upon past and projected patient utilization:

- Active medical staff by specialty and age.

- "Campus-based" active medical staff versus "off campus" staff.

- Admissions by service category by physician.

- Admissions by type of payor by physician.
Typical Hospital Medical Staff Organization

Medical Staff Executive Committee

Chief of Medical Staff

Vice President of Clinical Services

Department of Surgery
Department of Medicine
Department of Outpatient Care
Clinical Support Services

Surgical Subspecialties
Medical Subspecialties
Outpatient Clinical Services
Laboratory Pharmacy Radiology Pathology
- DRG analysis by physician.
- Non-affiliated referrals to the hospital by major category of referral.
- Analysis of specific physicians accounting for 50% or more of the hospital’s admissions on a combined basis.
- Adequacy of specialty coverage versus community medical needs and compared with competition. Where are specialists needed?
- Analysis of physicians competing directly with the hospital in its market area--those providing services which the hospital also provides.

Projecting Future Market Position

The end result of the analysis of market position is a reasonable five-year projection of patient utilization and rates by type of service and by type of payment, which when multiplied together give total revenues. In this way, the intimate and logical relationship between market position and revenues becomes clear. Patient utilization, market position, and market share should be evaluated keeping in mind their influence upon cash flow. One should look for a logical flow of the historic, the present, and the future patient utilization, and dramatic deviations from trends need to be well-explained.

Above all, the assumptions underlying patient utilization forecasts need to be carefully examined. Otherwise, utilization forecasts are just numbers on a page which, if not properly justified, will lead to incorrect cash flow projections and an inaccurate valuation.
The Analysis of Regulatory Position

The Impact of Regulatory Position Upon Value

As highly regulated organizations, hospitals constantly incur costs associated with their conformance to local, state and federal regulations imposed by dozens of agencies. Some of these costs can be significant and can affect future cash flows, thereby influencing value. Any thorough hospital valuation needs to take into account the organization's own regulatory history and its expected regulatory status as measured in terms of additional capital and operating costs.

By "regulatory position" we are referring to a hospital's standing with various outside organizations which in some way regulate aspects of a hospital's facilities or business. Some of these organizations include:

- Federal, state and local legislative bodies.
- Agencies of the federal government, including the Health Care Financing Administration, the Social Security Administration, the Environmental Protection Agency, the Department of Energy, the Office of the Inspector General, the Bureau of Quality Assurance and numerous other agencies.
- State and federal licensing agencies.
- Municipal and county health departments and zoning commissions.
- Third party payors such as insurance companies, public health departments, Medicare and Medicaid.
- State and local health planning agencies.
- Medical and hospital peer review organizations such as the Joint Commission on Accreditation of Healthcare Organizations.
- State and local fire and life safety inspectors.

Hospitals and their various departments and subsidiaries are among the most highly regulated of all businesses. They are regulated from several points of view:

- Their physical facilities must meet certain standards and conform to certain codes.
- Their operations require certain minimum licensed staff.
- The materials they use—especially drugs and nuclear medicine materials and substances—are tightly regulated.
- They must maintain certain licenses and certain forms of insurance coverage.
- Payments to hospitals by government third party payors are regulated in utility-like fashion.

These major categories of regulation have an impact upon revenues, expenses, liabilities and capital expenditures. Regulation in its various forms can have a significant effect upon income and cash flow—and, therefore, value. For example, if a hospital has been mandated to upgrade certain facilities by a regulatory agency, the cost of such renovation must be taken into account in calculating future net cash flow, and the impact upon cash flow will depend upon the amount of added cost as well as the method by which the improvements are financed. Similarly, if new regulations require a hospital’s department is required to hire new types of highly skilled licensed staff, the department’s expenses and cash flow could markedly change.
The point here is that regulation imposes ongoing and future costs upon hospitals which are not always obvious in an examination of financial statements or past history, and if the value of a hospital business is tied to its ability to generate future net cash flow, then these regulatory costs—both operating and capital costs—must be taken into account during the valuation process.

Understanding the Scope of Regulation

The examination of a hospital’s regulatory status involves both issues specific to the hospital in question and issues which affect the hospital industry as a whole. In general, a hospital’s regulatory status will depend upon:

- Regulatory trends affecting the entire hospital industry.
- Regional and local regulatory actions.
- The interaction of a specific hospital in question with various regulatory agencies and organizations.

It is important during the hospital valuation process to adequately assess the impact of existing and pending legislation, executive branch directives, insurance industry guidelines and other regulatory trends affecting the national hospital industry as well as those affecting hospitals within a state or region. Two widely known examples of governmental action which dramatically affected the nation’s hospitals during the 1980s were the implementation of the DRG-based reimbursement system and the elimination of the Periodic Interim Payment (PIP) program. Those actions had far-reaching effects which influenced the cash flow of virtually every hospital in the United States. Selected other examples of nationwide regulatory initiatives include:
• Medicare/Medicaid fraud and abuse legislation and HCFA regulations.

• Regulations implementing automated Medicare claims processing.

• Department of Energy regulations concerning the proper shielding of CAT scanners and other radiological devices.

• Environmental Protection Agency medical waste disposal regulations.

• Office of the Surgeon General's advisories on the safe handling of AIDS patients.

In some instances, regulation of other types of health providers can affect hospitals. For example, the federal government is moving toward greater regulation and standardization of physician fees through "relative value scales"—a concept not dissimilar in theory to DRGs. As physician fees become more tightly regulated, hospitals will inevitably be affected, in some cases positively and in other cases negatively. Another example of this indirect influence of regulation is the regulation of nursing homes. Hospitals who own nursing homes or operate long term care beds will find their expenses in this area increasing during the early 1990s as an entire new set of staffing and quality of care regulations is phased in by the federal government. Many states are also turning to diagnosis-based and intensity-based reimbursement of nursing home care, utilizing RUGs (Resource Utilization Groups), a concept not dissimilar to DRGs for hospitals.

State and local regulation can also affect hospitals. The most obvious example of the impact of state regulation is the regulation of Medicaid payments. Unlike Medicare, which is a national program with fairly consistent standards for hospitals, Medicaid is a shared federal-state funding program and is administered largely by the states to pay for the health care of the "medically indigent" population; Medicaid covers hospital care, nursing home care, physician office visits, outpatient care and other related services for those who qualify. However, the relative economic condition of various states, the attitude of various state legislatures, and the
KEY FACTORS IN EVALUATING REGULATORY POSITION

- Status of Licenses and Permits
- State and Federal Inspections
- J.C.A.H.O. Surveys
- Malpractice or other Litigation
- State and Federal Regulatory Climate
- Reimbursement Regulations/Controls
relative indigent populations of the various states all cause differentiations in the administration and reimbursement of the Medicaid program, and because of poor funding in many states hospitals are not fully reimbursed for their costs in treating Medicaid patients, leading to a growing financial problem known as "uncompensated care".

Another example of state and local regulation of hospitals is the area of health planning. Although the Health Systems Agencies were abolished in the early 1980s, most states still have Certificate of Need laws and still exercise some forms of health planning at the state level. With hospital occupancy rates at low levels in most areas, there is no longer a rush to expand beds; however, hospitals still need to replace outmoded inpatient facilities, and there are numerous types of outpatient facilities and major equipment purchases which can fall under the jurisdiction of state health planning agencies. From a valuation standpoint, an assessment may be required of the ability of a hospital to obtain the necessary approvals to replace outmoded facilities or enter into new activities.

**Hospital-Specific Regulatory Issues**

As indicated above, the present and future regulatory position of a hospital is determined by two factors:

- The general local, state, and federal regulatory climate, including the legislative and reimbursement trends;

and...

- The specific regulatory status of the hospital in question, including its relations with government regulators, its contracts with third-party payors and its anticipated operating and capital requirements resulting from regulatory activities, recently passed legislation or recently conducted inspections.
Identifying and evaluating the present regulatory status of a hospital involves looking into several key areas of regulatory activity:

- **Licensing**: It is usually necessary to determine whether licenses are current and when they come up for renewal. Hospitals operate numerous departments which require separate licensure. If licenses have ever been suspended or revoked, the details should be investigated.

- **Professional Standards Certifications**: Various health professionals are licensed to operate within specific hospital departments and to manage the departments under established guidelines. Surveys of professional certification conducted by the federal government, state government and municipal government need to be examined to determine their status. Many hospitals are surveyed for accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the detailed survey results should be examined by anyone performing a hospital valuation, since JCAHO surveys investigate issues such as physical facilities, medical staff adequacy, management and quality of patient care. In addition, some of the medical specialty societies conduct independent surveys of specific hospital departments from time to time to make certain that the services are operated in accordance with certain professional standards.

- **Facilities Surveys and Inspections**: Numerous federal, state and local governmental agencies inspect all or portions of hospital facilities periodically. Fire, life safety and environmental inspections are common and frequently result in the need to remodel or modify facilities. In addition, hospitals surveyed by the JCAHO are reviewed for the adequacy and condition of facilities. The objective during a valuation is to identify areas where the hospital is mandated to make physical improvements and to identify the costs and timing of such improvements.
• **Citations and Deficiencies:** One needs to examine citations and deficiencies identified by governmental or professional organizations as well as the actions, if any, taken to correct such problems. Citations and deficiencies can apply to physical facilities as noted above or can apply to less tangible areas such as quality of care, staffing and professional certification. Again, the objective is to identify areas which will need to be addressed in the foreseeable future and, where possible, to pinpoint the costs of correcting deficiencies.

• **Regulatory Litigation:** Few hospitals are able over time to avoid some type of litigation or administrative hearings with regulators. Hospitals have a right to defend what they believe to be sound decisions. From a valuation perspective, it is important to determine the type of litigation or administrative action as well as what the cost (or revenue) outcome of such actions has been or is expected to be. Obviously, serious license revocation actions have a different implication than routine quarrels with regulators over architectural designs or equipment maintenance.

• **Malpractice Litigation:** The overall adequacy of a hospital’s malpractice insurance and risk management programs can influence cash flow, balance sheet reserves and operating expenses. Although this topic will be reviewed in a coming section, from a regulatory standpoint the objective is to review the malpractice history of the institution, focusing especially upon recent malpractice lawsuits or other actions. Although the future level of malpractice liability is difficult to predict since medical malpractice is such a case-specific matter, the general “track record” of a hospital in this area can point the way to its future potential liabilities.

• **Reimbursement Litigation or Administrative Action:** Nearly every hospital has been involved in reimbursement appeals or contested settlements of one kind or another, and the larger, complex medical centers may be engaged in several simultaneous reimbursement actions affecting different departments or subsidiaries. Some “actions” merely involve accountants and attorneys
representing the hospital before intermediaries in non-formal settings, whereas others may actually go to administrative courts or even into the civil judicial system. In a valuation assignment, it is important to distinguish between routine actions of this nature and those which are more serious and potentially more costly. By examining the past and present history of the institution in this area, it is possible to make reasonable predictions of potential liabilities or potential settlements. Of course, the area of reimbursement is strongly influenced by the quality of the institution's financial management.

- **Regulatory Actions Against Physicians or Staff:** Regulatory actions directed toward health professionals such as license revocation proceedings, fraud and abuse allegations or malpractice suits can impact a hospital as significantly as the individual professionals who are involved. Malpractice and fraud and abuse can result not only in monetary liabilities to the hospital but also in serious damage to an institution’s image and reputation. The financial impact of such events will affect the underlying value of the business depending upon the magnitude of the problem.

- **Discrimination, Restraint of Trade, and Other Actions:** Actions related to sex discrimination, sexual harassment, restraint of trade, conspiracy to defraud, conspiracy to interfere with contracts, conspiracy to fix prices, conspiracy to monopolize—all of these and more are regulatory issues which can impact value depending upon their severity. A hospital does not have to be a guilty party to suffer serious financial consequences from legal or regulatory actions. Hospitals can spend hundreds of thousands of dollars defending themselves in civil proceedings, and legal, accounting and consulting fees can add up to tremendous liabilities draining cash flow.

- **Actions Challenging Tax-Exempt Status:** During the turbulent 1980s in health care, the not-for-profit segment of the hospital industry saw challenges arise from local, state and federal authorities questioning the tax-exempt status of many hospitals. In some cases these
challenges came from municipalities or states wishing to have not-for-profit hospital "corporations" begin paying real estate and sales taxes. In other instances, the federal government—usually through the Internal Revenue Service—questioned the underlying basis for a hospital's eligibility for tax-exempt status. Many of these challenges revolved around questions about a hospital's "charitable purpose"; the concept of exempting certain charitable organizations from taxes dates back to 1601 to Queen Elizabeth I of England. In the United States this concept was formally written into laws and regulations by the Congress and the Internal Revenue Service. In any event, the loss or even partial loss of tax-exempt status brings huge costs to a hospital, significantly affecting cash flow and value. In a valuation assignment of a 501(c)(3) or otherwise not-for-profit hospital, qualified attorneys should be asked to do a "tax compliance audit" to determine whether the hospital has been or could be exposed to regulatory actions at any level in this sensitive area.

- **Internal Revenue Service Actions**: In addition to questioning the tax exempt status of a hospital or medical center, the IRS has the power to audit such organizations and to claim what they may judge to be "unrelated business income".

Other recommended steps are to investigate the following:

- Check the status of licenses. Are they current and are they unrestricted? If licenses are temporary or qualified, why?

- Has there been litigation with regulators? Was Medicare or Medicaid fraud and abuse ever alleged?
- Check reports of physical inspections and quality inspections conducted by the state and by the federal government. Are there citations, deficiencies, or penalties? Was decertification ever threatened or carried out? Have deficiencies been corrected?

- Often it is a good idea to talk with the state regulators, especially with respect to a facility with a history of regulatory citations. The state regulators are not difficult to find since they sign all reports and correspondence.

- If the facility is JCAH accredited, ask to see the last two or three accreditation survey reports.

Determining the regulatory history and status of a health care business is not difficult, although it can be time consuming for the more complicated enterprises such as hospitals. Assessing the future regulatory environment and how that will affect the regulatory position of the business in question is a more difficult, more subjective task. Information concerning the general regulatory climate of a health care business can be obtained from the business’ trade association. All health care sub-industries have active trade associations, and an important role of these associations is to keep track of and lobby for or against legislation and regulations. Three levels of legislative and regulatory activity need to be looked at: the local, the state, and the federal activity.

Local regulatory activity of health care usually takes the form of zoning and building code regulations. Municipal governments also regulate ambulance services and other emergency services such as paramedics. State regulatory activity of health care usually includes inspection of physical facilities, certificates of need, licensing of health professionals, licensing of facilities, quality assurance, care of the medically indigent (Medicaid), and all forms of price and rate controls.

Federal regulatory activity can include all of the above activities, and federal regulations are nearly always adopted by the lower forms of government. Federal regulatory activity includes standards for physical facilities,
inspection for quality control, environmental protection standards, standards for medical professionals, criteria for non-for-profit status, control of medical research and medical education, regulation of Medicare and Medicaid reimbursement, occupational health and safety (OSHA) and numerous other activities.

Studies have been conducted showing that complex health care facilities and businesses such as hospitals are regulated by several hundred local, state, and federal agencies. No independent evaluator has the time to thoroughly investigate regulatory trends among all of these agencies, and therefore the health care trade associations serve a crucial purpose by keeping track of legislation and regulation affecting their respective constituents. The important goal of examining these trends is to isolate those which have or could have a significant impact upon the facility and business in question and to attempt to quantify that impact where possible.

Regulatory trends affecting a specific facility based upon its own regulatory history should be easy to identify. If a facility has been cited for not having proper bathroom facilities, the cost of improving those facilities to conform to codes must be taken into account in the valuation process. If the liability insurance funds were found to be inadequate, the cost of proper liability insurance needs to be taken into account in projecting future expenses. If the ratio of nurses to patients was found to be inadequate, new nurses will need to be hired and their cost factored into operating projections.

**Regulatory Position and Value**

In conducting a hospital valuation, one must rely upon both the hospital's own administration and outside parties such as the hospital's attorneys and accountants to properly evaluate the institution's regulatory position. Studies have been conducted showing that hospitals are regulated by dozens of local, state, and federal agencies as well as by third party payors and health care industry organizations. It is neither possible nor necessary to examine every single regulatory area during the valuation process, but it is important to identify those areas which have influenced or could influence the institution's financial or market status.
Often, the impact of regulatory factors requires a judgement as to how materially such factors will affect a specific hospital. Regulatory issues take on importance with the context of hospital valuation by virtue of their ability to influence:

- Capital expenditures on physical facilities and equipment.
- Balance sheet reserves, liabilities and contingent liabilities.
- The types, numbers and levels of staffing.
- Other operational expenditures.
- Special allowances, penalties or settlements.
- Changes in tax-exempt status or in the taxability of income.

Assessing the future regulatory environment and how that will affect the regulatory position of the business in question can be a difficult and a somewhat subjective task. Information concerning the general regulatory climate of the hospital industry can often be obtained from hospital trade associations such as the American Hospital Association and other professional associations such as the Healthcare Financial Management Association or the American College of Healthcare Executives. An important function of these associations is to keep track of and to take positions for or against legislation and regulations. Three levels of legislative and regulatory activity need to be looked at: the local, the state, and the federal activity. All three of these areas impact the regulatory position of hospitals and, in so doing, impact operating performance, capital requirements and, ultimately, value.
The Analysis of Hospital Operations

The objective in analyzing a hospital’s operations during the valuation process is to identify those elements relating to the management, staffing and programs which affect the organization’s patient utilization, reputation, physical facilities and financial performance. The end result of an analysis of operations is to determine the strong points and the weak points which affect the institution’s financial performance, community image, market share and future capital needs. In theory, the analysis of “operations” can mean almost any aspect of the hospital in question; in practice, there are several key areas one can isolate to evaluate operations:

- Quality and depth of top management.
- Quality of department heads and key supervisors.
- Quality and adequacy of nursing staff.
- Performance criteria versus competitors.
- Management control systems and information systems.
- Financial management systems.
- Labor relations.
- Medical staff quality control.
- Scope and quality of medical programs.

One will immediately note that the above list contains areas which lend themselves to objective, quantitative analysis as well as areas which require more subjective analysis. Underlying all of these items is a fundamental question which needs to be asked about a hospital being valued:
To what degree is the institution able to provide *quality* care, *relevant* to its market(s), *competitively*, *effectively* and *efficiently*?

To a significant degree, the object of examining a hospital’s operations is to identify the quality, effectiveness, and efficiency of the organization. As with other aspects of the valuation process, both the hospital’s management and outside experts must be relied upon to one degree or another for information and analysis; unlike some other aspects of the valuation process, this stage of valuation often requires careful judgments which are difficult to quantify.

The circumstances under which the valuation is being performed can affect the approach to this phase of valuation. For example, valuing a hospital that is a going concern which is being sold or refinanced but where the existing management and staff will remain in place is a different matter from evaluating a business which is being sold to new management—although in both cases the staff below the management level may remain in place.

**Quality of Care**

Both the viability and the value of a hospital are strongly affected by the *quality of care* it provides. And quality of care is, in turn, influenced by the quality of a hospital’s medical staff, nursing staff and related professionals; quality is also influenced by the availability of proper facilities and equipment. Consumers and regulatory agencies are intently quality conscious when it comes to health care services.

Although quality of care is difficult to measure, government regulators as well as health care self-regulatory bodies such as the JCAHO are increasingly scrutinizing health facilities based upon "patient outcomes". Despite the reluctance of some physicians and health care administrators to attempt to measure quality of care, the impact of quality upon reputation, patient mix, scope of services and cash flow is significant enough to make a genuine attempt during a hospital valuation effort. Some general indicators of hospital quality of care do exist:
• State and Federal inspection reports listing code citations and deficiencies.

• Surveys by the JCAHO.

• The degree of patient retention and repeat business.

• The qualifications of medical staff.

• The availability of qualified nursing staff.

• For inpatient facilities, the relative number of infections, complications, accidents and deaths and the evaluation of other "patient outcomes".

• The number and types of malpractice or damage suits.

Although the above measures can be difficult to ascertain, quality of service affects many aspects of a health care business, including the ability to attract and retain patients, the ability to attract and retain qualified staff, image in the community, relations with regulatory agencies, and reimbursement and cash flow. For these reasons, most health care providers believe that good patient care is good business.

