Strategies and Solutions for Financially Troubled Rural Hospitals:
*Preserving Hospital Services in the Rural Community*

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Community Role—Impact on Course of Action

- Principal and, in some cases, only reasonably accessible source of hospital and other healthcare services in a rural area.
- Often the major employer or one of the major employers—employment rate and tax revenue impact.
- Often the highest, or one of the highest, wage scales of employers in the area—tax revenue impact.
- The financial health of other employers is often tied to their business relationships with the hospital—cascading effect.
Community Role—Impact on Course of Action

• Loss of facility will likely require many employees to relocate.

• Often the principal borrower for local banks.

Means that any loss of a hospital or major reduction in services has a much more significant impact than in urban areas.
Other Factors Impacting Course of Action

• Lack of capital/revenue surplus to fund capital improvements and other expenses.
• Lack of significant endowment.
• Lack of urban comparable facility, equipment, IT, and other infrastructure often need major upgrades to attract physicians.
• More difficult to recruit and retain physicians.
Economic Update

• Exposure to Medicare has increased, especially in rural hospitals, shifting revenue streams away from commercial payors.

• In Fiscal Year 2013, operating revenue growth for U.S. not-for-profit hospitals dropped to an all-time low of 3.9% and was outpaced by expense growth for the second straight year.
Economic Update

• Moody’s has reported that during fiscal 2013, 25.1% of surveyed hospitals and health systems reported operating losses, up from 17.2% in 2012 and 13.8% in 2011.

• Since the beginning of 2010, 43 rural hospitals—a total of more than 1,500 beds—have closed.

• Half of the closed hospitals shuttered completely, the other half were converted to rehabilitation facilities, nursing facilities, emergency department, or outpatient clinics.
Political and Practical Issues Facing Hospital Management and Boards

• Viewed very much as a community asset. Many stakeholders including: General community; employers; community leaders; lenders; investors; patients, politicians; employees; and physicians.

• Board often made up of key community leaders. Risk to board members’ business and community reputations often leads to tunnel vision.

• Depending on financial situation of hospital may be significantly in debt and/or with a negative or small positive operating margin, with limited access to capital and little endowment significantly accelerating time frame in which a solution must be found. Lessens leverage and options. Also makes the hospital more susceptible to a negative event.

• Often no alternative hospital where care can be readily transitioned.
Causes of Distress—Both External and Internal Factors

Distress for hospitals typically occurs over time due to multiple factors. The following are examples of external and internal causes of distress:

<table>
<thead>
<tr>
<th>External Factors</th>
<th>Internal Factors</th>
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<tbody>
<tr>
<td>Increased competition from encroaching systems</td>
<td>No strategic/financial direction or plan</td>
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<td>Change in practice patterns and referrals resulting in lower volumes</td>
<td>Cost structure</td>
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<td>Poorest quality perception</td>
<td>Acceptance of poor performance for extended time</td>
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<td>Loss of major employer resulting in lost volume</td>
<td>High turnover of physicians and personnel</td>
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<td>Reduced reimbursement and new payment methodologies</td>
<td>Poor quality/compliance problems</td>
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<tr>
<td>New reform and compliance regulations with associated cost</td>
<td>Decreasing operating margins/lack of capital</td>
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<tr>
<td>Economy</td>
<td>Fraud/lack of controls</td>
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<tr>
<td>New methods for accessing patient ACOs</td>
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Early Warning Signs

• Days cash on hand
  – What is the industry standard?
  – What is the actual amount on hand?
  – Is there a discernible trend?

• Accounts payable
  – Generally paying within terms?
  – If not within terms, how far outside of terms, on average?
  – What change, if any, has there been in the “days to pay” over the prior year?
  – Has the hospital received any demand letters or had legal action taken against it in the past 12 months?
Early Warning Signs

• Accounts receivable
  – Days to collect
    • What is the industry standard?
    • What is the actual number?
    • Is there a trend?
  – Have there been any reimbursement rate changes?
  – Have there been payor mix changes?
Early Warning Signs

• Personnel matters
  – Have any individual providers departed within the past 12 months? If so, how many?
  – Have any department managers or directors left within the past 12 months? If so, how many?
  – Has there been a change in management within the past 12 months?
  – Has there been any change in accounting personnel within the past 12 months?
  – With respect to changes in personnel, have such changes been voluntary, through lay-offs, consolidation, or through a combination of each?
  – Have there been any practice areas or departments discontinued in the past 12 months?
Early Warning Signs

• Physical condition
  – What is the general condition of the facility?
  – What is the general condition of the equipment?
  – Capital expenditures
    • Were there any capital expenditures within the past 24 months?
    • Are there any scheduled capital expenditures within the next 12 months?
    • Have budgeted capital expenditures from prior years actually been used on the related items or where they used in other areas?
Challenges Faced By Distressed Hospitals

• Covenant breaches
  – Triggering acceleration of loan repayment or bond obligations, withdrawal of additional committed monies, lack of access to new monies, and imposition of more stringent covenants by lenders.

• Breach of payor contracts
  – Resulting in claims for damages and loss of patient base and revenues.