**Effectiveness and Competitiveness**

The effectiveness and competitiveness of a hospital is related to the quality of health care, the capacity to provide care, the pricing of services, the relevance of services to the market and the existence of similar services within the market served by the hospital in question. In a multi-faceted hospital these factors may vary on a department-by-department basis, and it may be necessary to segment the analysis of a hospital's effectiveness into the key departments. Effectiveness and competitiveness are related to the following factors:
- The quality of the medical staff.
- The range of medical programs and their "fit" into the markets served by the hospital.
- The ability to provide adequate, qualified nursing staff.
- Areas of special regional excellence.
- The ability of the institution to "capture" patients within its market for the services it offers.
- The condition of facilities and equipment.
- The interaction between the hospital and other types of health care providers.
- The utilization and financial performance of the hospital in question versus other providers in the market.

Like quality of care, the concepts of effectiveness and competitiveness are somewhat subjective. In some ways, these factors are easier to measure when they are lacking; one notices poor quality, ineffective management and a poor market position. Of course, these factors do not always apply across all the departments of a hospital. Some departments may be better managed and better positioned in the market than others depending upon their physicians and staffs, the facilities and equipment they have and the relative availability of their services in the overall market served by the hospital.

Efficiency

Efficiency has become a critical element in the survival of hospitals. Because of dramatic rises in health care costs, which many politicians and regulators have characterized as "uncontrollable" health care inflation, both the government and the private insurance industry have attempted to force
health providers to become more efficient, primarily through the use of price and reimbursement regulation. In health care, efficiency means providing quality care with "appropriate" resources and at the lowest possible cost.

A striking example of forcing efficiency upon hospitals is the DRG program. DRGs--called "Diagnostic Related Groups"--are regulations stipulating how long individuals of various age groups should be hospitalized for particular illnesses. The government has stipulated certain numbers of "allowable" hospital days per illness per age group, and deviations from these standards must be well-justified or the hospital and the physicians are not reimbursed for the amounts of the deviations. DRGs have forced hospitals to more efficiently allocate nurse staffing and other resources. It is likely that efficiency standards will eventually be imposed upon physicians, clinics, and other types of health care providers, mainly through controls upon third party payor reimbursement.

The measurement of a hospital's operating efficiency is a somewhat easier task than measuring the quality of care and the effectiveness of services. There are some objective, quantifiable indicators of efficiency:

- Cost per patient day versus competing hospitals.
- Cost per major DRG category versus competing hospitals.
- Ratio of staff per patient versus competition for major departments.
- Degree of deviation from DRG standards or similar standards.
- Amount of "uncompensated care" as a percent of revenue.
- Percentage and amount of contested third party claims.
Providing quality care in an efficient hospital operation can be extremely difficult in the highly regulated world of health care. Some health professionals believe that the government has crossed the line between encouraging efficiency and mandating lower quality health care, while on the other hand, many insurers are convinced that the entire health care industry can become even more efficient without compromising quality. The quality of health care and the amount of health care a person needs are subjective concepts. As the technology of health care permits people's lives to be prolonged or improved through expensive procedures involving organ transplants, limb replacements, and other high-cost care, the tension between providing health care and paying for health care will increase, forcing society to ultimately decide "appropriate" levels of care.

Nonetheless, the hospital which prospers and acquires value as an operating business in the future will be one which can properly define its market, adhere to high quality standards, and control its expenses.

Management and Personnel

Of all the ingredients involved in determining the value of a hospital, the management, the board of trustees, the medical staff and the other professional personnel are among the most important. The market position, the condition of facilities, relations with regulators, quality of service—all of these crucial elements derive from the people managing the business and providing the patient care, and the value of the organization is intimately related to the quality and performance of its management and its staff. Where a hospital's operations are concerned, the existing management and the institution's operating history have at least as much influence upon value as do plans for the future, and plans for the future need to be looked at realistically to determine their degree of implementability, whether or not the hospital's existing management is expected to remain in place.

Although the quality of management and staff can be a function of education, credentials and experience, the true measure of key operating personnel lies in the operating results and characteristics of the business itself. Some key questions need to be asked concerning a hospital's management:
KEY FACTORS IN EVALUATING OPERATIONS

- Quality/Depth of Management
- Quality of Care
- Historical Financial Results
- Auditors' Management Letters
- Staffing and Expense Levels
- Cost Reports
- Accounts Receivable Management
- Level of Uncompensated Care
• What kind of organizational and management structure is governing the hospital? Does the structure lend itself to efficient operations?

• How active is the board of trustees?

• Is there a strategic plan and a capital plan, and are they followed and updated?

• How active are the medical staff committees and is there meaningful peer review?

• What is the condition of the facilities and the equipment? Is management providing state-of-the-art health care, within reasonable limitations?

• What has the business accomplished? Has market share increased or decreased, and why?

• Is the business attaining the operating margins it should? How does the hospital compare with similar competitors on the basis of various financial performance criteria?

• Does the hospital have a good reputation? Is it known for quality and for keeping up with medical technology?

In addition to addressing the above questions, it is necessary to examine the area of labor relations. This involves relations with unions, relations with nonunion personnel and relations with independent contractors.

Unionization has not overwhelmed the health care industry as a whole, but unionization has seriously affected certain segments of the industry, especially in certain geographic areas. Areas which have had a history of heavy unionization of industry in general also logically tend to be more unionized in the field of health care. Unionization can affect both the financial performance of a hospital and the quality of staff and patient service. Where unions are present in health care, terminating bad employees can be difficult or impossible, and in a business or service as people-sensitive as health care, a few bad employees can cause a negative ripple effect, tarnishing the entire business.
TYPES OF HOSPITAL INFORMATION SYSTEMS

- General Ledger Accounting
- Billing and Collections
- Cost Reporting
- Budgeting
- Internal Financial Reporting
- Admitting Systems
- Outpatient Treatment and Collections
- Medical Records/Treatment Records
- Patient Scheduling
- Nurse Staffing Systems
Most hospitals are only partially unionized. Maintenance workers, drivers, kitchen workers, and other workers with little or no patient contact may be unionized without affecting nurses, nurse aides, social workers, and others. Several local organizing units of national unions, however, have made inroads in unionizing nurses in certain parts of the country. Where unions play a significant role in a health care facility, the value of the facility can be affected in several potential ways:

- The raw financial impact of paying higher wages.
- Contingent liabilities for future raises and higher employee benefits under union contracts.
- The lowering of operating efficiency.
- Negative effects upon the quality of service and the motivation of employees.
- Restrictions upon the ability to make personnel additions, deletions, and other changes which, in turn, can affect efficiency, competitiveness, and market share.

Contracts, affiliations and agreements with outside parties can influence hospital operations and financial performance. On the one hand, independent contractors often provide valuable services and patient referrals. On the other hand, contractors need to be evaluated based upon their costs in relation to the services they deliver and in relation to the alternatives available to the hospital.

Some hospitals and hospital subsidiaries rely heavily on "contracted management". Outside specialists are frequently brought in on a contractual basis to manage certain departments, and in some cases management companies are brought in by owners to manage the entire business. Although these arrangements can be a positive influence on a health care business, this is not always the case. The expense of management contracts, the qualifications and track record of such managers, and the
continuity of their services into the future all need to be examined. The issues often come down to who is doing the on-site managing and service delivery and how dedicated they are to the success of the health care business in question.

When a valuation is performed where one hospital plans to assume control of another hospital, employment contracts and contracts with independent agents need to be evaluated in light of the plans of the acquiring hospital and in light of the method of acquisition (e.g., acquisition of stock, merger, acquisition of assets). The entire area of personnel compensation, employment contracts, vendor contracts, specialized provider contracts and contracts with unions needs to be carefully examined during the valuation process. These and other types of contracts can create significant unalterable future obligations which can impact cash flow and value.

Whether a hospital is unionized or not, employee benefits need to be examined carefully; in hospitals the personnel and related benefits costs are usually one-half to two-thirds of total operating costs. Benefits are not necessarily negative in terms of value; keeping employees who provide good service and enhance the image of the business is as important as knowing what level of employee benefits is appropriate.

Management Systems

The quality and level of sophistication of management information systems and financial control systems can be as important to the overall condition of a hospital as the quality of patient care. It is one thing to be good at providing patient care and another thing to be properly compensated for such care.

Management systems typically fall into four general areas:

- The management of patient care.
- The management and maintenance of physical facilities and equipment.
• The management of staffing mix and levels.

• The management of accounts receivable--billings and collections.

The underlying question with respect to all three areas is:

Is there a recognition of the importance of management systems, are there personnel capable of implementing such systems and are such systems in place?

When people think of "management systems", they often confine their thinking to financial management systems such as reimbursement, billings, collections and capital finance. However, in the modern day setting of highly regulated hospitals striving to cope with DRG restrictions and the issue of "uncompensated care", systems that assist a hospital in operating at an efficient staffing level and with proper facilities can be at least as important as traditional accounts receivable management.
The Evaluation of Physical Facilities

The Effect of Facilities Upon Value

In the customary valuation of a hospital, a physical inventory of all facilities and equipment is taken so that the "hard assets" can be identified and analyzed. A physical inventory can be limited to the major items, especially if the purpose of the valuation is to arrive at an income-oriented value. In any purchase which is structured as an asset purchase, however, it is advisable to have as complete an inventory as possible. The evaluation of a hospital’s physical facilities needs to be conducted from several points of view. Such an evaluation should be able to determine:

- The original cost basis and the reimbursement basis of the facilities and equipment.

- The replacement cost of the facilities and equipment.

- The depreciated value of the facilities and equipment.

- The existing condition and functional utility of facilities and equipment and the identification of items which are obsolete.

- Required improvements, if any, of facilities and equipment and the costs of such improvements based upon:

  a) Federal or state inspections.

  b) Accreditation surveys by the JCAHO.

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c) Improvements considered imperative by the medical staff.

d) Any other improvements based upon obsolescence.

Identification of facilities and equipment on the basis of the above criteria will permit various types of asset-based valuation techniques to be utilized depending upon the objectives of the valuation itself. Note that the above list includes an identification of required improvements. Although this step involves a certain amount of judgment as to what is "required" and what is not, it is an important step if one is to arrive at a realistic valuation of physical facilities, especially if the valuation relates to the merger or purchase of a hospital.

Identifying required improvements to physical facilities is not mandatory in undertaking a hospital valuation, but this step is strongly recommended. The reason has to do with the concept of "value" as being the future ability of a business to generate a return on investment. If one wishes to obtain a realistic projection of all future cash flows, then cash outlays attributable to required improvements of physical facilities and equipment become as important as cash outlays for personnel and other operating expenses. Although caution needs to be exercised in defining "required improvements" to obtain a fair and realistic valuation (by differentiating between required improvements and desired improvements), to ignore such requirements would mean ignoring a significant area of influence upon future cash flow and, therefore, upon the present value of the hospital as an operating entity.

The replacement cost, reimbursement basis and depreciated value of facilities and equipment are standard elements of valuation, but these concepts have limited uses which need to be recognized depending upon the purpose of the valuation. Valuation of hospital facilities for purposes of insurance, determination of tax treatment, and determination of the cost basis for reimbursement of "capital items" are all legitimate, but limited purpose, types of valuation. The valuation of strictly physical assets is important within these contexts but is not to be confused with assigning a valuation to the hospital as an operating business entity.
KEY FACTORS IN EVALUATING PHYSICAL FACILITIES

- Conformance to Fire, Life Safety, Licensing Codes
- Condition of Physical Facilities Relative to Competitors
- Regulatory Requirements to Upgrade Facilities
- Functional Obsolescence of Buildings
- Functional Obsolescence of Equipment
- Required Improvements from a Functional, Regulatory, and Competitive Standpoint
The Limitations of Hospital Physical Assets

We have stressed that with respect to hospitals, the physical assets assume importance only when they are earning assets within the business operation. Because the resale market and salvage value of these assets is limited by their specialized nature and because they are not usually convertible to alternative uses, the concept of "market appreciation" of health care facilities and equipment does not apply. Hospitals are not like fine residential neighborhoods, where values consistently increase. The value of hospitals lies in their ability to operate as hospitals, and to maintain their value they must constantly upgrade physical facilities, medical equipment and overall patient care services.

This does not mean that the value of a hospital cannot increase; it can increase as a going concern. To do so, the facilities and equipment must remain up-to-date, and the other business fundamentals must be strong. As only one element of a hospital's business, the physical facilities are important but cannot viably achieve their fullest value except as part of an ongoing operation. From a valuation standpoint, it is necessary to determine whether the facilities and equipment are reasonably up-to-date and to identify those required improvements which must be made. Because of the rapid rate of technological change in health care delivery, few hospitals or other types of health care facilities remain truly "state of the art" for long; the state of the art in health care is itself such a dynamic concept that one needs to be satisfied with the concept of a "reasonable state of competitiveness".

The question which is frequently asked about health care facilities is not how much of an asset the buildings and equipment are but how much of a liability they are going to become in the future and how much money it will take to keep them functionally current. Hospitals are the most vivid example of this point. The cost of building a state-of-the-art hospital has increased, on a per bed basis, nearly tenfold since 1965. Part of the increase, of course, is inflation, but a large portion of this increase is the constant redefinition of what "state-of-the-art" means; another factor driving up hospital construction and remodelling costs is the ever more stringent and more complex building, fire and life safety codes for hospitals.
Evaluating the Existing Facilities

As with other aspects of the hospital valuation process, evaluating physical facilities is best done with the assistance of the hospital's own management in conjunction with outside experts such as health care architects, contractors, and structural engineers. The input of outside experts is not always essential for the valuation of facilities such as physicians' office buildings—as long as one understands their medical equipment needs—but outside expertise is essential for the more complicated inpatient care activities of hospitals and nursing homes. How much input is necessary depends, of course, on the scope and purpose of the valuation and on the expertise of those conducting the valuation.

It is a good idea to involve the members of the administration as well as key members of the medical staff in evaluating the physical facilities of a hospital. In fact, it is virtually impossible to conduct a physical inventory, to determine the functional utility of buildings and equipment or to identify required improvements without the cooperation of those who are managing the hospital and overseeing patient care. One of the most important individuals to include in this process is the hospital's own director of buildings and grounds (called by different titles depending upon the hospital in question).

In examining the existing condition of facilities and equipment, several issues are involved:

- What is the overall appearance of the hospital or medical center from a marketing and image point of view?

- To what degree do the facilities permit modern patient care programs to be carried out?

- Do the facilities and equipment permit the hospital to be responsive to its market(s)?

- What is the condition of the physical plant and what are the problem areas?
• What is the condition of major equipment?

• What is the functional utility of the hospital’s various component areas on a department-by-department basis?

As mentioned previously, functional utility in health care is a constantly changing standard, and from a strict point of view no health facility remains "state-of-the-art" for very long. The important aspect of functional utility in this context is the relative usefulness of the facility and the equipment in light of patient care delivery, medical practice, and competitive facilities. This is why evaluating the functional utility of the hospital’s various departments usually involves interviews with management and with members of the medical and nursing staffs; in hospitals such interviews should be conducted on a department-by-department basis, since it is common to find variations in the relative functional utility among the various hospital departments.

As mentioned above, evaluating functional utility frequently involves having an outside health care architect and a building engineer examine the facilities. Some health care architectural firms employ nurses and physicians on a consulting basis so that they can render opinions as to the usefulness of the space planning and the equipment. The assessment of the functional utility of medical equipment may require experts familiar with specific types of equipment as well as the physicians overseeing the use of the equipment.

Functional utility affects several important aspects of a health care business:

• The ability to attract and retain medical staff.

• The effectiveness and efficiency of health care delivery.

• The competitive position of the health care business.

• The perceptions of the hospital on the part of patients.
Although judgments concerning functional utility are sometimes difficult to make, they are, nonetheless, necessary in the valuation of facilities where technology and delivery changes as rapidly as in the hospital field. Once an inventory of the existing facilities has been conducted and those facilities have been evaluated on the basis of their condition and functional utility, those conducting the valuation can turn to the issue of what required improvements need to be made of a hospital's buildings and equipment.

Maintaining the Regulatory Position of Facilities

Maintaining facilities from a regulatory standpoint is something which must be done in order to satisfy the many local, state, and federal regulators and to maintain the health care operating license(s) in good standing. Determining what improvements need to be made in this area involves three steps:

- Examining inspection and survey reports to identify what, if any, improvements have been ordered but not made. This step sometimes involves interviewing the outside inspectors or surveyors themselves to confirm the specific requirements for upgrading buildings or equipment.

- Determining from national and state hospital trade associations, health care architects and hospital attorneys what recent or anticipated facilities-related regulations are about to be mandated.

Some hospital executives may downplay inspection and survey reports and upcoming facility regulations, saying that they have been "grandfathered" into not having to comply or that they have been given a "verbal waiver" from such regulations. In some instances, inspectors do give facilities leeway in complying with certain codes and regulations which would be expensive or unduly impractical to implement. However, state and federal inspectors have become stricter in recent years, especially when a health
care operation changes hands. When new ownership takes over a facility, the inspectors usually take a fresh and more comprehensive look at the facility, taking the opportunity to enforce up-to-date codes and regulations.

Thus, if an existing hospital is being purchased by an outside organization, it is sometimes necessary for the purchasers to have inspectors or surveyors examine the facility to evaluate its degree of regulatory compliance and give an estimate of what codes or regulations could be expected to be enforced under new ownership. This is a crucial and often ignored area of health care valuation, but it is clear that the costs to bring a facility "up to code" are really acquisition costs which must be taken into account in any valuation involving a change of ownership.

Maintaining the Competitive Position of Facilities

Let us turn to a discussion of maintaining the competitive position of a hospital's facilities and equipment. Maintaining facilities from a competitive standpoint involves three issues:

- Satisfying the reasonable needs of the medical staff so that they can remain up-to-date in providing services.

- Keeping abreast of competitors who provide similar services, and knowing the direction of service delivery in the particular sub-industry.

- Keeping abreast of consumer expectations and maintaining a reputation of being up-to-date.

These are often subjective issues which will elicit different reactions depending on whether one is speaking with the management, the medical staff, the consumers or the competitors of a given health care business. Because subjective judgment plays a role in the determination of what facility improvements are necessary for a hospital to maintain its competitive
position, some valuation analysts would avoid this area entirely, claiming that the identification of facilities' improvements based upon maintaining competitive position is beyond the scope of traditional valuation practice.

On the other hand, hospital valuation itself is beyond the scope of traditional valuation practice, and it would seem that a truly realistic hospital valuation would need to take into consideration the relative competitive position of facilities and the expected financial requirements to maintain or achieve a healthy competitive position, since the costs to maintain or upgrade a hospital's facilities influence expected cash flow and value.

Two different attitudes can be taken in looking at the value implications of required improvements to maintain competitive position:

- Listing the facilities and equipment considered functionally obsolete and non-competitive and deducting some dollar amount from the hospital's value.

- Determining the costs to make the facilities and equipment functionally current and factoring those costs into the overall projected cash flows, which are then discounted to arrive at the hospital's overall value.

Although the first approach is useful for items which are clearly obsolete and of little or no value, the second approach is recommended as a more thorough and accurate estimation of what is expected to happen in the future—which is, after all, what hospital valuation is all about. In addition to being able to pinpoint specific estimated costs for required improvements, one can factor those costs into the total cash flow projections for the hospital, segregating such projections into "operating projections" and "capital requirements". Although it is more time consuming to identify specific facilities improvements and to estimate their costs, the end result will inevitably be more accurate than simply deducting from value those items that are outmoded.
In interviewing a hospital’s medical staff concerning required improvements to facilities and equipment, one needs to keep in mind that the medical staff will want the latest equipment and technology available. They read their trade publications, they are solicited by equipment vendors, they attend continuing education seminars and they talk with colleagues about the latest developments in their respective specialties. Balancing the desires of the medical staff with the realities of financial resources--keeping in mind what the competition is doing--is a constant struggle for hospital executives. Thus, when interviewing medical staff department heads to identify those improvements which should be undertaken for the hospital to remain effective and competitive, the object is to identify those items which are essential as opposed to simply a physician "wish list".

Consumers have become more knowledgeable about health care delivery, and they usually have high expectations when it comes to obtaining the latest treatments. The media frequently cover new health care techniques, and several cable television channels devote significant air time to health care issues. As noted earlier, consumers will often not hesitate to switch physicians or hospitals if they feel they will receive better or more advanced treatment. Having reasonably up-to-date facilities is important in attracting and retaining patients, and making such facilities known to consumers is important as well.