• Breach of physician contracts
  – Resulting in claim for damages and loss of key referring/admitting physicians and general damage to physician relationships and the ability to recruit new physicians.
Challenges Faced By Distressed Hospitals

• Breach of vendor contracts
  – Resulting in claim for damages and lack of access to key equipment, supplies, services, etc. necessary for the operation of the facility.

• CBA actions for failure to abide by terms.

• Jeopardy to licenses and accreditations.

_These legal challenges are often public and can result in a damaged image with key governmental stakeholders, patients and the media which can trigger additional and deeper financial problems._
Fiduciary Obligations Applicable to Choosing Your Course of Action

• Members of boards of directors/trustees have the following fiduciary duties:
  – Duty of care
  – Duty of loyalty
  – Duty of obedience to the mission (non-profits only)
Duty of Care

• Requires the board to be informed about any proposals, alternatives, the condition of the hospital, and impact on the hospital—both short term and long term—of any particular decision.
Duty of Loyalty

• Requires that board members advise other board members of relevant conflicts of interest and set aside conflicting loyalties when making a decision. Board members must evaluate options and make decisions as truly independent board members or may have to abstain from certain votes.
Duty of Obedience to the Mission

• Normally, the board of a non-profit owes its primary obligation to the fulfillment of the mission.

• If the organization experiences financial difficulty, the board may need to subordinate fulfillment of mission to other interests, including those of the organization’s creditors.
Board Role—Bottom Line

• Board members should be
  – Proactive
  – Fully informed
  – Conflict-free

• Must do/“no brainers”
  – Active participation in meetings and review of documents
  – Challenge management
  – Supplement management when necessary with outside advisors
  – Stay informed on legal obligations
  – Disclosure of conflicting interests
Strategic Alternatives for Hospitals
Options

• Remain independent
• Affiliation arrangement
  – Can be limited or comprehensive—financial, clinical, co-marketing, IT, etc.
  – Can be final arrangement or “stepping stone” to a sale.
  – Most smaller rural hospitals have some form of affiliation arrangement in place.
  – Some affiliation arrangements are more “sizzle than steak”, having been created on paper, but never fully implemented.
• Sale—full or partial
• Merger
• Distressed turnaround
## Comparison of Options

### Remain Independent

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>• Preservation of autonomy/independence</td>
<td>• Lack of a monetization event</td>
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<tr>
<td>• Community-specific focus</td>
<td>• Lesser access to capital</td>
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<tr>
<td>• Lack of culture and strategic vision disruption/clashes</td>
<td>• No assumption or “backstopping” of debt</td>
</tr>
<tr>
<td>• Small hospital approach—not part of larger system and its bureaucracy</td>
<td>• Lack of financial support for operations</td>
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<tr>
<td>• Potentially no loss or reduction of key health system components or material changes in operation</td>
<td>• Lack of economies of scale and access to lower cost vendor arrangements</td>
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<tr>
<td>• More facile organization, not subject to a system bureaucracy</td>
<td>• Greater difficulty in physician recruiting and retention</td>
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<td></td>
<td>• Lower access to specialized clinical services</td>
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<td></td>
<td>• Poorer ACO/payor contract access</td>
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<td></td>
<td>• Less protection against competition</td>
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<tr>
<td></td>
<td>• Loss of access to a larger system’s resources and infrastructure, such as advanced IT systems</td>
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<td></td>
<td>• Lack of a strategic partner and the strengths and protections that provides</td>
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Comparison of Options

Affiliation

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
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</thead>
<tbody>
<tr>
<td>• More autonomy and local control than in sale/merger</td>
<td>• Not as protective of local interests as remaining independent</td>
</tr>
<tr>
<td>• May preserve greater protection of community focus than sale/merger</td>
<td>• Usually no monetization event</td>
</tr>
<tr>
<td>• Less disruption of culture, strategic vision, and local operations than</td>
<td>• Not as many financial and other benefits as provided under a sale/merger</td>
</tr>
<tr>
<td>sale/merger</td>
<td>• Not as integrated as what occurs under a sale/merger</td>
</tr>
<tr>
<td>• Access to certain financial, clinical, and infrastructure benefits not</td>
<td></td>
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<tr>
<td>otherwise available</td>
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## Comparison of Options

### Sale/Merger

<table>
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<th>Advantages</th>
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</thead>
<tbody>
<tr>
<td>• Monetization event or significant financial commitments</td>
<td>• Lack of the advantages of staying independent</td>
</tr>
<tr>
<td>• Greater access to capital</td>
<td>• Risk of picking the wrong purchaser—more difficult to break apart than an affiliation.</td>
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<tr>
<td>• Debt assumption or support</td>
<td>• Your future is now tied directly and materially to another entity over which you have little of no control.</td>
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<tr>
<td>• Better market positioning with ACOs and payors</td>
<td>• Costs for undertaking project</td>
</tr>
<tr>
<td>• Protection against competition</td>
<td>• Alienation of medical staff, employees, management, or other key community stakeholders</td>
</tr>
<tr>
<td>• Economies of scale and access to better vendor pricing</td>
<td></td>
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<tr>
<td>• Access to resources and infrastructure of a system</td>
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<tr>
<td>• Enhanced physician recruiting and retention</td>
<td></td>
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<tr>
<td>• Access to clinical specialization and redundancy</td>
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Process Recommendations