The reality of the hospital industry is that very few organizations can afford to keep all the latest equipment all the time. The important task in evaluating future requirements for facilities and equipment is to determine what the medical staff requires to be reasonably up-to-date and what the competition is doing. From a valuation point of view, this entire issue should be approached from the standpoint of comparing the facilities of the business being valued with competitors in the same market. If the business in question has clearly fallen behind with respect to its facilities and equipment, then the cost of becoming current must be taken into account in the overall valuation. On the other hand, if a business clearly has an edge with more advanced facilities and equipment, then such a competitive advantage would add to the relative value of the facilities and the business.
The Analysis of Financial Position

Financial Position: A Reflection of Business Fundamentals

The financial condition of a hospital is the end result, or reflection of, the various elements of its business, whether they are elements the hospital can control such as marketing, management and maintenance of facilities, or elements the hospital cannot control such as government regulation. From a valuation standpoint, it is important to understand those elements which have contributed to a hospital's existing financial position; hopefully, the analysis of the market position, the regulatory position, the operations and the physical facilities will go a long way toward this end.

Examining a hospital's financial statements without knowing much about the fundamentals underlying its business places one at a disadvantage, especially in a valuation situation. The purpose of examining business fundamentals is to be able to make reasoned assumptions about future projections of patient utilization, operating income and expenses, and capital requirements. Thus, the examination of historical and present financial statements should be undertaken in conjunction with the examination of the underlying business fundamentals so that one can truly understand the dynamics behind the financial statements.

The goal in approaching the valuation of a hospital as a complete business entity is to be able to make reasonable projections of key items:

- Patient utilization by major category of service, including subsidiaries and related organizations.
- Operating income and operating expenses, adjusted to eliminate extraordinary items.
- Receipts of special grants, gifts and bequests to the extent they are reasonably expected.

- Cash requirements for capital expenditures relating to required improvements of physical facilities.

- Requirements for set-asides of insurance reserves, contingent liabilities, malpractice settlements and other special purposes.

The objective in making such projections is to be able to construct a consolidated five year forecast of net cash flow, taking into account as many items as can be prudently predicted. The elements comprising the forecast can then be separately discounted to arrive at a reasonable range of present value of the hospital as a going concern, with values of specific assets factored into the overall business valuation as necessary (see Chapters 7 and 11). However, the present value calculations are only legitimate to the extent that the cash flow projections are meaningful, and the cash flow projections are meaningful only to the extent they take into account the analysis of the key areas of business activity discussed in this chapter:

**Market Position:**

A hospital's relative market status, the quality of its medical staff, the hospital's scope of services, and its past and projected utilization by type of patient.

**Regulatory Position:**

The degree of regulation of facilities and operations, the regulatory history of the organization, and the expected relationships with third party payors and other regulators.
**Operations:**

The effectiveness and efficiency of operations, the quality and adequacy of staffing, and the overall quality of management.

**Physical Facilities:**

The quality, capacity, and condition of physical facilities and equipment and the projected requirements for the future.

The above items and the many elements comprising them are the contributing factors to:

**Financial Position:**

The condition of the hospital’s balance sheet, its liquidity, its receivables position, its projected assets and liabilities, and the projected timing and adequacy of revenues.

**The Financial Analysis of Operations**

The financial analysis of operations involves examining a hospital’s historical financial performance and constructing base line assumptions for five year operating projections. The historical analysis of financial statements reflects the underlying business fundamentals discussed in the preceding sections of this chapter, including positive and negative aspects of the hospital’s operations and its management. In addition, the key financial executives of the hospital should be interviewed to provide information concerning financial management procedures, staff and systems; during a valuation assignment, it is necessary to analyze the hospital’s financial operations in addition to patient care, plant maintenance, purchasing and other aspects of operations.
Common Organization of Hospital Finance Office

Chief Financial Officer

Information Systems

Controller

Accounting

Billing

Third Party Collections

Internal Audit

Budgeting

Accounts

Credit/Insurance Payable

Purchasing

Banking and Finance
The financial analysis of operations includes analyzing financial results in the following areas:

- Patient care departments.
- Financial operations and financial management.
- Plant maintenance.
- Purchasing, including purchasing of both supplies and equipment.
- Personnel and staffing.

Interviews with the hospital's financial officers, combined with the examination of historical financial statements, are designed to answer the following questions:

- What has been the trend of revenues and expenses, and how does this trend relate to hospital utilization?
- Is there evidence of financial controls and sound financial planning? How extensive and accurate is the budgeting process? How do budgets versus actual results compare?
- What kind of computer systems are in place for patient admissions, patient charting, billing, collections, general ledger accounting, budgeting, staffing, management reporting and other elements of operations?
- Is the hospital able to control staffing and other expenses in relation to shifting utilization patterns, and how is this done?
- How does the financial condition of subsidiaries affect revenues and expenses of the "main hospital" (i.e., through subsidies, indirect charges, capital infusions, etc.)?
• What kinds of accounts receivable management systems are in place? Do these systems include pre-admission certification and claims counseling? Is receivables processing automated or manual, and is the hospital tied into any outside automated insurance service bureaus?

• How does accounts receivable management relate to cash flow? How does the mix of payors relate to cash flow?

In terms of examining the financial statements themselves, it is recommended that the following information be studied during a hospital valuation:

• At least the past three years’ financial statements, noting trends in income and expenses, profits, cash flow and unusual adjustments or extraordinary items.

• The Medicare and Medicaid cost reports, which should be examined by outside experts familiar with these reporting systems. These reports provide more information than customary financial statements.

• The levels of debt and equity and changes in those levels during the past several years (equity is referred to as “fund balances” in the financial statements of most not-for-profit health care organizations).

• The "per patient day" and "per outpatient treatment" revenues and costs, noting trends. Where possible, these items should be compared to the figures for similar facilities within the same market, noting the limitations of these comparisons.

• DRG costs for selected illnesses, factoring out capital costs if possible and comparing selected DRGs with those of other area hospitals of similar size and similar range of services. Many local and state agencies
publish hospital DRG information, and hospital trade associations also maintain data banks of comparative hospital financial information.

• Auditors' letters to management and any other management consulting reports commenting upon the quality of financial controls, record-keeping, and receivables.

• Identifiable tax liabilities, withholding tax problems, and any other local, state, or federal tax problems, including impending tax increases and, in the case of not-for-profit hospitals, including any threats to tax-exempt status.

It should be noted that the quality of financial management and financial controls can significantly affect hospital operations and financial performance. Poor record-keeping, inadequate financial planning, and lax billing and receivables management all negatively impact financial results. Problems with financial management can be a reflection of inadequate overall management.

Receivables management, of course, is especially important in hospitals—billing and collecting money in a timely manner from patients, insurance companies and government payors. Often, the cash flow and, therefore, the value of a hospital can be improved just through better financial management. As many hospital chief financial officers know, financial management is just as much a part of operations as providing patient care.

Analyzing historical financial statements and the related issues discussed above provides a context within which to examine future financial projections and provides insight into the potential future performance of the hospital in question. Knowing about the existing or intended management and staff as well as other operational characteristics of the business will assist in determining the degree to which the numbers contained in financial projections are numbers that can be made to happen—and the reasonableness of making projections happen is what hospital valuation is really about.
KEY FACTORS IN EVALUATING CASH FLOW

- Quality of Financial Management
- Timeliness and Adequacy of Reimbursement
- Mix of Payors
- Regulatory Controls
- Required Cash for Maintenance/Improvements
The Qualitative and Quantitative Aspects of Cash Flow

As indicated previously, the financial performance of a hospital reflects the combined effect of all of the fundamental elements of the business. Thus, the historical and projected cash flow are a reflection of:

- The past and expected market position.
- The past and expected regulatory position.
- The quality, effectiveness, and efficiency of operations.
- The requirements to maintain and upgrade physical facilities and equipment.

The concept of cash flow in a health care business--especially a hospital--possesses both quantitative and qualitative aspects. While the amount of cash generated by operations is, of course, important, so are the quality and timing of cash generated by operations. Since they are largely reimbursement-dependent businesses, hospitals are vulnerable to problems with the quality and timing of receivables. Gross accrued revenue is not as important as cash revenue, and identical types of hospitals with the same gross accrued revenues can vary widely in terms of cash flow.

The issues of quality and timing of cash generated by operations are a function of:

- The types of patients by payment category.
- The specific payors who provide reimbursement.
- The quality of financial management.
## COMPARISON OF AVERAGE HOSPITAL DAY COST BY METHOD OF PAYMENT 1987

<table>
<thead>
<tr>
<th>METHOD OF PAYMENT</th>
<th>PERCENT ABOVE OR BELOW COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>26.7% Above Hospital Cost</td>
</tr>
<tr>
<td>Blue Cross</td>
<td>16.9% Above Hospital Cost</td>
</tr>
<tr>
<td>Medicare</td>
<td>-0.4% Below Hospital Cost</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-10.3% Below Hospital Cost</td>
</tr>
</tbody>
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**SOURCES:** Urban Institute, and Celtic Life Insurance Company
These three characteristics need to be examined both in light of the past experience of the business and in light of the future plans and expectations of the business. Examining the reasonableness of cash flow projections is as important as examining the assumptions underlying revenues and expenses. If management is assuming an improvement in future cash flow, this needs to be well-documented and fully understood, regardless whether the existing hospital management is expected to remain in place or new management is taking over through a merger or acquisition.

A growing problem within the hospital industry is the problem of "uncompensated care". Although this problem is most serious in hospitals themselves, it also affects physicians, clinics and other types of entities which may be intimately related to a hospital in question. Uncompensated care is patient care which is provided but not paid for.

The major forms of uncompensated care are charity care, bad debts, and third party "allowances". Charity care is patient care which is given away as a deliberate matter of policy on the part of a healthcare business; charity care is an anticipated item. Charity care as a percentage of health care revenues has declined in recent years. Bad debts are usually amounts owed by individuals, most often the co-insurance portion of insurance coverage which, for one reason or another, individuals cannot or do not pay. Many health insurance policies have 80%-20% co-insurance, where the policy holder pays the 20% portion. As treatment becomes more expensive for certain illnesses, many people have difficulty paying this portion. Bad debts as a percentage of health care revenues have risen significantly in recent years.

"Allowances" are items which third party payors do not cover or dollar amounts they will not pay above certain "caps". The problem of allowances has grown dramatically in recent years with respect to government-based third party payors as these payors, in an effort to control costs, constantly redefine what they consider to be "allowable costs". The Medicaid program, which is a shared state-federal reimbursement program for the "medically indigent", has become notorious for reducing or capping benefits, and Medicare has also narrowed its definitions of allowable costs in certain areas, although the DRG reimbursement system has simplified some of these problems--as long as the hospital falls within its allocated DRG limits.
The problem is that once a patient is hospitalized, it is extremely difficult not to provide care, especially with the threat of malpractice suits. Physicians and clinics also face this problem.

Even when Medicaid does agree to reimburse for care, their payments can be very slow in coming, causing working capital problems for providers. The whole area of uncompensated care is most serious in the Medicaid and Medicare programs, and hospitals which are heavily reliant upon these programs can experience severe cash shortages. Anyone valuing such organizations needs to take a hard look at how realistic cash flow projections are, keeping in mind that in health care the difference between "booked revenue" and "cash revenue" can be significant.

The Healthcare Financial Management Association recently surveyed over 500 hospital chief financial officers and asked what were the major causes of uncompensated care with respect to Medicare, which comprised 38% of the revenue of the hospitals surveyed (Measuring the Financial Health of Hospitals, Ernst & Whinney and the Healthcare Financial Management Association, 1988). The CFO's listed the following areas:

- Inadequate formulas for allocating malpractice, bad debt, and home office costs.
- Failure to pay a fair return on invested capital.
- Failure to pay a proportionate share of the costs of serving indigent patients.
- Failure to consider higher costs of serving elderly patients.
- Failure to revise cost reports to include costs determined to be "allowable" by federal courts.
The regulatory trends relating to reimbursement are moving in the direction of lower reimbursement, not greater or fairer reimbursement. The recent and anticipated direction of state and federal reimbursement policy must be taken into consideration in evaluating the integrity of a hospital's revenue base. In addition, the advent of managed care is expected to eventually eliminate full indemnity health insurance, so that even private insurers will contract with hospitals for specific services at specific prices, and such contracts must be evaluated for their impacts upon hospital revenues and net cash flow.
Consolidating the Analysis of Business Fundamentals

Formulating Consolidated Projections

The purpose of evaluating the numerous factors discussed in this chapter is to gain an understanding of the various elements which affect a hospital’s utilization, facilities, operating results and cash flow. In the final analysis, the numbers in projections only reflect the ability of a hospital to manage the fundamentals of its business and to cope with the dynamically changing health care markets, and any valuation technique is only as good as the underlying data and projections upon which that technique is based.

The analysis of historical information is conducted to obtain a complete picture of the existing organization. The historical trends and present condition of the organization can then form the basis for reasonable five-year projections of revenue, expenses and cash flow. These projections, together with the physical inventory and other valuation information, form the basis for calculating hospital value. With historical information as a point of departure, examining each of the areas below should produce the following projected information for at least five years unless otherwise indicated:

*Market Position:*

Projected patient utilization for inpatients and outpatients by payor category (e.g., private pay, private insurance, Medicare, Medicaid).
**Regulatory Position:**

Projected capital expenditures to conform to codes and projected personnel/benefit expenditures to conform to expected staffing requirements. Projected known changes in workmen's compensation reserves, malpractice insurance reserves, environmental protection conformance, and financial requirements relating to other local, state, or federal codes and regulations.

**Operations:**

Projected operating income and expenses for at least five years, taking into consideration patient mix, reimbursement, uncompensated care, personnel changes, union contracts, additional reserve requirements, rate changes, debt service depreciation, and all other items which affect projected income and expenses.

**Physical Facilities:**

Projected capital expenditures for all new or renovated physical facilities and projected capital expenditures for equipment for at least five years. Such projections should take into account the need to maintain equipment and facilities in a current condition from a functional, regulatory, and competitive standpoints.

**Financial Position:** The projected statement of cash flow should take into account all of the above projections and should distinguish between operating cash flow and non-operating cash flow. Operating cash flow is cash flow from operations, whereas nonoperating cash flow is cash flow relating to capital expenditures, anticipated sales of assets, payments of principal on debt obligations, and cash requirements for special accounts.
The end result of these projections--much of which should be performed by the hospital's management, its accountants, and other experts--is a consolidated statement of cash flow, an example of which is shown in the exhibit. The objective is to identify both operating and nonoperating sources and uses of cash by major category.

The Importance of Analyzing Business Fundamentals

The ultimate objective of analyzing and evaluating the many factors discussed in this chapter is to produce a reasonably accurate hospital valuation in which the assumptions underlying the valuation are sound. The choice of a particular valuation technique may depend upon a number of variables including the purpose of the valuation, the goals of those requesting the valuation and the applicability of one methodology or another to the task at hand. If the underlying assumptions about the hospital, its facilities and its business direction have been well researched, then virtually any legitimate valuation method will yield meaningful results. On the other hand, if there has been little or no research into the business fundamentals underlying financial statements, financial projections, utilization projections and other assumptions, then the resulting valuation is likely to have less validity regardless of which valuation technique is chosen.

The focus of this chapter has been the valuation of hospitals as entire physical and operating entities. The amount of work involved in examining all of the areas discussed will depend, of course, upon the size and the complexity of the hospital organization in question. Many of the steps described in this chapter require the input of outside experts; some of these steps can be conducted only by outside experts, who must then give those conducting the valuation the results of their work in an intelligible and relevant form--that is, a form which is relevant and useful in a hospital valuation assignment.

It is important to keep in mind that a hospital valuation is not a feasibility study, an architectural plan, a long range strategic plan, a capital development program or a personnel plan--although each of these may influence portions of the valuation. A hospital valuation assignment must take into account actual historical events and the most probable future events
based upon certain specific assumptions. On the one hand, it is impossible to perform a meaningful hospital valuation without making reasonable projections of future operating condition, facilities requirements and capital requirements; on the other hand, projections of these items must be based upon a logical flow of events from the historical and the present into the future.

The purpose of a hospital valuation can greatly influence the type of projections which are being made. For example, a hospital undergoing a valuation for financing purposes should be examined in light of its continuing management structure and operations, taking into account any new facilities and programs which are being financed. A hospital being valued for acquisition by another hospital may be totally changed as a result of the acquisition. In such a case, it would be important to consult with the acquiring hospital to determine the basis for the valuation of the acquired hospital. The key question is:

Is the acquired hospital to be valued on the basis of operations and management continuing as is, or should the acquired hospital be valued on the basis of what management, facility and program changes are actually planned by the acquiring institution?

If the acquiring hospital wishes to use the valuation as a basis for determining the fair purchase price of the to-be-acquired hospital, then it is probably advisable to value the hospital in question based upon the hypothetical continuity of management but taking into account required improvements in physical facilities, since such requirements would tend to lower the effective present value of the hospital. On the other hand, if the acquiring hospital wishes to use the valuation as a basis for obtaining acquisition financing, then the acquiring hospital would likely want the valuation to reflect its actual plans for the to-be-acquired institution since, presumambly, those plans would entail improvements in operations, programs, facilities and net cash flow.
In the latter instance—where a valuation is based upon programs to be implemented in the future—those conducting the valuation need to assess the realistic likelihood of new programs and facilities achieving management's expectations. This is an example of the usefulness of independent outside experts, for such experts can provide some objectivity during the sensitive process of making future projections.

It is important to know the scope of the hospital valuation when examining the business fundamentals of a hospital and consolidating those fundamentals into utilization, income and cash flow projections. Many hospitals own whole or partial interests in related businesses or joint ventures, and the valuer needs to understand up front whether these businesses are to be included in the valuation. If so, the key business fundamentals of each of these separate businesses need to be examined separately, with separate utilization and cash flow projections which can be factored into a composite picture of the entire organization, its subsidiaries, its joint venture partners, and its related businesses can be achieved.

Valuers and financial analysts differ as to whether taxes, depreciation and financing assumptions should be included in cash flow projections for valuation purposes. This depends partially, of course, upon the purpose of the valuation and upon whether the hospital's depreciation and financing assumptions are expected to change. The goal of any valuation is to present as realistic a picture of the future as possible so that the reasonable range of present value reflects expected future events. In general, if depreciation is expected to be a source of cash, then it should be reflected as such, and if debt service or equity participation is known, then these items should be incorporated as well into the overall cash flow projections.

Where a change of hospital ownership is taking place, the acquiring organization may wish to have two sets of cash flow projections—one set incorporating the actual ongoing depreciation, taxes and financing conditions of the existing hospital and the other set of projections incorporating the acquiring organization's financing plans. In this way, one value can be established for the purpose of establishing the purchase price of the hospital in question, while the other value more accurately reflects the post-takeover potential of the to-be-acquired hospital.
Since financing costs and related requirements can have a significant impact upon future cash flow, some assumptions about financing need to be made even if financing details are unknown. It is unrealistic to present a hospital valuation which does not include financing assumptions and their influence upon future operations and cash flow, since the whole goal of a valuation is to attempt to accurately and completely present the impact of future events upon value.

Historical cash flow and future cash flow may be based upon different sets of assumptions, especially if a change in ownership is contemplated. New owners may borrow money, for example, at different interest rates and on different terms than the existing owners, and these assumptions need to be taken into account—and disclosed—when projecting future cash flow for a hospital whose ownership changes. Likewise, where changes in cash flow from the present to the future involve underlying changes in patient utilization assumptions or patient mix assumptions, these assumptions need to be well-documented.

It is sometimes necessary to "conform" financial assumptions in past financial statements to the assumptions used in future projections and to, in effect, "re-state" the past financials in a format consistent with the future projections. The reverse can also apply, where assumptions used in preparing historical financial statements are carried forward to the financial projections. Conforming past and future financial assumptions applies especially with respect to financing assumptions, where one needs to see the impact of the projected amounts of debt and equity and the projected costs of capital.

Consolidating the Cash Flow Projections

Once the various projections of utilization, operations and cash requirements have been made, they should be consolidated and formatted in a manner permitting various valuation assumptions and techniques to be used. Separating the data into logical categories allows the various elements to be independently manipulated during the valuation process. Subject to unusual characteristics of a hospital organization which may require additional
categories, the following categories of five year projections will normally be adequate. It should be noted that these categories should be separately projected for the hospital and each of its major subsidiaries:

**Patient Utilization:**

Patient utilization should be projected by payor type and should be segregated into inpatient and outpatient utilization. Sub-categories of utilization may be appropriate for major "treatment centers" within the overall hospital organization.