• A poor process can derail any undertaking.
• A good process always starts with a firm understanding of:
  – Your current status and timeframe within which you must make and implement your decision.
  – The market options available to you.
  – The relative pros and cons.
  – Stakeholder viewpoints.
  – Roadblocks and chances of success.
• There must be a structured process that identifies how you will proceed, goals and objectives, who will be responsible for what, and a timeframe.
• Develop realistic and practical criteria for the idea partner(s) with the goal of comparing potential partners to the agreed upon criteria.
Process Recommendations

• There must be a full commitment to see it through and of the resources necessary to do so, including making it a priority for management and providing requisite resource support, including use of outside consultants.
• Key stakeholder buy-in must be cultivated and obtained—timing and level of stakeholder involvement are key issues.
• Progress must be audited and “slippage” addressed promptly.
• “Outliers” and “disrupters” need to be dealt with effectively, in as non-adversarial manner as possible.
Important Issues for a Sale/Merger/Affiliation

• Consideration
  – Cash and/or debt assumption and/or other financial commitments (services, facilities, equipment, IT, etc.).
  – Fair market value?—How to determine?

• Commitments regarding mission, culture, and local autonomy to the extent possible.

• Appropriate governance representation and decision—making protections—degree of local control.

• Business/strategic plan.

• Level of financial support of operations—separate profit/cost center or part of integrated system?
Important Issues for a Sale/Merger/Affiliation

- Level of capital commitment, intended uses, and preconditions.
- Commitments regarding current service types and levels, facility locations, equipment, and clinical staff.
- Commitment regarding current management team.
- Plan regarding personnel reductions in force.
- Compensation levels and benefit plans.
Important Issues for a Sale/Merger/Affiliation

• Commitment regarding ACO and network participation.
• Commitment regarding access to key payor contracts.
• Plan to improve clinical depth and access to new specialty services.
• Agreement to not locate a competing facility within service area.
• Assistance with physician recruiting.
Important Issues for a Sale/Merger/Affiliation

• Commitment to maintain current third-party joint ventures and other relationships.

• Marketing assistance.

• Plan of access to better vendor pricing or cost savings through shared equipment, technology (including IT) and personnel.

• Plan regarding medical staff—separate or integrated.
Special Considerations for Facilities in Financial Distress

• When evaluating the options presented herein, facilities in financial distress face certain additional requirements and challenges.

• As discussed previously, if an entity is insolvent (cannot meet its expenses when they come due), the fiduciary duty of the board shifts to maximizing the recovery for creditors of the entity.
Bankruptcy: Chapter 11

• Chapter 11
  – We are seeing an increasing number of Chapter 11 cases. Chapter 11 is not an ideal solution and should only be a “last resort” solution. Early use of other options can avoid the need for Chapter 11 filing.
  – If faced with an uncooperative lender or other “unsolvable” problems.
  – Is fundamentally a federally protected method for a business to reorganize itself and keep operating, free of a creditor-caused shutdown.
  – A hospital can go into Chapter 11 voluntarily to reorganize or facilitate a sale or can be involuntarily forced into bankruptcy by creditors.
Bankruptcy: Chapter 11

• Chapter 11
  – Can be used to accomplish two results:
    • A defense to third-party actions on default, permitting the hospital to continue operating while working to remedy situation.
    • Freezes third-party actions, permits the hospital to allocate limited financial resources to key operational needs, and to structure and implement a plan of reorganization in a more controlled and less crisis-oriented environment.
Bankruptcy: Chapter 11

• Chapter 11
  – Risks of Chapter 11:
    • Reporting of event can be “sensationalized,” as healthcare has wide appeal to various audiences. Media and competitors can misrepresent nature and impact of the filing which can increase financial problems.
    • More difficult to attract patients.
    • Negative impact on personnel and physician retention.
    • Negative impact on financing investment options, particularly given today’s restricted capital markets. There are declining sources for Chapter 11 financings and often come at a higher cost of capital or unfavorable equity terms.
    • Impact of appointment of Patient Care Ombudsman.
    • Can distract management from focus on operations.
Bankruptcy Options for Distressed Entity

• Remain independent using chapter 11
  – If options limited, can use chapter 11 process to reduce debt
  – Stigma attached, but it lessens with each chapter 11 case in the media (Chrysler, Detroit, L.A. Dodgers)
  – Must have a financial plan to emerge from chapter 11
    • What will change so cash flow improves long term?
    • Is there a branch or department to be added or abandoned to change financial forecast?
  – Who will fund chapter 11 and emergence from chapter 11?
Bankruptcy Options for Distressed Entity

• Sell the hospital in chapter 11
  – Seek bank support for a sale outside of chapter 11, but be prepared for the bank to refuse.
  – Having court order gives comfort to buyer, may result in higher price.
  – Buyer with strong financials may result in a well capitalized, strong facility.
  – Likely to result in a hospital that can survive and prosper in the face of additional changes.
Questions?