**Operating Revenue:**

Operating revenue should be projected to correlate with the patient utilization by payor type as projected above. In this way, if assumptions are made changing utilization by payor category, these may be conveniently factored into the revenue projections independently of other factors. The projections of operating revenue should be made before and after "allowances" for each payor category.

**Donations and Contributions:**

Most hospitals now maintain foundations as separate corporate entities which can be valued as such (see Chapter 10). However, donations and contributions coming into the "main hospital" entity should be projected separately. In addition, these items need to be accounted for as "restricted" versus "unrestricted".

**Personnel Expense:**

Projections of personnel expense should be categorized into "patient care" and "non-patient care". In addition, projections should take into account and separately
footnote major union contracts. Finally, the personnel projections should segregate out "salaries and wages" versus "employee benefits".

**Other Expenses:**

Other expenses include contractual expenses, supplies, utilities and professional services. These expenses should be separately projected, since they are susceptible to varying inflation rates.

**Depreciation:**

Depreciation should be separately projected for "plant" versus "equipment". Depreciation projections need to take into account the removal of obsolete equipment as well as the addition of new equipment. In addition, the depreciation attributable to required remodelling programs associated with "regulatory position" requirements.

**Financing Costs:**

Financing assumptions and costs should be separately projected for major categories of financing and for major categories of hospital assets. This includes financing terms and costs for sources of both equity and debt financing.

**Cash Outlays for Facilities:**

The cash portion of acquisition costs for equipment and facilities remodelling should be projected once such items are known and once financing assumptions are known. It should be noted that items such as interest, dividends or lease payments will be reflected separately in the projections of the "financing costs" above.
Other Cash Outlays:

These outlays should include any other major categories of projected cash distributions or set-asides not covered above.

The projections outlined above will necessarily originate from a variety of sources, including outside experts. Once they have been made and once the assumptions underlying each set of projections is understood, those conducting the valuation can assign discount rates and other assumptions to the component forecasts. Each component can then be discounted to its appropriate present value, and then the components can be consolidated into a total "present value of net cash flows". This present value can then be examined in light of the physical inventory, asset values and other valuation techniques to arrive at a reasonable range of value for the hospital and its subsidiaries.
CHAPTER 9

VALUING HOSPITAL CORPORATIONS,
SUBSIDIARIES AND RELATED BUSINESSES

The Recent Hospital Reorganization "Craze"

If one were to compare the organization charts and legal structures of most hospitals today with those of the 1970s and before, one might wonder how those relatively straightforward, "simple" organizations of the past survived as long as they did; on the other hand, one might wonder how some of the complex hospital organizations of today could possibly function effectively. During the 1980s the hospital industry underwent what one can only describe as a "reorganization craze" which caused single entity, straightforward community hospitals to become multiple entity, multi-tiered "health care corporations". It became truly amazing how complicated the right attorneys could make even the smallest community hospital organization--and get paid (a lot) for it!

Notwithstanding the temptation to attribute hospital reorganizations to a desire of hospital administrators to be called "Presidents" or "Chief Executive Officers", or the temptation to attribute such an infectious trend to some conspiracy on the part of the legal profession, there really were some legitimate reasons to make the simple hospital organizations of the past more complicated:
• Hospital corporate restructuring permitted for-profit subsidiaries of not-for-profit hospitals to be formed without jeopardizing the tax free status of the main hospital entity.

• Initial corporate restructuring activities permitted the effective circumvention or mitigation of some Certificate of Need regulations.

• Tax free foundations could be established to separately assist in raising donations and other capital.

• Subsidiaries could be "spun off" to form joint ventures.

• The establishment of new corporations could limit the liability of the main hospital under certain circumstances.

• Under old Medicare and Medicaid regulations, it was advantageous to place earning assets—especially "non-provider" assets—in separate but related corporations in order to maximize reimbursement to those hospital entities providing patient care.

• Forming multiple corporations was a way to diversify business activities and enter non-traditional areas.

• Multiple corporations required multiple boards of directors, and this was sometimes viewed as a way of involving additional community leaders in the activities of hospitals and their related entities.

Two of the most significant advantages of corporate restructurings—avoidance of health planning regulations and maximization of reimbursement—have virtually disappeared in light of significant legislative and regulatory changes affecting these areas during the 1980s. The reimbursement regulators now set fees through the DRG system and through the Prospective Payment System. Most reimbursement systems today provide little or no incentive to create convoluted corporate entities, since the old step-down cost-based reimbursement has given way to fee setting among federal and state regulators and among many private insurers through managed care contracts.
In addition, the proliferation of for-profit subsidiaries of not-for-profit hospitals has aroused the attention of local, state and federal regulators who have begun to question the tax exempt status of some hospitals. The idea of tax exempt status is to grant such status to organizations which have a "charitable purpose" according to the Internal Revenue Service. Even though a hospital may have a for-profit subsidiary in a separate corporation, that entity may be viewed as "substantially operated in connection with" or "supervised or controlled by" the hospital for purposes of examining both the tax exempt status of the overall parent organization and calculating "unrelated business income (UBI)" tax liability. Although most hospitals are able to convince regulators that their for-profit activities are incidental activities and that their primary mission is the provision of patient care in support of their "charitable purpose", the entire area of hospital tax status has gained notable attention and promises to be an area of continuing scrutiny.

Nearly all not-for-profit community hospitals have engaged in some form of corporate restructuring or reorganization, ranging from the straightforward establishment of related businesses such as nursing homes or emergency clinics to the creation of a complex multi-layered structure resembling the organization chart of General Motors. Some of the more common corporate structures are:

- **Foundation Structure**, in which a foundation is created which, in turn, owns and controls the hospital.

- **Foundation Holding Company**, in which a foundation and its board establish various related entities and elect their boards, who in turn appoint administrators and executives to manage the various entities.

- **Provider versus Non-Provider Structure**, in which entities which provide health care to patients are segregated into one corporate superstructure, while entities engaged in other activities (e.g., laundries, consulting, equipment leasing) are assembled into another corporate superstructure.
• *Corporate Tiers by Provider Type*, in which the various types of providers (e.g., hospital, nursing home, retirement center, clinics, home care) are each contained within separate corporations; these corporations may, in turn, be controlled by a holding company which may be called a "foundation", a "sponsor", an "owning corporation", a "partnership" or some other entity.

• *Catholic-type Superstructure*, in which a hospital organization may be related to other organizations through various degrees of affiliation or ownership, but where these organizations share a common "mother" entity whose powers or degree of ownership and control can range widely depending upon the specific circumstances. This structure was first used in religious multi-hospital systems.

These are just a few of the more common types of hospital structures and superstructures. The types of structures and their names are virtually countless, and a detailed analysis of the advantages and disadvantages of various corporate structures is beyond the scope of this book. Nonetheless, we are interested here in the valuation implications of various corporate structures, especially those involving the creation of operating entities or the ownership of assets (and liabilities).

**The Impact of Corporate Structure on Value**

There are unquestionably valid reasons for creating hospital subsidiaries and related corporations, but the main reasons for doing so today are business-oriented reasons rather than regulatory reasons. Just as any other type of industry might create a subsidiary, a related corporation or a joint venture for sound business reasons, hospitals have sound reasons for doing so. In general, hospitals will have made the right decision in diversifying or restructuring if there are legitimate business reasons for doing so, and some of these reasons include:
• Protecting the "main hospital" from liability arising from diversification activities.

• Keeping debt and equity obligations of diversified activities separate and distinct from those of the main hospital and protecting the credit standing of the main hospital.

• Attracting equity investors in a for-profit venture.

• Owning real estate, office buildings or clinics jointly with others, including physicians.

• Keeping "unrelated business income" totally distinct in a separately controlled organization.

• Giving control of non-acute care businesses to management teams who specialize in these specific activities.

All of the above objectives are legitimate and can enhance business performance and value if they are implemented properly. However, a number of areas need to be cautiously examined in a valuation where subsidiary and related organizations are involved as part of an overall hospital valuation:

• What type of corporate structure does the hospital have and how are the main hospital and its affiliated entities owned, controlled and managed?

• What entities are being valued and what is their exact relationship to the main hospital?

• To what extent has the main hospital corporation taken on contingent liabilities with respect to subsidiary or related corporations? Examples include partial or whole guarantees of debt, lease guarantees, guarantees to supply personnel and expertise, guarantees to remodel
or build facilities or to purchase equipment and guarantees to provide services such as marketing and promotion.

- Is the balance sheet of the main hospital legally separable from those of subsidiaries?

- To what extent are subsidiaries engaged in activities involving possible malpractice, and are they independently (and adequately) insured?

- To what extent does the corporate structure permit anyone to "pierce the corporate veil" in bringing an action against a subsidiary or related corporation which could involve the main hospital corporation?

- If a subsidiary corporation fails or files for bankruptcy, can this involve the main hospital corporation? To what extent are creditors in a given state permitted to pierce the corporate veil?

- Do the activities of subsidiaries and their relationship to the main corporation leave open the possibility of challenges to tax-exempt status, either on a local, state or federal basis? In this regard, is all unrelated business income being reasonably accounted for, reported and appropriately taxed?

- Are transfers of assets or working capital from the main hospital corporation to subsidiaries handled so as to minimize reimbursement or other regulatory challenges? The same question would apply to transfers back from subsidiaries to the main corporation.

- What labor relations agreements and regulations with subsidiaries affect the main hospital corporation, and is there a change in this regard if the hospital changes ownership?

- What other implications exist in the legal, capital, operating and reimbursement areas from a change in hospital ownership, and does the existing corporate structure affect these implications?
- What are the specific interests, obligations, assets and liabilities (contingent or otherwise) of joint ventures, affiliations or contractual arrangements where the hospital participates with outside parties?

- Where hospital-physician affiliations, joint ventures or other arrangements are involved, what is the exposure, if any, to fraud and abuse or other regulatory problems?

Many of these and other questions need to be answered by qualified attorneys and accountants who have specific expertise relating to those issues outlined above and other issues which may arise. In conducting a hospital valuation where subsidiaries are involved, one is attempting to identify any and all elements which could impact upon the institution's market position, regulatory position, operations, physical facilities and financial position.
Valuing Individual Subsidiaries and Related Entities

The approach to the valuation of hospital subsidiaries and related entities will depend partially on the purpose of the valuation and partially on the nature of the entity being valued. There are two general circumstances surrounding the valuation of hospital subsidiaries:

- The valuation of the subsidiary is being conducted in connection with the valuation of the entire hospital organization.

- The subsidiary is being valued separately from the hospital as a "stand alone" entity for purposes of investment, borrowing or sale/merger.

General Approaches to Valuing Subsidiaries as Part of Hospital

When a subsidiary or related entity is being valued as part of an overall hospital valuation, those elements which contribute to or subtract from value on a "net" basis need to be isolated from elements which are already being taken into consideration in the hospital valuation. The objective is to identify the net "value added" to the overall hospital organization. Following are some pertinent issues:

The Hospital's Ownership Interest: Hospitals do not always own full interests in subsidiaries and related entities. In general, hospitals tend to own 100% of most subsidiaries which provide inpatient care or which are intimately connected with the "main hospital" operations. On the other hand, hospitals co-own interests in nursing homes, retirement centers, community health clinics, renal dialysis clinics and numerous other types of businesses which
| HOSPITAL DIVERSIFICATION/JOINT VENTURE ACTIVITIES |
|-------------------------------------------------
| Inpatient SNF | Cardiac Rehabilitation Programs |
| Nursing Homes | Home Health Services |
| Retirement Housing | Health Maintenance Organizations |
| Freestanding Surgery Centers | Preferred Provider Organizations |
| Off-Site Primary Care Clinics | Collections/Claims Administration |
| Off-Site Emergency Centers | Psychiatric Services |
| Wellness Centers | Substance Abuse Programs |
| Occupation/Industrial Medicine Programs and Clinics | Outpatient Psychiatric Centers |
| Physical Therapy | Women's Health Centers |
| Sports Medicine | Mobile Diagnostic Center |
| Freestanding Rehabilitation Clinics | Freestanding Diagnostic Centers |
| Outpatient Rehabilitation | Birthing Centers |
| Fitness Centers | Medical Office Buildings |
| | Reference Laboratories |
| | Medical Equipment Leasing |
provide health care but are not directly part of the main hospital. It is vital to determine exactly what the ownership interests are and whether those interests include physical assets or simply business interests.

**Identify Assets, Liabilities, and Contingent Liabilities:** Related to identifying the exact ownership interests is the task of identifying assets and liabilities related to those interests. Some assets—such as non-compete agreements, exclusive operating agreements, management agreements or other preferential contracts—are not always obvious, but these items do have economic value. As indicated previously, the identification of liabilities and contingent liabilities is also vital; these include both the liabilities of the subsidiary itself and those which could be attributable to the main hospital corporation. In some instances the main hospital provides guarantees of debt, rental payments, personnel, facilities or other expenses; these guarantees or partial guarantees create actual or contingent liabilities which must be evaluated on the basis of their probability of enforcement—that is, is it likely that the subsidiary will need to call upon a guarantee, and if so, in what amount and over what period of time?

In other instances, the laws of a given state need to be examined to determine whether the main hospital corporation could be held liable for debts or other obligations of the subsidiary in question irrespective of whether or not specific agreements exist. In addition, for subsidiaries which are partially owned by the hospital, one needs to determine the relative financial strength of the co-owners as well as their position as debtors or creditors and their other rights and responsibilities in the ownership arrangement.

**Identify the Net Economic Benefits/Costs to the Hospital:** It is more common than not that hospital subsidiaries have a complex relationship of inter-dependency with the main hospital. This relationship may be confined to simple contractual provisions wherein the hospital provides certain facilities and staff, or the relationship may involve transferring patients back and forth, lending or supplying
staff, management assistance, assistance in financial management and billings, and other forms of assistance difficult to quantify.

In attempting to determine the "value added" of the subsidiary, it is often necessary to "net out" the flow of money, manpower, assets or services from the hospital to the subsidiary. The objective is to determine the true net economic impact of the subsidiary upon the hospital. It is possible for a subsidiary to be making a profit on its own income statement and to be a net cost to the hospital in terms of its overall cash flow; yet even in such a circumstance a subsidiary can add value to the hospital if it is a demonstrated source of additional assets or market share or if the existence of the subsidiary causes the main hospital itself to be more profitable.

**Identify Legal and Regulatory Issues Relating to Subsidiaries:** Subsidiary organizations of hospitals often have their own set of regulatory and legal issues to deal with apart from those of the main hospital. Prominent examples of this include the licensing and regulation of nursing homes, retirement centers, renal dialysis clinics and home health agencies. Such entities may be dealing with an entirely different set of regulators and regulations than hospitals, and their reimbursement rules may be different as well. It is important to evaluate the regulatory and legal status of subsidiaries, including potential legal liabilities such as malpractice.

**Evaluate Other Business Fundamentals:** To realistically evaluate the impact of a subsidiary upon the value of the overall hospital organization, it is usually necessary to evaluate the subsidiary's market position, regulatory position (discussed above), operations, physical facilities and financial position. Two questions need to be answered in this regard:

In what ways is the subsidiary adding to or subtracting from the value of the overall hospital organization, including the impact upon net cash flow?
What are the reasonably expected specific obligations of the parent corporation or "main hospital" in the foreseeable future?

*Separately Value Certain Assets:* Some hospital subsidiaries hold assets which can be considered as general real estate and which should be separately valued as such. Such assets include office buildings, land, apartment buildings and other general use properties. In the case of medical office buildings, care needs to be taken so that the valuation takes into account the possible limited use of such buildings or the costs of their conversion to general office use. In any event, the valuation of these types of assets is a well-established technology and will not be reiterated here.

The objective in evaluating all of the above items is to be able to factor the economic contribution of the hospital's interest in the subsidiary into projections of net cash flow. It is recommended that the expected cash inflows and outflows be separately identified for each subsidiary prior to being consolidated into the overall hospital valuation; in this way, assumptions regarding subsidiary performance and financial requirements can be separately changed to analyze their impact upon the value of the overall hospital organization.

**Approaches to Valuing Subsidiaries as Distinct Entities**

There are circumstances under which the subsidiaries of hospitals need to be valued by themselves in the absence of a valuation of the entire hospital organization. Some of these circumstances include:

- The sale of a subsidiary by the hospital to an outside purchaser.
- The sale of a subsidiary in a management buy-out.
FACTORS TO CONSIDER IN EVALUATING HOSPITAL DIVERSIFICATION ACTIVITIES

- Management Expertise
- Market Risk, Market Potential
- Financial Risk, Financial Potential
- Availability of Capital
- Expected return on and return of capital
- The sale of a hospital’s interest in a joint venture.

- The prearranged buy-out of a subsidiary at a fixed date established by a previous purchase.

- The financing of a subsidiary based upon its own credit characteristics.

- The liquidation of a failed subsidiary.

- The survival of a subsidiary of a failed hospital.

The actual approach in valuing a subsidiary depends to a degree upon the subsidiary’s business activities and upon its composition of assets and liabilities. Some subsidiary health care enterprises are service businesses without significant physical assets. Others are capital intensive, requiring highly specialized equipment. Still other subsidiaries are capital intensive but are not necessarily single use facilities; medical office buildings can fall into this last category.

In general, the valuation of subsidiaries of hospitals requires examining the same general categories of business activity which need to be examined in a hospital valuation—market position, regulatory position, operations, physical facilities and financial condition. Obviously, the details of the business fundamentals will differ from those of the hospital, depending upon the exact nature of the business carried on by the subsidiary. Even so, the specialized nature of health care entities and the limited market for many facilities require that the valuation favor the income and cash flow approaches. In cases where clear alternative uses are possible for physical assets and where market sales comparisons exist for such assets—such as an office building—a traditional real estate valuation or "appraisal" may be feasible, as long as that valuation recognizes the "cost of conversion" to make the medical office building suitable for more general office use.

One of the more difficult tasks in valuing a hospital subsidiary, a related entity or a joint venture in which the hospital has a greater or lesser interest is separating out the effect of the hospital’s ownership from the operations, cash flow and financial condition of the subsidiary or other entity. Some items to be examined include:
• Subsidies of operations provided by the hospital. Such subsidies may take the form of initial start-up capital or ongoing operating capital. The issue is, what do operations of the subsidiary look like without the subsidies?

• Indirect forms of support by the hospital to the subsidiary, including management talent, market assistance, discounts on supplies and other forms of favorable treatment.

• Support in the form of rent subsidies, rent guarantees, equipment leases, favorable land contracts, below-market loans and other forms of support which are not available in the "open market" or which would cost more if purchased in the open market.

• Loan guarantees and capital infusions which may disappear in the absence of hospital ownership.

• Contractual obligations of the hospital in support of the subsidiary which may be cancelled if hospital ownership is terminated.

• Non-compete agreements or other contracts limiting the activities of the subsidiary or its medical staff should the entity cease to be controlled by the hospital. If the hospital is willingly selling the subsidiary, of course, such agreements would probably be cancelled.

• Zoning, licensing or other regulatory provisions empowering the subsidiary to operate in connection with a hospital but restricting operations or permits in the absence of hospital ownership.

• The imposition of real estate or other taxes triggered by the break-off of a subsidiary from a parent hospital.

The overall objective here is to attempt to quantify the impact of the separate valuation of a "stand-alone" subsidiary upon the business fundamentals of that subsidiary, with the end result being revised operating, capital and cash flow projections. Most hospital subsidiaries which are
being independently valued are tied to the hospital in various ways, and identifying and untangling these ties nearly always affects the projected financial condition—and the value—of the subsidiary in question.

The following sections describe some of the major business issues surrounding the valuation of some of the more common health care enterprises affiliated with hospitals. These sections do not provide exhaustive discussion and valuation analysis but, rather, are presented to raise some of the major issues one needs to keep in mind when valuing these types of health care organizations.
Valuation of Nursing Homes

Industry Profile

The most significant demographic event occurring into the middle of the next century will be the growth of the older population of the United States, both on an absolute basis and as a percentage of the overall population. Life expectancy is projected to increase for both elderly males and elderly females, with females continuing to live longer on average. In addition, the most dramatic segment of population growth will be the population over age 75. The nursing home population will continue to be dominated by persons age 75 and over, as is presently the case. Nearly 75% of nursing home discharges occur in the 75+ age group, and many of these discharges are the result of death, with heart disease, cancer and stroke dominating the list of causes of death.

The nursing home industry grew most dramatically following the introduction of the Medicare and Medicaid programs in the mid-1960s. Medicaid--the program for the "medically indigent"--accounts for the largest portion of government-funded nursing home care, and the introduction of this program encouraged much new nursing home construction in the period 1965-1975. In the mid-1970s the government began restricting construction of new nursing homes in hopes of holding down Medicaid expenditures, and the number of nursing home beds began to level off. The demand for nursing home services, however, has continued to increase, with the need for medical care accounting for the largest proportion of nursing home admissions.

Despite the growth in nursing home beds, most of the population age 65 and over is still cared for at home, with wives, daughters, and other female friends and relatives accounting for nearly three-quarters of such care. Care of the elderly by relatives has been gradually declining as the result of the
## NURSING HOMES BY CERTIFICATION, U.S., 1987

<table>
<thead>
<tr>
<th>Certification</th>
<th>Number of Homes</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>8,045</td>
<td>31.4%</td>
</tr>
<tr>
<td>Intermediate Care Facility</td>
<td>5,375</td>
<td>20.9</td>
</tr>
<tr>
<td>Uncertified Nursing Home</td>
<td>2,968</td>
<td>36.1</td>
</tr>
<tr>
<td>Residential Facility</td>
<td>9,258</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25,646</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

**SOURCE:** U.S. Department of Health and Human Services  
National Center for Health Statistics
mobility of Americans and the growing tendency of families to institutionalize the sick elderly. Home health care is expected to become a significant force in care of the elderly, with nursing homes gradually caring for only the sickest elderly patients.

Nationally, the occupancy of nursing homes has exceeded 90% for several years, and as nursing homes increasingly become sub-acute care facilities for patients discharged from hospitals as well as more intensive health care facilities for the elderly, occupancy is expected to continue to rise. Even now, nearly one third of nursing home admissions are short term and rehabilitative in nature. The longer term lengths of nursing home stay usually reflect the patterns of chronic illness present in the elderly over age 75.

There are over 25,000 nursing homes in the United States, divided into four types of facilities:

- Skilled Nursing Facilities
- Intermediate Care Facilities
- Uncertified Nursing Homes
- Residential and Personal Care Facilities

Skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) provide the more intensive levels of nursing home care and are most likely to be Medicaid-eligible. Depending upon which state a facility is operated, Medicaid may also cover certain types of assisted living, personal care, and so-called "residential" facilities which have nursing services. Although most nursing homes and similar facilities are operated as distinct, independent physical facilities, a growing number of hospitals are providing beds licensed as nursing homes, usually skilled nursing facilities.

In terms of ownership, the nursing home and personal care industry is dominated by for-profit organizations—in a ratio nearly exactly the opposite of the hospital industry which is dominated by not-for-profits. For-profit
organizations dominate the ownership of both skilled nursing facilities and intermediate care facilities, owning some 75% of all nursing homes. Some 20% of nursing homes are owned by not-for-profit facilities, and the remaining 5% are government owned. There are some 900 hospital owned nursing homes in the United States, excluding nursing homes only partially owned or affiliated with hospitals.

Although the overall U.S. health care expenditures by and for the elderly are dominated by hospital and physician spending and by Medicare reimbursement, Medicaid is the primary program for reimbursing long term care. Out-of-pocket expenditures account for 25% of all personal health care expenditures by the elderly and for more than 56% of expenditures for nursing home care.

Because of the way the Medicaid regulations are written, people must exhaust their personal resources before becoming eligible for Medicaid reimbursement in a nursing home. Thus, many patients begin their nursing home care as private pay patients and end up as Medicaid patients. Several elderly groups and legislators have pointed out the unfairness of these requirements for patients to become virtually impoverished in order to qualify for Medicaid. Some private insurance companies are now beginning to offer forms of long term care insurance, but the policies are usually not comprehensive and can be very expensive.

Regardless of how the Medicaid program is changed in the future and how the insurance industry responds to the challenge of funding long term personal care and nursing home care, there is no question that the growth in the elderly population and the increasing numbers of people over age 75 and 85 with disabling chronic illnesses will result in a markedly higher nursing home population into the 21st Century. The challenge of caring for the enormous numbers of elderly expected to require nursing home or personal care will demand that many new facilities be built and that some existing hospitals or portions of hospitals be converted into long term care facilities.

The growing long term care industry is expected to pose multiple challenges and opportunities for hospitals. While the nursing home industry is expected to grow and while the increased intensity of care of nursing home
patients presents opportunities for hospitals, the management of nursing homes and their sources of funding are far different than that of hospitals—as some hospitals have painfully discovered.

**Characteristics Affecting Valuation**

Below are some of the characteristics of nursing homes and personal care facilities relevant to their valuation.

*Limited Use Facilities*: We have already commented upon the limited use nature of health care facilities, especially inpatient facilities. The convertibility of nursing homes to alternative uses is limited by their design and layout, by their internal configuration and often by their location. Nursing homes and personal care facilities are designed to specific codes in most states; federal design and safety codes also apply. In addition, medical design characteristics are important in the provision of patient care, depending upon what patient care programs are implemented. Finally, design of elderly care facilities is often a function of patient and staffing levels as well as traffic patterns, and these patterns are usually quite different from general use housing facilities.

*Reimbursement Dependent*: Nursing homes and personal care facilities are, in general, highly dependent upon third party reimbursement—especially Medicaid. Since Medicaid is a shared state-federal program, with the states contributing an average of 41% of cost, the level and nature of Medicaid reimbursement varies from state to state. The states vary widely in their relative amounts of per patient day reimbursement, in cost controls of reimbursable expenses and in the types of expenses they cover.
Private Pay Dependent: Over half of nursing home revenues nationally come from patients and their families, and a much higher percentage of the revenues of personal care facilities come from patients and their families. This is in marked contrast to hospitals, most of which receive less than 10% of their revenues from private pay. Private payment for these services is generally not regulated and is, therefore, a function of what the market will bear. Private pay rates can be as much as 50% higher than Medicaid payments on a per diem or a monthly basis, thereby making private pay patients a source of high operating margins and cash flow. For this reason, competition among nursing homes for private pay patients is fierce. Analyzing the total market of private pay patients as well as the market share of the given facility is crucial to establishing the value of nursing homes and personal care facilities.

Heavily Regulated: All inpatient facilities giving elderly care services are heavily regulated by the local, state, and federal governments. The type of regulation depends in part upon the intensity of medical care and in part upon the state where the business is located. The regulation of nursing homes and personal care facilities includes both inspection and regulation of physical facilities and the monitoring and regulation of patient care. Increasingly, both the federal government and state governments are monitoring the "medical outcomes" of elderly patients, especially in nursing homes, and regulators are "decertifying" facilities where patient care is determined to be inadequate.

Image Sensitive: Any health care business serving the elderly must maintain a proper image in order to attract patients. Because the nursing home industry has had numerous scandals relating to poor patient care, prospective patients, their families, the medical community, and the press are all cognizant—if not skeptical—of the quality of facilities and patient care. The issue of image applies not only to patients and their families but also to inspectors and regulators. A positive image is difficult to maintain but is nearly impossible to regain once it is lost.
Hospital-based nursing homes often market their high quality standards and, potentially, have the ability to maintain a competitive advantage in terms of image.

Analyzing Nursing Home Business Fundamentals

Valuations of nursing homes in connection with hospitals could occur as the result of the sale or financing of an existing hospital-based nursing home or as the result of a hospital contemplating the acquisition or construction of a nursing home or the conversion of acute care beds to long term care beds. As with other types of health care businesses, it is important to evaluate the fundamental present and future business elements of a nursing home or personal care facility prior to using any valuation approach to establish a reasonable range of value.

Market Position

The market position of a nursing home or personal care center includes its ability to attract patients, its mix of patients by payor category and the position of the business relative to competitors within its service area. Historical market position and patient utilization can serve as reference point to make projections of future utilization and market position. Departures from historic trends need to be well-documented, since the financial projections are based in large part upon projected patient utilization and patient mix by payor category.

In contrast to the hospital industry where new hospitals are not being built, new nursing homes can be built in many parts of the U.S. The valuation of a facility not yet built involves an assessment of the overall market, the competition, and the reimbursement environment and involves the preparation of realistic patient or resident utilization projections. One major issue with respect to a new facility is the issue of the "fill-up" rate. A liberal amount of time should be allocated for a new facility--even
a hospital-based facility—to become fully occupied; historical fill-up time periods for new nursing homes and personal care facilities range from twelve to eighteen months, except for larger institutions which can require up to two years to become fully occupied.

Nursing homes or personal care centers with a high proportion of Medicaid patients are more vulnerable to cash flow problems than are facilities with a high percent of private pay patients, and in such cases the present and expected state Medicaid reimbursement environment needs to be carefully examined. With respect to the ability to attract private pay patients, both the overall market demand for services and the number and types of competing facilities is important in evaluating the likelihood of achieving private pay utilization projections.

**Regulatory Position**

The historic, the present and the expected regulatory position of a nursing home or personal care facility are all important in evaluating the business. The compliance with regulations and codes affects a nursing home’s reputation with regulators, its reputation in the community, its market penetration, and its physical facilities. The degree of regulation of Medicaid rates and payments affects cash flow. Nursing homes are highly regulated and frequently inspected, and both state and federal regulators have become increasingly strict in enforcing code violations. Regulators are concerned not only with the physical facilities but also with the amount and quality of staffing and the quality of patient care. Hospital-based nursing homes have the potential to establish high standards of quality care, although these standards may exceed the ability of Medicaid to provide adequate funding.

New legislation is almost continually developed at the state and federal levels pertaining to nursing home care, and such legislation is usually distinct from legislation affecting the hospital industry. Powerful national senior citizens organizations lobby for improvements in the quality of
nursing home care, while the Health Care Financing Administration attempts to improve quality through its "survey and certification" process. Unlike the hospital industry, the nursing home industry is not significantly impacted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); only slightly over 1,000 of the nation's nursing homes are accredited. Those conducting a nursing home valuation need to be aware of impending state or federal legislation which could have an impact upon the facility in question. Such legislation could involve either regulations affecting physical facilities, patient care or reimbursement.

*Operations*

The most important issues with respect to the operations of an existing nursing home or personal care facility are its management and its staffing. If a hospital is acquiring a nursing home where the existing management is to remain in place, then the operations will continue to be a reflection of their abilities and effort. If new management is envisioned, the experience of such management and their track record with similar facilities needs to be evaluated. One cautionary note: hospital management personnel are not necessarily qualified to manage nursing homes.

Often, hospital-based nursing homes share services and receive support from the main hospital. This support can include simple arrangements such as shared laundry or dietary facilities to more complicated arrangements involving shared medical services. As with the valuation of any hospital subsidiary, the valuation of a hospital-based nursing home needs to take into consideration the operational and financial impact of such arrangements.

The quality of care and the quality of the nursing home facilities is a reflection of the owners, managers and staff, and the perception of quality in a hospital-based nursing home can affect the perception of quality of the hospital itself. Although quality of care is a somewhat subjective element, it is important nonetheless--especially in caring for
the elderly--for quality of care affects the patient mix, the image in the community, and the regulatory position of the business.

**Physical Facilities**

The primary objective in evaluating physical facilities is to determine what future capital expenditures are necessary for facilities and equipment, and then to factor those requirements into the cash flow projections to be used in establishing value. Determining the future capital expenditures for facilities and equipment involves two major issues:

- What expenditures are necessary to maintain a proper regulatory position?
- What expenditures are necessary to replace or remodel functionally obsolete or noncompetitive physical assets?

The first of these two issues should be relatively straightforward to determine based on inspection reports from government regulators. The second issue involves judgments concerning obsolete facilities or equipment and usually involves management, the medical staff, architects, engineers, or other outside experts. An independent building inspection of any existing facility is recommended.

The goal in evaluating physical facilities is to identify what expenditures need to be made within the next five years in order to keep the facilities reasonably up to date and competitive.
**Financial Position**

As with hospitals, the financial position of a nursing home is the result of its underlying business fundamentals and the result of the financial management systems of the nursing home. As is the case with all health care businesses, the quality of financial management has an impact upon financial performance and cash flow.

Unlike the hospital industry, the nursing home industry is largely a for-profit industry. While hospital-based nursing homes may be not-for-profit, more than 15,000 of the nation's nursing homes are for-profit (investor owned) organizations. The analysis of the financial statements of for-profit nursing homes requires special expertise. Owners of most for-profit nursing homes and personal care facilities share two common traits:

- They are tax-aversive.
- They are profit-motivated.

These traits often significantly affect the presentation of financial statements as well as other characteristics of these businesses. Since the goal of many owners is to maximize cash flow and minimize income taxes, owners will frequently include items in the income statements which do not affect operations. Some of these items include:

- Management fees paid to a related corporation controlled by the facility's owners.
- Relatives on the payroll as employees or consultants.
- Executive "perks" such as unnecessary travel, entertainment, automobiles, management pensions, and bonuses.
• Loans to and from related parties which do not relate to the operation of the business.

• Leases of physical facilities from an individual or individuals to an operating corporation.

The issue of valuation as relates to the above points is not whether these and other operating and accounting techniques are correct, but how they distort the "true operating statement" of the business. In order to properly evaluate historical data and make financial projections, nursing home financial statements frequently need to be "cleaned" of unnecessary or irrelevant items in order to achieve an accurate representation of the true operating business so that projections of future cash flow can be relied upon to assist in calculating value. Unless one is an expert in nursing home accounting, the valuer should rely upon outside accountants or consultants to assist in reviewing and, if necessary, reconstructing financial statements.

One important resource available for any nursing home or personal care facility with Medicaid patients is the annual Medicaid Cost Report. Cost reports are required by all states participating in the Medicaid program in order to calculate cost reimbursement under Medicaid. Although the format of cost reports varies from state to state, cost reports tend to be much more detailed than customary financial statements. By using cost reports, the analyst can obtain detailed information concerning occupancy and operations and can also identify and eliminate irrelevant items. As with financial statements, cost reports should be examined by someone totally familiar with them.

Another important area of financial statement analysis is the area of "capital cost reimbursement". As with hospital valuation, the issues relating to reimbursement of depreciation and other capital costs can have a significant impact upon value, especially in a change of ownership situation. Capital cost reimbursement includes reimbursement of depreciation, depreciation recapture, reimbursement of debt service, and reimbursement of equity or ownership interests (often called the "profit allowance" or "ownership allowance").
The cash flow of a nursing home or personal care facility needs to be examined in light of both the amount of cash flow and the future reliability of timely cash flow. We have commented throughout the discussion on the importance of knowing the present and projected patient mix of a health care business, and this is particularly true of nursing homes and personal care facilities, which can be Medicaid-dependent. Evaluating cash flow includes not only operating cash flow but also receivables. Balance sheet receivables are technically assets, but if they are constantly adjusted downward because of "allowances" when they reach the income statement, such receivables need to be viewed as partially contingent. Cash flow is also a function of the quality of financial management. Some hospitals and nursing homes blame all of their cash flow problems on government-based payors, when in fact at least part of the problem rests with poor in-house accounting systems.

Valuation Approaches

There are three types of valuation approaches which are helpful in establishing a reasonable range of value of nursing homes and personal care facilities:

- Income valuation approaches
- Asset valuation approaches
- Sales comparison approaches

As with hospital valuation, asset and income valuation approaches should be combined for nursing homes and personal care facilities. Unlike hospitals, where sales comparison approaches are nearly impossible to conduct, sales of nursing homes and personal care facilities do occur with enough frequency to provide relevant comparative sales data to be used as a frame of reference. At the same time, however, the comparative sales data for nursing homes is generally state-wide data, and as with other types of health care facilities, such data does not usually take into account the
differences among facilities in terms of scope of services, age, physical condition, management, patient mix, and other business characteristics. For nursing homes and personal care facilities, therefore, sales comparisons need to be made on a regional basis, and they are useful more to establish reference points than to establish a valuation.

Cost approaches to valuation are useful and relevant for establishing the value of totally new facilities and for establishing the value of physical assets for purposes of insurance, taxation, and certain categories of reimbursement. As is the case with hospitals, Medicare and Medicaid have specific rules governing reimbursement of capital items, debt service, and depreciation. Unlike the hospital industry, where Medicare formulates national guidelines, the nursing home industry is more dependent on Medicaid, and each state formulates its own Medicaid reimbursement guidelines and cost controls. These guidelines include issues such as recapture of depreciation upon sale, reimbursement of interest, reimbursement of capital costs, and reimbursement of other ownership-related items.

As with hospital valuations, the most reasonable range of value of a nursing home will be achieved through a combination of discounted cash flow analysis and asset valuation approaches. The reasonableness and credibility of the valuation will depend upon:

- The accuracy of the cash flow projections, which in turn depend upon the accuracy of the analysis of the key areas of business fundamentals discussed previously.
- The assumptions used in calculating terminal value and in calculating present value.
- The degree to which the purpose of the valuation is taken into account in developing assumptions.
Valuation of Retirement Housing Facilities

Industry Profile

Because of the growing size of this sub-industry and because residents of retirement housing facilities are generally elderly persons, the retirement housing industry and the health care industry are closely interrelated. Many hospitals, physicians, and other health care groups have built or invested in retirement housing facilities, and the need for such facilities is expected to increase dramatically in the coming years.

Before discussing the valuation of retirement housing facilities, we need to define what is meant by "retirement housing". Retirement housing is the provision of congregate housing services to elderly persons. The emphasis here is on housing, although health care services may be provided to one degree or another. Some of the differences between retirement housing facilities and nursing homes or other health care facilities are as follows:

- The primary purpose of retirement housing is to provide housing services to the well elderly.

- Most retirement housing services are not reimbursed by Medicare or Medicaid. The predominant form of payment is private payment.

- Although health care services may be offered in retirement housing facilities, they are offered as an adjunct to basically healthy residents. Retirement housing facilities generally do not house the sick elderly; they are cared for in nursing homes, personal care facilities, and other settings.
The retirement housing business is generally not a high profit margin business. These facilities rely upon a high occupancy of people paying fixed monthly rentals, combined with good expense controls, to generate positive cash flow.

By being oriented mainly to the well elderly population—people who have a choice of where they reside—and by being dependent upon private pay revenues, retirement housing facilities are highly market sensitive and are vulnerable to many changing market forces that do not affect other types of health care facilities.

Retirement housing facilities can be either for-profit or not-for-profit. Many church groups and hospitals have established not-for-profit facilities. Many developers and private investors have established for-profit facilities. Both kinds of facilities have worked well, and there have been notable failures as well among both types of facilities. The not-for-profit facilities have tended to have a higher degree of credibility among elderly residents.

Although the difference between a facility that is primarily retirement housing and a facility that is primarily health care can sometimes be difficult to determine, one "rule of thumb" exists. Health care facilities are eligible for reimbursement by Medicare and Medicaid; housing is not. Still, some health care services available to residents in an elderly housing facility may be reimbursable. The primary source of payment of retirement housing facilities is private payment, not Medicare, Medicaid or insurance. There are many types of retirement housing facilities, including:

- Retirement apartment buildings with retirement apartments.
- Retirement "communities" containing several buildings.
- "Congregate Care" facilities, which provide access to some health care services, have housekeeping and linen services, and provide meal preparation including a common dining area.
• "Life Care Communities" or "Life Care Facilities", which provide both housing and health care services, including a nursing home. The theory of such facilities is to be able to provide "care for life" of residents through a variety of facilities located on the same "campus". This theory is also sometimes called a "continuum of care".

Retirement housing is paid for in a variety of ways. The most common method of payment is a monthly rental fee. In some cases this monthly fee includes a housekeeping fee and a fee for one or more prepared meals per day. Many retirement housing projects take up front fees of one kind or another from residents prior to or at the time they move into the project. In some cases, these fees are paid in order to create an interest earning pool of funds which is used to reduce monthly rents and other expenses. In other cases, up front fees--sometimes called "endowment fees"--are paid to create funds to be used for future services such as health care services. The types of up front fees and the amounts of such fees vary widely, depending on the scope of services offered. In general, "life care communities" charge large endowment entry fees--$50,000 to $150,000--because these fees are used to create a form of self-insurance against future nursing home and other medical costs.

The payment of up front fees can have a stabilizing influence on a retirement housing project, both financially and in terms of creating a stable resident population. Up front fees can be viewed as an asset, but where they are to be used to offset future medical expenses, they are a contingent liability as well.

From a valuation standpoint it is important to understand the different types of retirement housing and how a specific project fits into the overall retirement housing market. Because retirement housing relies almost exclusively upon private payments by individuals, understanding the retirement market in a given area is critical to developing realistic occupancy projections and realistic rates and charges. Many retirement housing and life care projects have "missed the market", resulting in some large bankruptcies and making many lenders skeptical of the industry. And, because retirement housing is not a high profit margin business to begin with, a retirement housing project must identify and appeal to a specific population if it is to attract and retain residents, and therefore, value.
Analysts point out that most retired persons choose to settle at or near their original homes and that retirement housing options are more attractive to people closer to their original families, friends, and surroundings. In either event, retirement housing involves a change in lifestyle, and there is no question from the demographic statistics that many retired persons are choosing to relocate as part of such a change. Regardless of whether people relocate prior to entering a retirement center or not, they look for housing near where they live.

Residents of retirement housing facilities, like residents of nursing homes, tend to be predominantly female, reflecting gender ratios among the elderly. Residents of retirement facilities also tend to be over 75 years old, and the evidence increasingly points to retirement centers as suitable for the mobile elderly in this age group, although they may have at least one chronic non-debilitating medical condition. The original concept of many developers of having retirement centers filled with active people ages 55 to 70 has just not happened, and most market research indicates that people—especially married couples—want to stay in their own homes as long as possible.

There is no question that most elderly persons have the combined assets and income to afford retirement housing. At the same time, it is clear from market research and from numerous failed retirement housing facilities throughout the U.S. that care needs to be taken in designing and pricing such projects. In general, those which appeal to the "middle markets" of retired persons, and which are priced accordingly, have the greatest chances for success. Research has shown that the elderly do have assets but that they often have limited incomes, and they do not want to exhaust either their assets or their incomes on retirement housing expenses, however justified those expenses may be relative to the expenses of home ownership.

Successful start-up retirement centers employ extensive preconstruction marketing efforts as well as significant efforts to attract residents during the first year of operations. Many lenders require "presales" or "prerentals" prior to making a construction loan for a retirement project. Projects which are successful tend to have high occupancy levels and waiting lists.
 Characteristics Affecting Valuation

There are a number of characteristics applicable to retirement housing facilities that do not apply to other types of health care facilities. Some of these characteristics affecting valuation are as follows:

**Private Pay Dependent:** Retirement housing is not reimbursed by third party payors. Although some medical expenses for residents of retirement housing facilities may be reimbursable, the large share of retirement housing revenues comes from private monthly payments. This means that to be successful, a retirement housing facility needs to attract and retain residents who want to reside in the facility and who can afford to pay the fees.

**Market Sensitive:** Residents of retirement housing facilities are generally the "well elderly". As such, they do not have to live in an institutional or congregate setting. They have choices, and most elderly people choose to remain in their own homes. The occupancy of a retirement housing project will depend upon:

- The overall proportion of elderly population in the market.
- Its ability to charge competitive fees versus other other housing options.
- Its ability to offer services that people want and cannot get in other settings.
- The degree of competition from similar facilities in the market.
- The ability to convince people to live in a congregate retirement setting.
Where people have a choice of what kind of housing they want and a choice among facilities in a market area, success in the retirement housing field requires having good facilities, good programs, a good marketing program, and competitive rentals. Unlike the hospital and nursing home industries, where the construction and licensing of new facilities is highly regulated, there are few regulatory barriers to entry into the retirement housing field. Most of the barriers are financial and market barriers. This means that new retirement housing facilities can be built in a given market and can compete directly with existing facilities. On the other hand, it means that to make feasible the construction of a new facility, overall market demand must be weighed against the supply of existing facilities.

In general, new entrants into the retirement housing field need to be able to attract residents who have never before lived in such a facility. This means changing people's housing patterns and expectations. Convincing the well elderly to move out of their homes and into a retirement housing facility takes time. Often, convincing the elderly means convincing their adult children, their accountants, and their attorneys as well. When an elderly person or couple gives up a home to move into a retirement housing project, they expect physical security and continued financial security, and the physical and emotional dislocations involved in such a move should not be underestimated.

Many retirement housing projects have been built and have remained largely unoccupied because, for one reason or another, they "missed the market". Numerous developers would "throw up" a facility expecting the elderly to flock to move in. Many developers have underestimated the intelligence of the elderly citizen as well as the difficulty in convincing someone to change their lifestyle--and changing lifestyle is what elderly housing is about. For new retirement housing facilities, a great deal of market research needs to be done prior to designing and building the facility. Market research involves both an assessment of the existing retirement housing market and an assessment of the tastes, desires, and budgets of the target market of potential elderly residents. Because the marketing aspects
of retirement housing are so difficult, many lenders will not consider financing a new project until residents have signed up and placed significant "reservation deposits" on apartment units.

*Occupancy Sensitive*: Retirement housing is not a high profit margin business. It can be a lucrative business if the facility is fully occupied, but retirement housing revenues are generally fixed monthly revenues paid by residents. As such, the cash flow of such facilities is occupancy driven, as opposed to other types of health facilities which are both occupancy driven and service driven.

*Vulnerable to Competition*: Entry into the retirement housing market is easier from a regulatory standpoint than entry into the hospital or nursing home market. Certificates of need are not required in retirement housing, since retirement housing is not reimbursed by Medicare or Medicaid.

Like the multi-family housing business, retirement housing is vulnerable to competition. Unlike the multi-family housing business, retirement housing appeals to a limited market--the well elderly, most of whom have other housing options. Because the elderly housing market for retirement facilities is finite in any given community, only a certain number of facilities are truly needed. Each new retirement facility in a community must carefully identify and be able to appeal to a specific elderly market segment.

*Price Inelastic*: Within any given socio-economic segment of the elderly market, there is a fairly narrow price range at which housing is considered affordable. An identification of the specific elderly market and the price tolerance of that market is critical to success in the retirement housing
<table>
<thead>
<tr>
<th>Distance</th>
<th>Retirement Center</th>
<th>Nursing Care Oriented Facility</th>
<th>Rental Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 miles</td>
<td>10%</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>5-10 miles</td>
<td>33</td>
<td>27</td>
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<td>11-15 miles</td>
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<td>16-20 miles</td>
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<td>21-25 miles</td>
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</tr>
<tr>
<td>Over 25 miles</td>
<td>19</td>
<td>13</td>
<td>12</td>
</tr>
</tbody>
</table>

business. Failure to identify a specific market and to match that market with proper services and pricing of those services will result in "missing the market".

The pricing of retirement facilities is related to the quality of the facilities, the amount of space per apartment, and the scope of routine services offered. Facilities which offer meals, emergency call buttons, housekeeping, recreation, and other services can factor these services into their pricing and can market to the elderly accordingly. In such instances, prospective elderly residents need to compare the housing and other services of the retirement facility or community to their present housing, food, and other expenses.

A retirement housing facility will be successful if it can identify a discreet segment of the elderly market in its service area, price its housing and other services to conform to the market, and convince enough people in the target market to change their lifestyles and move into the facility at the price range offered.

*Possible Convertibility to General Use*: Some retirement housing facilities may be convertible to general apartment use. Other facilities may not be convertible or may be convertible only at great expense. The degree of convertibility depends upon the design of the facility, the size and layout of apartments, and the amount and type of specialized fixed equipment and facilities. Convertibility of retirement apartments to general housing apartments generally comes down to a question of cost. Facilities which can be converted to general use and still remain price-competitive in the general housing market can be considered convertible to alternative uses.

Overall, in valuing retirement housing facilities it is important to bear in mind that these facilities are primarily housing, not healthcare, facilities and that they compete to attract residents who generally have a choice of housing and
lifestyle. The ability to provide price-competitive services and to attract and retain residents is the key to the success, and the value, of retirement housing facilities.

Analyzing the Business Fundamentals

As with other types of health care valuation, it is important to construct five year utilization, operating, capital, and cash flow projections by analyzing the fundamental elements of the business of a retirement center. Below are some comments on each of the key business areas.

*Market Position*

We have already commented that retirement housing facilities are highly market sensitive. The valuation of an existing, occupied facility involves examining the following elements:

- The length of resident stays and the degree of turnover.
- The overall size of the age and income-qualified market.
- The entrance of new competitors into the market.
- The quality of facilities and programs versus competitors.
Since the elderly residents in retirement housing facilities tend to be fairly stable residents, once a facility becomes occupied it tends to remain occupied as long as the physical condition remains good and as long as the programs remain current.

The market position of an already-built but only partially occupied facility becomes a function of its ability to fill up the remaining units. In such a case the market position, and the related ability to develop realistic utilization projections, becomes a function of several factors:

- The age of the facility in question; newer facilities take time to fill up, since the prospective elderly residents often take months to make decisions.

- The pricing of the facility versus the competition and relative to the age and income qualified targeted market.

- The management and the marketing program of the facility.

Evaluating the market position and developing projected occupancy statistics of a brand new retirement center involves considerable market research. Although we advise the valuer to rely upon qualified outside third parties to conduct such market studies and to prepare reasonable occupancy projections, some of the key elements of a market evaluation for a new facility are as follows:

- Definition of the "market area" to be served by the retirement center.

- Determination of rates, fees, and scope of programs.

- Definition of the size of the age and income-qualified population in the defined market area.
• Identification of competing facilities and their rates, services, and target markets.

• Focus group interviews with potential residents.

Although the cost approach to valuing a new facility is a legitimate valuation approach, a retirement center--like other health care businesses--acquires value by virtue of its ability to generate long term cash flow, and cash flow is generated by occupied apartments. Therefore, the market analysis and the resulting fill-up and occupancy projections for a new facility form the basis for income, expense, and cash flow projections.

Regulatory Position

Retirement housing is regulated primarily by the individual states, and the degree of regulation varies widely by state as well as by the type of retirement housing. Since health care is not the primary service of retirement housing facilities, health care licensing is not generally required of such facilities. Of course, they need to conform to general apartment-type building codes and regulations as do other multi-family facilities. Retirement centers which do provide nursing homes on their campuses need to have those homes licensed and conformed to applicable regulations, just as any other nursing home would need to do.

Retirement centers which take significant up-front deposits and "life care" communities are subject to additional regulations in many states. In some cases, life care communities are regulated by the commissioner of insurance in a given state--the theory being that large deposits for future medical care can be considered a form of insurance. Numerous life care communities have failed because of unfunded or inadequately funded future medical liabilities.
Operations

Retirement centers operate much as apartment centers, except that many retirement centers take up front fees and their services are more extensive than those of general apartment complexes. Most retirement centers, for example, offer common dining facilities, housekeeping services, emergency services, security guards, recreation activities, and transportation to shopping and special events.

Fundamentally, however, retirement centers rely upon a stable population which pays a monthly "rental" fee—even though the fee may be called something else. Monthly fees usually include one or two common meals per day and include a number of the other above services. The income and expense statements of retirement centers are not complicated, and in many ways resemble those of apartment buildings, with the added resident services of course.

The management of a retirement center is not complicated once the facility is fully occupied. Attaining full occupancy, however, can be time consuming and difficult. It is not uncommon for retirement centers to require an eighteen month to two year fill-up time. Having management and marketing personnel who are sensitive to the needs and desires of the elderly and who have a demonstrated track record of success in the field greatly strengthens the chances for a successful retirement facility.

Physical Facilities

The condition of retirement center facilities is extremely important to both prospective tenants and existing tenants. As indicated earlier, the residents of retirement centers tend to be the well elderly—people who do not need to be institutionalized and who have a choice of lifestyle and residence. Many of these people are living in an apartment center for the first time in years, and they are comparing
their new living conditions to having their own homes. Therefore, the quality of the housekeeping, the maintenance, the food, and other amenities becomes a topic of incessant conversation in a retirement facility; as residents talk to their friends and relatives outside the retirement center, word spreads quickly and the place develops an image.

Unlike hospitals and nursing homes, the physical facilities and equipment in a retirement center do not become functionally obsolescent over short periods of time. While upkeep and preventive maintenance are important in retaining existing residents and attracting new ones, retirement centers are not continually purchasing expensive new medical equipment. From a valuation standpoint, the condition of physical facilities is a question of allocating enough money annually to keep the facilities in good condition and allocating enough for major periodic expenditures such as a new roof or a new air conditioning system.

Financial Position

Since retirement housing facilities are not dependent upon third party payors for cash flow, assuring a steady stream of revenues simply involves having a high occupancy level and having residents who pay their rent or monthly fees on time. The issue of the timeliness and adequacy of cash flow becomes relevant to retirement centers which provide extensive, reimbursable health care services. Some retirement "campuses" contain nursing homes, personal care facilities, adult day care, and other geriatric health services. These services are, of course, vulnerable to cash flow problems to the extent residents use Medicare-eligible services or deplete their financial resources and become Medicaid eligible.

The issue of cash flow also arises for "life care" facilities which take large up front deposits from residents and use such deposits, or endowments, to cover all or a portion of
future medical costs. Early life care facilities purported to cover all medical costs, including full time nursing home care. In more recent years, life care facilities have learned that limitations must be placed upon contingent medical liabilities and have limited the amount of nursing home and medical care provided out of "endowment funds". Valuing the assets and the contingent liabilities of life care facilities is important in terms of the overall business valuation, but probably should be done with the assistance of accountants familiar with life care endowments.

Valuation Approaches

Unlike many other types of health care businesses, all three of the traditional approaches to valuation do apply to one extent or another in valuing retirement facilities. Because such facilities are basically housing facilities, the cost approach and the sales comparison approach to valuation are relevant, as long as one understands the specific differences between the facility in question and the market comparables.

As with other health care facilities, the value of a retirement housing facility is ultimately tied to the ability to produce future income. Market comparisons are most useful, therefore, in determining the reasonableness of the rates and fees of a retirement center versus alternatives. These "alternatives" include both competing retirement centers and, the case of the elderly, competing lifestyles. Knowing basic rental rates for housing services used by the market segment targeted by the retirement center and adding to those rates the fees for the added services specific to the retirement center will give the valuer a realistic range of total expected rentals which can then be compared with other settings.

Cost approaches to the valuation of retirement centers are, of course, relevant for brand new facilities where replacement cost and asset value are tied together. Cost approaches can also be useful in determining "alternative uses" for the retirement facility. However, the costs of conversion to alternative uses can be high, depending upon the sizes of apartments and the other elderly-specific facilities built into the project.
While on the surface many retirement facilities may appear to be easily convertible to general apartment housing, factoring in the costs of conversion may result in the necessity to charge rentals higher than the general housing market will bear.

The income approach to valuing a retirement facility is similar to the income approach to valuing a rental apartment complex, except that the determination of reasonably expected income and expense can be more difficult for a retirement project. Projecting fill-up rates and occupancy levels for newer retirement centers requires extensive market research—and caution. The elderly do not move as quickly as the general population, especially when they are often moving out of their own homes.

Achieving and maintaining stable occupancy results in achieving and maintaining stable cash flow. In a retirement housing project, stability of income and cash flow are the key ingredients in valuation. Because of the fixed monthly rental nature of such housing, and because there is a practical limitation on annual rent increases, the rate of profit margin of such projects tends to remain stable. The retirement housing business is a volume-driven, relatively low margin business where revenue stability and expense control are the keys to success.

As with other types of health care valuation, financial projections should be used to employ discounted cash flow techniques discussed earlier. Various discount or yield rates can be employed in the present value and discounting calculations to arrive at a reasonable range of value. The range of value can then be compared with general apartment housing values in the market area to arrive at a valuation frame of reference. One must keep in mind, of course, that retirement housing facilities generally provide services that other types of apartment housing do not and that, therefore, the monthly rental fees and other fees are likely to be higher for retirement housing.
Valuation of Medical Practices

Industry Profile

When we speak of valuing the "practices" of health care professionals, we are speaking about both the physical facilities and the business entities. As with other types of health care valuation, the medical equipment and supplies used by health professionals is of limited value outside a practice setting, and it is the patient base and the net cash flow from those patients which actually creates value.

Most health care practices do not require elaborate, single-use health facilities. The vast majority of health care professionals practice in office buildings, and they bring in examination tables and moveable equipment to one degree or another, depending upon the type of practice. Some physicians, of course, require more equipment than others, and spend most of their time treating patients in the office setting. Dentists, optometrists, chiropractors, dermatologists, plastic surgeons and audiologists, for example, have expensive equipment in their offices and require specially designed spaces within an office building. Family physicians, on the other hand, require less equipment, although their office space still needs to be designed to accompany patient traffic and treatment rooms.

It follows that physicians who perform procedures on patients in the office tend to need more specialized equipment and more specifically-designed office space. It also follows that such professionals operate more capital intensive businesses, in that the cost of their equipment is a significant cost in setting up their office. In some cases the "office" may be a sophisticated multi-specialty clinic which provides a wide range of outpatient services in its own right.
The most significant development with respect to physicians in the past two decades has been the significant increase in the numbers of practicing MDs, dentists, chiropractors, and other medical professionals. In the 1960s the Federal Government determined that there were too few physicians serving certain "medically underserved" areas of the U.S. and decided to encourage more young people to enter the medical profession. New medical schools were organized, and the government began providing student loans and grants for medical education on a widespread basis.

Both the absolute number and the proportion of practicing physicians have increased markedly since 1970. The number of active practicing MDs in the nation has increased 66% since 1970, and the number of physicians per 100,000 people has increased by 41% during the same period. Equally dramatic increases have occurred with respect to dentists, chiropractors, and other medical professionals. Many analysts and government regulators believe that although these increases have improved access to health care services and encouraged competition, the increases in practitioners have also fueled rising health care costs. Both the annual inflation in medical fees and the volume of such fees have been rising at about 15% per year consistently for the past decade.

The most common type of practice remains the solo practitioner, with solo practices accounting for more than half of all active physician practices. In recent years, however, group practices have grown as a percent of total practices as physicians band together to purchase the ever-expensive equipment, staff, and facilities required. Incomes vary among types of physicians according to medical specialty, with the more specialized practitioners receiving more income. However, liability insurance also varies by specialty, and liability insurance premiums have increased significantly since the mid-1970s.

In 1988 Congress began studies which are expected to lead to the assignment of "relative value scales" for all physician procedures. The purpose of these value scales would be to provide a standardized basis for reimbursement by Medicare, and it is expected that other third-party payors would join in with similar programs. If these relative value scales are implemented, they will affect and alter the incomes of most physicians, especially those with high percentages of Medicare patients. Some
PERCENT DISTRIBUTION OF SELF-EMPLOYED PHYSICIANS
BY SIZE OF PRACTICE, 1987

<table>
<thead>
<tr>
<th>ALL PHYSICIANS</th>
<th>PERCENT DISTRIBUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo Practice</td>
<td>55.1%</td>
</tr>
<tr>
<td>Two-Physician Practice</td>
<td>12.7</td>
</tr>
<tr>
<td>Three-Physician Practice</td>
<td>8.0</td>
</tr>
<tr>
<td>Four to Eight Physician Practice</td>
<td>13.8</td>
</tr>
<tr>
<td>Over Eight-Physician Practice</td>
<td>10.5</td>
</tr>
</tbody>
</table>

specialties would be favorably affected, while others would be adversely affected, and by influencing reimbursement these standardized relative value scales would greatly affect cash flow.

Regardless of what specific plan is ultimately adopted, the Federal Government is moving toward increased regulation in setting physician fees and—like the fee setting for hospitals, nursing homes and other health facilities, such regulation will significantly affect business valuation.

**Characteristics Affecting Valuation**

Most physicians share some common characteristics which are relevant in approaching the valuation of their businesses. Several of the more important characteristics are outlined below:

*Owned versus Leased Facilities:* Health professionals either own office buildings or lease space in an office building. If a physician owns an office building and leases a portion of the space to other tenants, the valuer needs to determine whether the building is to be valued as part of the assignment or whether only the physician’s practice is being valued. Many physicians and other professionals who lease space do own their own equipment, although some also lease their equipment, creating debt obligations.

From a valuation standpoint, the following points need to be made:

- Office buildings for general use can be valued as such.
- The "cost of conversion" of specialized medical office space needs to be factored into valuations for alternative uses.
- The cost of medical equipment may or may not be reflected in the operating statement of a medical practice.

- Medical equipment valued for sale takes on a different value than medical equipment which is part of an ongoing practice and is an *earning asset*.

*Patient Volume Driven*: All health care practices are patient volume driven, meaning that the value of the practice relates in large part to the volume of patients. The type of patients is also important, of course, in determining gross revenues. From a valuation perspective, it is important to note that projected changes in future patient volume need to be substantiated.

*Patient Loyalty Driven*: Although the health consuming public is less hesitant to change physicians or try a new type of health care professional, patient loyalty remains a major factor in all medical practices. Thus, if a practice is being valued for purposes of a sale to another practitioner, there will inevitably be attrition or loss of patients. The degree of patient attrition depends upon several factors:

- The type of medical practice.

- Whether other practitioners share the same office.

- The ages and type of patients.

Although the degree of patient loyalty is sometimes difficult to measure—and ultimately involves some subjective judgment—the issue must, nonetheless, be dealt with in any health care practice valuation, especially if the valuation involves a change in practice ownership.
Payment Mix: A significant percentage of all professional office revenues are paid by individuals. Insurance companies do cover office visits to one degree or another, depending upon the insurance company and upon the type of physician. Medicare and Medicaid also cover a portion of the cost of physician office visits. From a valuation standpoint, analyzing the mix of payments to a professional practice can be important in evaluating the timing and adequacy and timing of cash flow.

Management Intensive: Contrary to the belief of some who feel that physician offices are simple to manage, they do require extensive management, and poor office management can seriously harm a professional health care practice. Practices are management intensive in three areas: appointments, record-keeping and collections. Appointments must be made and scheduled in a way that accommodates the needs of patients and the practicing style of the physician. Although practice volume often dictates patient scheduling, a practice which runs consistently behind schedule—or which has gaps of unproductive time—is not an efficient practice.

Keeping good records and current patient charts is important for two reasons. First, physicians and nurses need to be able to refer to notes on their patients' conditions. Poorly kept patient charts make for inefficiency and exposure to potential liability. Second, patient charts are often used for billing purposes, and incomplete charts can lead to incomplete billings.

Collections represent the third management intensive aspect of professional health care practices. Managing billings, collections and accounts receivable is critical for a successful practice. Physicians, who were trained in medicine and not in business, need a competent manager or outside management service to handle accounts receivable. Medical practices are notorious for having a large percentage of gross revenues in uncollected receivables.
One valuation rule applies to medical practices: it is not what is billed that counts but what is collected. Often, physicians unknowingly work long hours and "lose" a quarter or a third of their revenues through incomplete or lost billings, bad debts, and uncollected insurance claims. Recent trends in automated, paperless medical claims processing will doubtless help physicians and other health professionals, but such innovations do not replace the need for a competent office staff who can manage scheduling, record-keeping, and collections. The financial statement of a medical practice is likely to be a reflection of how well or how poorly these functions are carried out, and it is not an exaggeration to say that the office staff of a health professional is important to the cash flow—and value—of the practice as is the professional himself.

Analyzing the Business Fundamentals

In conducting a valuation of the practice of a health professional, the purpose of the valuation has an impact upon the valuation approach. Because the business is a personal service business with a strong component of patient loyalty, it is important to know whether the practice will continue to be carried on by the existing professional, or whether the valuation is being made for a change in ownership.

Some of the leading reasons for valuing health care practices are as follows:

- The practice wishes to finance equipment or borrow money.
- A new associate is being brought in and is "buying into" the existing practice.
- The physician is retiring or moving away and is selling the practice.
• The physician has died, and the practice needs to be sold to existing partners or to a new owner.

• A hospital is investing in or "buying" a medical practice.

• A hospital is entering into a joint venture which requires a valuation of the medical practice for purposes of financing, determining relative contributions or negotiating the terms of a future buy-out agreement.

What does one buy when one buys a medical practice? One is really buying access to a base of patients. One may also be purchasing equipment and supplies, but it is the access to patients which renders the equipment and supplies productive. Buying access to patients does not guarantee anything. Patients are free to choose their physicians. Therefore, one needs to look closely at the market situation, the competing physicians, the degree of patient loyalty, the quality of facilities, the stability of staff, and other factors to determine a realistic "attrition rate" of patients. Few practices change hands without a loss of patients--the question is, how large will the attrition be?

Valuing an existing medical practice where the existing practitioner or practitioners will remain involves looking at a number of the business fundamentals, but does not involve examining the issue of patient attrition, unless it is clear that a practitioner will be leaving the practice shortly. When hospitals purchase the practices of active physicians, however, they need to carefully evaluate the purchase contract, the incentives offered and the net future benefits to the hospital.
Some of the business fundamentals which need to be examined in a valuation area as follows:

**Market Position**

Because of the personal nature of health care practices, the market position of a practice is a two-edged sword. On the one hand, patient retention in a well-run, stable practice tends to be high. On the other hand, practice turnover results in patient attrition, as we have already pointed out. The mere existence of like practitioners in a market need not negatively impact the market position of existing, successful practitioners. However, a newer physician can encounter problems attracting patients if there is already an abundant supply of like practitioners.

The market position of a physician can be influenced by the nature of affiliations with other health care providers, such as hospitals. Being on the medical staff of the right hospital can, in and of itself, generate patient volume. Being the sole specialist in a community will be an automatic strength in term of market position. Supply and demand forces are at work in the health professions as in any other profession, although in the health professions patient loyalty does play an important role.

The analysis of market position should produce a realistic projection of future patient volume, including a breakdown of where that volume comes from. Some specialists obtain patients strictly through referrals from other health professionals; other practitioners obtain patients from hospitals, nursing homes, and clinics. Still other professions advertise outright for patients. Determining the historic and the realistic future market position as well as projected patient flow is fundamental to valuing a medical practice which, after all, is a volume driven business.
Regulatory Position

Although medical societies and medical practice acts in the various states regulate the delivery of health care by health professionals, most practitioners are not heavily burdened by inspectors and other regulators. The regulatory position of a medical practice is determined in two principal areas: malpractice and reimbursement. A medical practice with a history of litigation needs to be carefully examined in light of possible liabilities, although in a change of ownership the malpractice and fraud issues usually remain with the past owner and do not carry over to the new owner. In a group practice setting, however, the entire group of physicians may be held liable, especially if malpractice involves jointly held medical equipment or jointly employed staff.

The insurance premiums for malpractice insurance have risen staggeringly in the past decade. The appraiser needs to take careful note of the contingent liabilities, malpractice premiums, and malpractice cases of any practicing health professional, especially if the practitioner in question intends to remain with the business.

With respect to reimbursement, all types of health professionals are increasingly dependent upon third party reimbursement for revenues, and the degree of regulation of fees varies depending upon the type of professional. In general, medical professionals are permitted to charge any fees which are deemed to be "reasonable" by third party payors. The definition of reasonableness depends upon the type of payor, but most third party insurers use ranges of fees prevalent in geographic areas which are charged by various types of professionals for various procedures and services.

As indicated earlier, in 1988 the Federal Government began an effort to study the possible standardization of all medical fees reimbursed by Medicare and Medicaid in an attempt to hold down the nearly 15% annual increases in physician fees nationwide. Such a standardized fee system would be based upon:
<table>
<thead>
<tr>
<th>SELECTED SPECIALTIES</th>
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<th>1987</th>
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</thead>
<tbody>
<tr>
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<tr>
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<tr>
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<td>Pediatrics</td>
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<td>Obstetrics/Gynecology</td>
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</tr>
<tr>
<td>Emergency Medicine</td>
<td>100,200</td>
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</tr>
</tbody>
</table>

SOURCE: American Medical Association
- The type of specialist or professional.

- The standardized "resources" used per procedure (resources defined as time, intensity, equipment, staff, etc.).

- The type of practice, geographic area, inpatient vs. outpatient, age and sex of patient, and other criteria.

It is quite likely that by the early 1990s all reimbursed medical and related professional fees will be regulated and will, therefore, be subject to standardized caps. Such fee regulation will definitely affect the potential maximum cash flow of medical and other professional practices which rely upon third party reimbursement. It will be important for anyone valuing such practices to determine the extent to which the revenues of such practices are dependent upon third party payors and to determine the nature of fee regulation at the time of the valuation and into the reasonably anticipated future.

*Operations*

We have already commented upon the management intensive nature of health care practices. Important to a valuation is an analysis of accounts receivable, bad debts, patient records, and other operational elements affecting cash flow.

The quality and stability of the "front office" staff and the nursing staff are important in assessing the overall quality of operations, although such assessments are, to a large degree, subjective. Many practitioners use outside "practice management" services to handle a variety of bookkeeping, billing, and accounting tasks, and often the practitioner is
better off using such a professional service than trying to handle this alone. Good management and efficiency alone add to the value of a medical practice, and this is almost always reflected in the bottom line.

It is recommended that financial projections of income, expense, and cash flow be made for professional practices during the valuation process as is the case with other types of health care valuation. It is also recommended that the salary expectations of the practitioners themselves be factored into such projections, so that the projections fully reflect the business as a whole.

*Physical Facilities*

The evaluation of physical facilities depends upon the type of practice being valued. Practices with extensive equipment and space require a different approach than practices using mainly conventional types of offices.

In general, the physical facilities should be examined on the basis of the condition and quality of equipment and space, as well as the overall environment. In a business as personal as health care, the patient environment can be important in setting the right tone and in enhancing patient loyalty. Friendly, warm touches in an office may not affect the way the practitioners do their job, but can affect the attitude of patients.

As in any health care valuation, it is important to determine whether physical facilities and equipment need to be upgraded, and if so, how much that will cost. In valuing a dental office, for example, the equipment of an elderly practitioner may be outdated and not suitable for today's young "high-tech" dentists and dental hygienists. The value of the practice in such a case is tied to both the patient volume and to the expected capital expenditures necessary to bring the facilities up to date.
Financial Position

As was pointed out earlier, the quality and time of health care practice receivables can be critical in influencing the cash flow—and therefore the value—of the business. Physicians, dentists, chiropractors, and other health professionals learn sooner or later that they are running a business. This is sometimes learned quite painfully.

Cash flow is influenced by the quality of management, as discussed above, and by the mix of patients by payor category. Knowing what the mix of patients is and how the payors are handled by management are both important elements in being able to realistically project future cash flow.

In projecting the future cash flow of a medical or other professional practice, it is recommended that salaries of the practitioners be factored into expense projections, in addition to staff and all other expenses. In this way, basic salary and benefits expectations are clear in the valuation process, and other investment, yield, and profit benefits can be analyzed within the context of a truer reflection of the business as a whole.

Valuation Approaches

Professional practices can be valued by a combination of the asset, the sales comparison, and the income techniques, with emphasis upon the latter two techniques. In addition to analyzing the business fundamentals of a medical practice, there are two keys to determining valuation:

- Determining the rate of expected growth of the practice.
- Determining the patient attrition rate of a change in ownership.
As with other forms of health care valuation, the sales comparison approach is helpful in establishing a frame of reference. In the case of professional practices, the approach is to determine what the "rule of thumb" is in a community or an area in terms of valuing the practice as a multiple of collected revenues. In many areas, stable medical practices are valued at 1 times revenues, with additional allowances for special equipment and other assets.

It should be stressed that the sales comparison approach can be more relevant to medical and related professional practices than to other types of health care valuation simply because of the larger numbers of such practices in relation to the numbers of other types of health facilities. In large metropolitan areas there may be several hundred or even several thousand practicing physicians, and even in smaller communities with one or two hospitals there may be fifty or more practicing physicians. Obtaining market comparable data for similar types of physicians is more useful than for other types of health facilities because the physical facilities of most physicians are not as important in valuation as other factors such as patient flow, patient retention, market position, and cash flow.

Although market comparisons of sales of physician practices can be helpful, they should be viewed only as a starting point in establishing value. The specifics of the business at hand must ultimately guide the appraiser to the establishment of a "reasonable range of value". If a practice has a fairly captive market that has generated dramatic recent growth, then such growth should be taken into account in projecting future revenues, and financial projections should become a part of a practice valuation just as with any other health care business. On the other hand, if the patient volume of an older physician has been falling off and the physician now wishes to sell the practice, the issue of patient attrition could be a large factor in establishing value.

The purpose of the valuation is important to keep in mind as well. For example, many multi-physician practices are valued for the purpose of establishing "key man" life insurance or for the purpose of arriving at a fair buy-out provision in the event one partner leaves or otherwise ceases to practice. Other practices are valued for outright sale to a new, incoming physician.
The issue of patient attrition--or loss of patients due to a changing practice ownership--must be examined in light of the circumstances surrounding the valuation. In the case of a multi-physician practice or clinic, for example, attrition caused by the departure of one partner may not be a serious problem, since other partners are there to immediately take care of the existing patient base and since the clinic is already a known entity by all of the patients. In the case of a solo physician selling a medical practice and leaving the practice entirely in the hands of a new, incoming physician, patient attrition could be significant, depending upon other market conditions such as the number of similar practitioners in the area. It is not uncommon for an incoming physician buying an practice from a retiring physician to lose as many as a third to one-half of the patients, and this possibility must be factored into the cash flow projections and the valuation process.

As with other forms of medical equipment valuation, the medical equipment of a practicing physician is worthwhile only in its ability to generate revenue, and there is not a high value for used medical equipment. Therefore, medical equipment must be valued at best based upon the equipment valuation formula described previously:

- Replacement Cost

less

- Depreciation

less

- Obsolescence factors.

Most routine office and medical supplies should be valued at book value, since it is likely they were acquired recently and will be usable. If the medical practice includes a clinic building, that structure should be valued based upon its specialized nature and its cost of convertibility to general use. If the facility is not convertible to general use, it is of limited value unless it is part of a medical office building in an area where other physicians would demand such a facility.
As with other types of health care valuation, the primary task in valuing a medical practice is to determine what is a reasonable future cash flow and to attribute a value to that cash flow. Although rules of thumb in medical practice valuation do exist in various communities, there is no substitute for an independent projection of cash flow based upon the fundamentals of the business discussed earlier. With respect to the projection of cash flows, it is recommended that the expected salary or salaries of the practice in question be factored into the expenses, even if the practice in question is a self-employed practitioner. In this way, one achieves a picture of an operating entity and can then separately identify discount rates, yield rates or rates of return for the business, for--whether physicians know it or not--they are operating a business.
Valuation of Home Health Agencies

Industry Profile

The provision of home health care has grown dramatically in recent years, and many hospitals have entered this industry as a way of diversifying their business as well as creating a "feeder" system for their other hospital services. Home Health Agencies have three major features:

- They are "alternative care" entities, meaning that they provide alternatives to inpatient hospital care.

- They are not as capital intensive as inpatient facilities, although they do require a significant amount of medical equipment.

- They can be highly labor intensive, requiring an adequate and dependable supply of nursing staff.

Home health agencies are essentially service businesses which do not require large physical facilities. Home health agencies utilize physicians, nurses, nurse aides, and other medical professionals to deliver health care services in the home, at the direction of physicians. Home health care includes a wide variety of services and also includes a variety of equipment. Medical equipment and related supplies can be a large portion of the assets of a home health agency. Such equipment includes respiratory therapy equipment, oxygen equipment, rehabilitation equipment, and a host of nursing, drug, and nutritional supplies. Home respiratory therapy and kidney dialysis, for example, are commonplace.
Nearly three-quarters of all home health visits are made to the elderly, and as such, home health care does qualify for reimbursement by Medicare. To receive such reimbursement, however, a home health agency must become Medicare certified. Private insurance and private pay for home health care accounts for more than half of home health revenues. From a valuation standpoint, a home health agency needs to be examined on the basis of the population base it serves, the adequacy of its staffing, the adequacy of reimbursement by third parties, and the value of its equipment (although many agencies lease their equipment). Home Health Agencies can operate out of an office building, except that they require space for mobile equipment.

The home health industry is a relatively new major force within the overall U.S. health care industry. It is interesting to note that, like the HMO industry and other forms of "alternative care", the most dramatic growth of home health agencies has occurred during the 1980s, although a good base of agencies was established during the 1970s as Medicare and Medicaid began to encourage the use of such care. The total home health market, which contains a number of medical treatment and preventive services, is expected to grow at least fourfold during the 1980s.

Even though the home care market has grown significantly, the National Association for Home Care estimates that there is a large unmet need for home care services as well as the possibility of providing much more home care to people who now seek care in other settings. With the vast majority of home care given to people over age 65, it is likely that as the technology and capabilities of home care improve, home care will replace some of the care which is now provided in nursing homes.

Home Health Care is funded primarily by private payment and by Medicare, which is the largest source of reimbursement for such care. In as much as most home care recipients are elderly who are covered by Medicare, nearly all home care agencies become "Medicare-certified" in order to be eligible for this reimbursement. As home care has become more heavily utilized during the 1980s, the Medicare funding of such care has grown significantly, with the largest growth occurring in the second half of the decade.
Characteristics Affecting Valuation

Following are some of the general characteristics of home health agencies which affect the approach to their valuation.

A Growth Industry: The home health industry has experienced dramatic growth in the past decade, as the industry profile illustrates. Home health care represents a leading form of alternative health delivery and is rapidly becoming tied to the trend toward managed care. Many experts believe that managed care will dominate the health care industry within the next decade. Continually improving medical technology is making possible an ever-increasing role of home health care, and some experts believe that home care will eventually dominate the care of the elderly. From a valuation standpoint, the fact that this is a growth industry which is "riding" current and future health care trends means that these industries will remain viable for some time to come.

A Consolidating Industry: With growth often comes eventual consolidation. Because of economies of scale and other considerations, the home health industries have begun to undergo a shakeout. In the home health industry the requirements for increasingly expensive portable medical equipment are forcing some smaller home health agencies out of business or into mergers with larger organizations.

From a valuation standpoint, it is important to understand the relative market position of a home health agency in relation to its competitors. With utilization of home health care increasing, the market can absorb new entrants--to a point. The relative newness of home health agencies means that they are competing with other forms of health care as well as with similar competitors. Knowing how a specific home health agency compares with its competitors in a given community in terms of both its services and its
relative market position will give the valuer a sense of the likelihood of the business’ survival as consolidation inevitably occurs.

*Volume Driven*: Home health agencies are volume driven businesses, and require a certain "break-even" volume to remain viable. Home health agencies measure volume in terms of the number of patients served, and they require a certain basic volume to cover staffing, equipment, management, and marketing expenses.

*Not Health "Facilities"*: Home health agencies are not health care "facilities" as such. Home health agencies deliver health care services in people’s homes; the physical assets consist of medical equipment and supplies. In the truest sense, home health agencies are health care service organizations and need to be valued as such. They are part of two important emerging forms of health care delivery—managed care and mobile care—two forms of alternative care that, in themselves, do not require specially designed buildings and facilities. They are not as capital intensive as other forms of health care, but they are just as cash flow driven and as specialized as other health care businesses.

**Analyzing the Business Fundamentals**

Following is a discussion of the five major areas of health care businesses as they apply to valuation of home health agencies.
Market Position

As with other health care businesses, the analysis of market position is used to create projections of future patient volume and utilization. Home health care is more easily understood than many other forms of health care by the consuming public, and since most home health care is used by the elderly, the capturing of market share is a fairly clear-cut task—though not necessarily an easy one. First of all, most home health services must be authorized by a physician. This means that home health agencies market to physicians, clinics, dialysis centers, and hospitals in addition to marketing directly to consumers. Some physicians instruct patients to use home care services and leave the choice of agency to the patient; other physicians recommend specific home health agencies.

Home health agencies must purchase a certain amount of expensive equipment as well as medical supplies for their users in order to achieve a "critical mass". In addition, home health care requires registered nurses, licensed practical nurses, nurse aides, physical therapists, and other types of health professionals. To be Medicare accredited, a home health agency must have a certain staff and equipment; thus, there is an initial capital cost of entry into the business. These barriers to entry can place a hospital at a competitive advantage, since hospitals are used to acquiring and managing specialized staff and equipment.

Market positioning of home health agencies is a function of marketing, competition and cost. Because many recipients of such care are elderly patients eligible for Medicare, the elderly are extremely cognizant of price, since they must pay the co-insurance portion of Medicare. Market positioning is also a function of service, and in the home health field good service often means having the latest equipment and technology in addition to having responsive staff. As it has become necessary to replace older equipment with newer equipment in order to remain competitive, some home health agencies have not been able to keep up with the capital requirements of this rapidly
HOME HEALTH: UNITED STATES
THE HOME CARE MARKET: EXTREMELY DIVERSE
AND INCREASINGLY COMPETITIVE

Major Product/Service Segments

Medical Home Care Market (Treatment, Rehabilitation, and Maintenance Care)

Services:
- Physician and nursing services
- Home aides, physical, respiratory, speech, occupational therapists
- Social support for patients and families, including respite care, adult and child day care services oriented to assistance with ADLs (activities of daily living) as well as chronic and/or disabling medical conditions and dementias
- Nutritional services
- Data Processing
- Claims processing
- Equipment services
- Home telemetry

Supplies, devices, products, and equipment:
- Oxygen/respiratory therapy equipment
- DME: durable medical equipment
- Rehabilitation equipment
- Nursing care supplies
- Drug Therapy
- Oral and total parenteral nutrition products
- Home kidney dialysis

Wellness Home Care Market (Diagnostic, Education, and Prevention)

Services:
- Diagnostic testing/screening
- Educational counseling and information
- Daily living support services (housekeeping, chore services, home maintenance)
- Health prevention services (exercise, nutrition)

Supplies:
- Self-diagnostic/screening products
- Self-treatment products
- Vitamins, nutritional supplements
- Exercise equipment
- Aids for daily living products
- Communication and security devices
changing business. Therefore, market position is related to the ability to remain current, which is, in turn, related to size and capitalization.

The end result of an analysis of market position for a home health agency is a projection of numbers of home visits by category, quantities of medical supplies sold, and equipment rentals. Because home health care is growing so rapidly, it is not uncommon to see dramatic projections of utilization of such services; however, the valuer needs to weigh the reasonableness of such projections in light of the ability to acquire equipment and labor to meet future needs, in light of expected competitive pricing, and in light of marketing efforts and relative present market position.

**Regulatory Position**

Home health agencies must be licensed and regulated by various agencies. Home health agencies provide direct health care services, and even though they do not provide care in a clinical setting, they are still subject to a variety of regulations. The two most important areas of regulation are staffing and equipment. Home health agencies must maintain certain types of staffing and certain ratios of staff to patients served in order to be properly licensed and to receive Medicare certification, which is crucial to success in the home health business.

Because such agencies are using life-saving and life-sustaining equipment such as dialysis and respiratory therapy equipment, this equipment must be in excellent condition, and inspectors do inspect the equipment and medical supplies of home health agencies, making agencies replace poor equipment to maintain licensure. For home health agencies, therefore, the regulatory issues relevant to valuation generally involve projecting future costs of maintaining proper staffing and maintaining proper equipment and supplies.
HOME HEALTH: UNITED STATES
HOME CARE SERVICES
PAYMENT SOURCES, 1987

PRIVATE SOURCES 54.8%
MEDICAID 9.7%
MEDICARE 32.2%
OTHER 3.3%

SOURCE: SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
Operations

Home health agencies are direct health care providers with health care staffs, medical equipment, vehicles, and related operating assets. Therefore, the effectiveness, efficiency, and competitiveness of operations becomes relevant from a valuation perspective. Home health care can be a profitable business, but it can be unprofitable if the mobile staff and equipment are not managed properly. Financial management systems, billing, collections and other controls are critical to success in the field of home care.

Physical Facilities

Home health agencies own equipment, supplies, vehicles, and other physical assets. As is the case with the valuation of other types of health care businesses, the valuer needs to determine the condition of these physical assets from the perspectives of both their functional utility and their competitiveness.

Health care equipment needs to be replaced more frequently than buildings, and the pace of technological change with respect to equipment creates the need to frequently upgrade equipment. In conducting a valuation the valuer needs to strike a balance between assessing the functional and competitive obsolescence of equipment and being realistic about the fact that no home health agency can always have the latest equipment. The objective is to estimate the reasonable expenditures for equipment and related facilities over at least the next five years, so that such capital expenditures can then be factored into the cash flow projections.
Financial Position

The revenue stream of home health agencies depends upon both private pay patients and third party payors. As with other health care businesses, it is important to evaluate both the adequacy of reimbursement and the timeliness of payments.

Valuation Approaches

Since home health agencies are such volume driven businesses which also own significant assets in the form of medical equipment, both asset-based and income-based valuation techniques are appropriate in establishing a reasonable range of value. In the case of home health agencies, medical equipment plays a role in establishing value, although the value of the equipment needs to take into account depreciation, functional utility and obsolescence. It is important to remember that with respect to any medical equipment, the value of the equipment outside of the operating business is limited. Therefore, the most reasonable approach to establishing equipment valuation is to use the following formula:

\[
\text{Replacement Cost} - \text{Depreciation} - \text{Obsolescence Factors}
\]
With respect to income valuation approaches, patient volume and related revenues are key to establishing value. As with other types of health care valuation, the quality of the valuation itself will depend upon two major factors:

- The reasonableness and completeness of the assumptions underlying the net cash flow projections, taking into account the analysis of the business fundamentals.

- The discounting and yield assumptions, given the purpose of the valuation and given the degree of relative risk.
Valuation of Outpatient Clinics
and Related Facilities

Industry Profile

When we speak of outpatient clinics and "related facilities" in this chapter, we are speaking of the following types of health care businesses:

- Outpatient Medical Clinics
- Outpatient Emergency/Urgent Care Clinics
- Outpatient Surgicenters
- Specialty Outpatient Clinics

With the exception of group medical practices, few of the above types of outpatient treatment settings existed prior to 1970, and there were not many of these facilities even in 1980. In fact, the 1980s can be viewed as the decade of the explosion of outpatient and alternative forms of health care. The dramatic growth in outpatient clinics and related facilities has been brought about by three forces:

- Improved medical technology, which has permitted an increasing number of medical problems to be treated on an ambulatory basis.
- Health cost containment efforts, including the growth of managed care organizations such as HMOs and PPO's.
• The growing desire of physicians to own and control patient care facilities.

• The recognition by hospitals that they need to be providing significant amounts of outpatient care to effectively compete in their respective markets.

The provision of health care in outpatient clinics has cut into hospital market shares, although many hospitals have themselves entered the huge outpatient market. Unlike hospitals, however, most outpatient clinics are for-profit businesses, and a large percentage are owned or controlled by physicians. A valuation of an outpatient treatment facility frequently involves both a building and various types of equipment. As is the case with other types of health care valuations, the objective of an outpatient facility valuation is to assess the overall value of the business. The value of an outpatient building and its equipment lies in its ability to generate cash flow; like other health care facilities, most outpatient facilities are single-use or limited-use facilities.

Like the HMO and Home Health Care industries, the ambulatory care industry has grown dramatically during the 1980s. The industry can be divided into four major types of facilities:

• Outpatient Medical Clinics

• Outpatient Emergency/Urgent Care Clinics

• Outpatient Surgicenters

• Specialty Outpatient Clinics

Outpatient Medical Clinics include multi-specialty, freestanding physician clinics as well as hospital-based outpatient clinics. Nearly 60% of all hospitals provide outpatient services (often called "ambulatory care services"). Outpatient Emergency/Urgent Care Clinics are usually freestanding facilities located throughout metropolitan areas or strategically located in rural areas where health care services are in short supply.
A significant percentage of such clinics are owned by either physicians or hospitals. Outpatient surgicenters are owned primarily by physicians and physician groups, and most surgicenters specialize in a limited variety of surgeries, with the most prevalent type of outpatient surgery being eye surgery. Knee surgery, cosmetic surgery, liposuction, and hemorrhoid surgery are all being performed routinely by outpatient surgicenters, and the list of types of surgeries performed on this basis is continually expanding.

Specialty outpatient clinics include dialysis centers, diagnostic imaging centers, cancer treatment centers, drug/alcohol treatment centers, and rehabilitative medicine centers. As various types of illnesses become treatable on an outpatient basis, the types of such specialty clinics is expected to increase. In certain areas, such as kidney dialysis, the outpatient industry is competing with the home health care industry, since home dialysis has become technologically possible. Treatment of chronic illnesses will, to a degree, be shared by the home health and outpatient industries in the coming years.

**Characteristics Affecting Valuation**

There are a number of characteristics specific to outpatient clinics and related settings which affect the valuation of those businesses.

*Growth Industry*: As the industry profile indicates, the outpatient service industry and its components have grown dramatically in recent years. There is little question that this segment of the health care industry will continue to grow and will lead many of the new developments in future patient care delivery.

Some segments of the outpatient care industry are older than others. For example, group medical practices with clinics have existed for years; many of these clinics have evolved into more sophisticated patient care facilities simply by acquiring new equipment. On the other hand,
surgicenters, renal dialysis clinics, and diagnostic imaging facilities are newer types of outpatient treatment facilities that are still evolving in terms of both their operations and the establishment of market position.

Although outpatient treatment continues to increase, there will inevitably be a shakeout among competitors in given market areas and among given types of outpatient facilities. This has already happened, for example, with respect to emergency clinics in some geographic areas. Knowing how a particular type of outpatient care is positioned within a given market area is important in the valuation process.

**Limited Use Facilities:** Like many other health care providers, outpatient clinics are, to one degree or another, limited use facilities. In some cases, such facilities are located in office buildings, using specially-modified spaces. More often, outpatient clinics and related facilities have their own specially-designed buildings. From a valuation standpoint, determining whether there is an "alternative use" involves determining the cost of converting these special facilities to more general uses.

The costs of converting to alternative uses will depend upon the nature of the facility, its design, and its equipment. In some outpatient settings, for example, the design of the facility and the nature of the equipment used is so specialized as to render the facility virtually a single-use facility. From a valuation standpoint, the degree to which the buildings and other physical facilities of outpatient clinics can be regarded as assets contributing to value depends, in large part, upon their relative convertibility to general use.

**Market Sensitive:** Although the provision of outpatient health care is a rapidly growing industry, certain areas are saturated with certain types of facilities. Types of clinics which encourage patients to "walk-in" or just call for an appointment--such as emergency centers and certain types
of day surgery centers—are vulnerable to too much competition, changes in medical technology, and changes in consumer attitudes.

Highly specialized outpatient clinics which provide advanced diagnostic or surgical services are not as vulnerable to market shifts because they usually have a base of physician referrals—sometimes the owners of the clinic themselves—and because the cost of entry is high for competitors. Clinics which provide more general emergency or family practice services are generally more vulnerable to competition. New technology can be a two-edged sword when it comes to outpatient services. Although new technology can provide services to patients which previously required hospitalization or more involved procedures, time is often required for the market to learn about and trust such new procedures. This includes both the consuming public and the rest of the medical community, who can be a source of patient referrals to clinics.

It should be noted that hospitals are becoming effective competitors in providing outpatient care, and they are often the best positioned entities in their respective communities to provide such care. Where a hospital gains a strong market share in the provision of outpatient care, it may be difficult for new market entrants to achieve effective market penetration.

Reimbursement Dependent: Most outpatient services rely upon a combination of private pay and third party reimbursement. The mix of private pay versus third party reimbursement depends upon what type of insurance coverage the patients have and, to a degree, upon what types of services are offered. In general, private insurance covers "necessary" outpatient treatment: that is, treatment prescribed by a physician other than for clearly elective procedures.

Some surgicenters and clinics offer cosmetic surgery, liposuction, and other clearly elective procedures, and most insurance carriers do not reimburse for these procedures.
In such cases, the clinic is relying totally upon private payment for services. A valuation of such a clinic must take into account the reliability of cash flow from private patients as well as the amount of bad debts. Clinics which rely upon private insurance, Medicare, and Medicaid are vulnerable to the same kinds of cash flow problems as other health providers if they do not manage their billing and accounts receivable properly. It is more often the case that outpatient care is subject to reimbursement limitations, just as with inpatient care.

*Volume Driven:* As outpatient facilities, clinics receive revenues based upon the numbers of patient visits and the specific services provided to each patient. As with other health care businesses, there is a certain "break-even" volume necessary to cover fixed facilities and personnel expenses. Once fixed expenses are covered, outpatient clinics can be high-margin businesses, subject of course to the various types of reimbursement. Even with reimbursement cost controls, a high volume outpatient clinic can generate high operating margins and high cash flows.

It is important to keep in mind that outpatient clinics provide an intensive level of service in a short time frame. When patients are visiting outpatient clinics, they are there for specific treatments, and they then return home. Beds and buildings are not required for extensive patient recovery. Nowhere is the profit margin differential between inpatient and outpatient services so dramatic as with day surgery clinics, sometimes called "surgicenters". The avoidance of overnight hospital stays reduces costs enormously, and outpatient surgicenters can perform surgical procedures at far less cost than hospitals while still making a large profit margin. Once the "breakeven" volume is achieved, additional volume brings forth significant marginal profits.
Analyzing the Business Fundamentals

As is the case with other types of health care valuation, it is important to analyze the key areas of an outpatient clinic’s business: market position, regulatory position, operations, physical facilities and financial position.

Market Position

The objective of an analysis of the market position of an outpatient clinic or related facility is to arrive at a reasonable five year projection of patient utilization by category of patient and type of payor. For single-purpose clinics such as kidney dialysis centers, the types of patients are fairly uniform; for multi-purpose clinics it is necessary to evaluate and project utilization by major type of service. The market position of an outpatient clinic is a function of its absolute patient utilization, its utilization relative to competitors, and its ability to receive referrals from other types of health care providers.

Outpatient clinics and related facilities market directly to consumers, and they also market to physicians and other health providers in a position to refer patients. Some types of clinics need to market more than others, both because of more competition in an area and because they may have newer technology about which they need to educate the public and the medical community. Although the field of outpatient care is growing rapidly, so is competition in many areas, especially with respect to the lower levels of patient care such as emergency clinics.

The projections of future utilization of an outpatient clinic must be made in light of competition, as well as in light of the general industry trends toward greater outpatient utilization of health care services. Answering several questions can help in evaluating the relative security of a clinic’s market position:
• Is the clinic marketing mainly to the public or to health care providers?

• Does the clinic have physicians with a regular medical practice and an existing base of patients?

• What affiliations does the clinic have with hospitals, nursing homes, or other institutional health providers?

• How strong are the local hospitals in providing outpatient care, and how much market share do they command?

• Is the clinic marketing a relatively new health care service or a well-established service?

• How many like competitors are there, and how are the competitors doing?

• Are competitors sufficiently spread out geographically so that they can each capture sufficient market share to be viable?

In general, outpatient clinics which have the following characteristics will tend to have the best chances of attracting and retaining a good market share; not all of these characteristics need to be present to establish good market position:

• Those with stable medical practices as their base.

• Those affiliated with hospitals with a high outpatient volume.

• Facilities with specialized equipment and a high cost of entry.
Regulatory Position

The objective of evaluating the regulatory position of an outpatient facility is to assess the historic regulatory activity, the future capital and labor requirements to comply with applicable regulations, and the overall reimbursement environment given the type of care provided and given the specific patient mix of the business. The degree of regulation of outpatient facilities depends largely upon the complexity of the facilities and the services offered. In general, outpatient facilities are not as heavily regulated as inpatient facilities, although they do need to comply with various codes.

The more complicated outpatient specialty clinics such as surgicenters and dialysis centers are inspected periodically. As with any other type of health facility, it is important to determine what the regulatory history of the facility is and what, if any, capital expenditures are going to be necessary to comply with codes and regulations. In addition, the more complicated facilities are required to maintain certain specific staffing levels.

Regulatory position is also important from a reimbursement standpoint. Different types of outpatient services are covered in varying degrees by insurance companies, Medicare, and Medicaid. In a valuation analysis it is important to know what percentage of revenues can reasonably be expected from third party payors, what the level of private pay is, and what the experience is from an accounts receivable point of view. In addition, it is important to determine whether future policies and regulations will permit additional reimbursement or will restrict reimbursement. The trend in outpatient care has been to increase reimbursement of services, especially where outpatient services can be rendered in place of inpatient care.
Operations

Undertaking an analysis of operations involves examining staffing levels, management, and financial results. Financial results are, to a large degree, a reflection of patient volume, management, and the degree of financial controls. As with physician office practices, the financial management of outpatient facilities can have a significant impact upon cash flow. Analyzing the levels of receivables, billings, bad debts, and other indicators of financial control is important in establishing the quality of financial operations. Evaluating the areas of scheduling, patient retention, staff stability, and malpractice litigation can give the valuer an idea of the quality of operations and the overall stability of the organization.

The analysis of past financial statements should give the valuer an idea of the relationship between patient volume and financial performance. If the profit margin is growing with volume, then this would appear to be an indicator of an efficient operation, since outpatient care is volume intensive once the fixed operating expenses are covered. The area of billings and collections is critical to the viability of outpatient facilities, and the management of billings and receivables can make a significant difference in cash flow. Because reimbursement for outpatient services is a constantly changing area, it is important that the financial manager of the facility know the latest reimbursement postures of the various third party payors and that he or she know how this impacts the business given their own mix of patients.

As with other health facilities and businesses, it is wise to use outside accountants or consultants in projecting patient utilization, staffing, operating revenues, and operating expenses, although management must be relied upon to provide the base data and to assist in developing reasonable assumptions.
Physical Facilities

The goals of evaluating the physical facilities of an outpatient clinic are twofold:

- Determine what capital expenditures are necessary in the next five years, or whatever the projection period may be.
- Determine whether the facilities have a practical alternative use, given the costs of conversion.

Identifying what capital expenditures are necessary during future years should involve an assessment of both space and equipment. Rapidly growing outpatient clinics may run out of space, and if the space cannot be expanded there may be a limitation on how many patients can be treated. It is more often the case, however, that future capital expenditures in an outpatient clinic focus upon equipment needs. In conducting a valuation, the valuer is interested mainly in what equipment will need to be replaced due to either wear and tear or to functional obsolescence.

Although the space configurations of outpatient facilities are designed for patient flow and patient treatment, the physical facilities of most outpatient clinics are fairly simple. Many outpatient facilities are housed in single-story buildings or in leased space which is modified to fit their needs. The convertibility of outpatient physical facilities usually depends upon the complexity of the clinic and the nature of its equipment. Some clinics require special fixed, lead-shielded walls for x-rays and nuclear medicine procedures. Surgicenters, of course, have operating theatres with both fixed and moveable equipment.

Most clinics have laboratories, treatment rooms, and other special purpose space. From a valuation standpoint, the issue of alternative uses must be analyzed realistically given the costs of conversion. In general, the simpler, less intensive types of clinics are easier to convert to alternative
uses, including general office space. The more complex clinics specializing in more sophisticated services are often expensive to convert, making them limited use or single use facilities from a practical standpoint.

Financial Position

As with other health care businesses, the issues of the timing and adequacy of cash flow are important in realistically determining future revenues. Outpatient clinics and similar facilities are dependent upon third party reimbursement for a large portion of their revenues. They are also dependent upon private pay revenues. As mentioned earlier, the financial management of outpatient clinics is crucial to their operation. This is true of all health facilities, but in the field of outpatient care the types of reimbursement are constantly changing, since many medical outpatient services are so new.

Billing and receivables management is important in the outpatient field. As a volume driven, high turnover business, it is necessary to keep track of billings and receivables and to collect as promptly as possible from third party payors. Examining the historical track record in this regard can be helpful in establishing a pattern of financial management that can be applied to the future.

Valuation Approaches

As with other types of health care valuation, outpatient clinics do not lend themselves to strong sales comparisons, since such clinics tend to be unique and since there is not generally a large enough number of identical types of clinics to make such comparisons meaningful. Therefore, a combination of asset and income valuation approaches is appropriate to the valuation of outpatient and related clinics.
Because equipment may comprise a large percentage of the assets of an outpatient clinic, the equipment component of assets may need to be valued separately, although this should be done with caution given the limited value of used medical equipment. Where equipment is valued separately it should be viewed as having the following general value:

\[
\text{Replacement Cost} \\
\quad \text{minus} \\
\text{Depreciation} \\
\quad \text{minus} \\
\text{Obsolescence Factors}
\]

Like the valuation of other types of health care facilities, the two major factors affecting the quality of the valuation result are:

- The reasonableness of the underlying assumptions which form the basis for cash flow projections, including the analysis of the business fundamentals.
- The degree to which discounting and yield assumptions reflect both the purpose of the valuation and the relative degree of risk.