PERSPECTIVE

The Role Of Investment Bankers In Nonprofit Conversions

When investment bankers set the value of a nonprofit hospital for its sale to a for-profit enterprise, is society getting a fair return on its investment?

by Gerard F. Anderson

THE ARTICLE BY STEVEN HOLLIS raises an important question: What is the appropriate interaction between investment banking and public policy? Here I pursue this topic in the context of the acquisition of nonprofit hospitals by for-profit hospitals. Specifically, I address three issues. First, how do investment bankers value nonprofit hospitals, and is their method of valuation contributing to the sale of nonprofit hospitals? Second, should society expect a return on its investment in nonprofit hospitals, even if the financial markets do not place an economic value on society's historical investment? Third, what constraints, if any, should be placed on the foundations created by the sale of the nonprofit hospitals?

How Do Investment Bankers Value Nonprofit Hospitals?

In most sales of nonprofit hospitals, the value of the hospital is determined by a formula. First, the hospital's earnings before interest, taxes, depreciation, and amortization (EBITDA) for the past twelve months is determined. Then EBITDA is multiplied by a factor to calculate the value of the hospital. In recent years a multiple of six times EBITDA has been applied to most sales of nonprofit hospitals, although the actual multiple varies from hospital to hospital depending on things such as the hospital's existing debt, its market share in the community, and the age of the hospital's capital plant. EBITDA times the multiple becomes the acquisition price. For example, if the hospital's EBITDA in the most recent year was $10 million, and the multiple was six, then investment bankers would calculate the value of the hospital at $60 million.

■ **Time period of evaluation.** There are several public policy concerns with this method of valuation. First, the method of calculating EBITDA is not an exact science, and many judgments are involved. Accountants and financial consultants can manipulate earnings, taxes, depreciation, and amortization to increase or decrease the calculation of EBITDA in a given year. It also is possible that a sale following one bad financial year can seriously undervalue a hospital. Reliance on the past twelve months of earnings can give a distorted picture of a hospital's long-run potential in certain circumstances. Thus, it is not surprising that Daniel Fox and Phillip Isenberg found that the value of assets was much higher one to two years following conversion from nonprofit to for-profit status in their study of conversions in California.[1] The attorney general in California is currently investigating whether the value of Good Samaritan Health System in San Jose was depressed by poor management in the eighteen months prior to its sale to Columbia/HCA.[2] For these and other reasons, it may be appropriate for the public to review the methods used by investment bankers to value a nonprofit hospital to make sure that such hospi-

Jerry Anderson is a professor of Health Policy and Management, Medicine, and International Health at The Johns Hopkins University, in Baltimore, Maryland. He also directs the Johns Hopkins Center for Hospital Finance and Management. This Perspective was invited in response to Steven Hollis's paper.

tals are valued appropriately.

■ **Factoring in price earnings.** In recent years most for-profit hospital chains have had price/earnings multiples in the fifteen to twenty-five range.[3] In other words, the stock market valued the price of shares in these companies at fifteen to twenty-five times their actual earnings in the current year. For example, the price/earnings multiple for Columbia/HCA on 31 January 1997 was eighteen.[4] The differential between the multiple given to the value of nonprofit hospitals, which is most commonly six, and the price earnings multiple of for-profit hospital chains has permitted for-profit hospital chains to purchase nonprofit hospitals at a relatively low cost. For example, Columbia/HCA may be able to purchase a nonprofit hospital at six times earnings, but that same hospital is valued at eighteen times earnings after it has been acquired by Columbia/HCA. Columbia/HCA can use this differential to purchase another nonprofit hospital, and the cycle continues. If the value of the multiples applied to nonprofit hospitals by investment bankers and the price/earnings multiples given by the stock market were closer, then for-profit chains would find it more difficult to acquire nonprofit hospitals.

Acquisitions of nonprofit hospitals by for-profit chains are likely to continue until the two multiples are more in line. The stock market increases in 1995 and 1996 have increased the price earnings multiples for most corporations, including those of for-profit hospital chains, to levels much above the long-run average. Investment bankers, however, have not changed the multiples they apply to nonprofit hospitals. The public may need to carefully monitor those multiples to assure that nonprofit hospitals are valued appropriately.

■ **Efficiency differences.** In the late 1970s and early 1980s there was rapid growth in the number of for-profit hospitals.[5] In 1986 for-profit companies controlled 107,000 hospital beds.[6] However, by 1993 for-profit hospitals controlled only 99,000 beds.[7] This reduction has been attributed to a number of factors, including the switch by Medicare from cost-based reimbursement to prospective payment; growth in managed care, which places a premium on value and reduces the demand for hospital services; difficulties experienced by for-profit chains in managing both hospitals and managed care organizations; and criminal investigations of certain for-profit chains.[8]

For-profit hospitals may warrant higher price/earnings multiples if they can demonstrate greater efficiency with the assets of nonprofit hospitals. A series of studies during the 1980s found that for-profits generally had higher costs and greater markups than nonprofits had.[9] The few studies that have been done subsequently have not shown major differences in efficiency between for-profit and nonprofit hospitals.[10] The one exception is a study funded by a group of nonprofit hospitals, VHA, Inc., which used Florida Agency for Health Care Administration data to show that investor-owned hospitals had 13.7 percent higher charges than nonprofit or public hospitals had.[11] Neither the historical data nor the limited current data suggest that for-profit hospitals can use the assets more efficiently than nonprofit hospitals can, which makes their much higher multiples puzzling.

■ **Public disclosure.** One of the major public policy concerns is the lack of public disclosure of the terms of conversion deals. In California a new law gives the attorney general the power to force public disclosure of the terms of the agreement.[12] The California attorney general's office recently used its investigational powers to question the decision made by the trustees of Sharp Health Plan to sell it to Columbia/HCA when two other for-profit hospital chains had offered substantially more money.[13] It remains to be determined if public disclosure will change the value or the terms of the sale.

With the recent merger of Tenet Healthcare and OrNda Healthcare, there are now only two major for-profit hospital chains that are purchasing nonprofit hospitals. Thus, it is possible that the for-profit chains will be able to use their oligopsony power to negotiate

deals that are favorable to the for-profit corporation. The lack of a competitive marketplace argues for additional public disclosure and for greater public review of transactions.

Should Society Expect A Return On Investment?

Investment bankers have developed one method for valuing the assets of nonprofit hospitals. Here I propose an alternative method of valuation that is based on society's financial contributions to nonprofit hospitals. An important public policy issue is raised when investment bankers place a value on nonprofit hospitals that is less than society's historical investment in such hospitals.

Nonprofit hospitals have benefited from significant investment by society since the first hospital was built in the United States. For example, immediately after the Second World War the federal government provided grants and low-interest loans to many nonprofit hospitals as part of the Hill-Burton program. The tax-exempt status of nonprofit hospitals allows donors to give them tax-deductible gifts, allows nonprofit hospitals to sell tax-free bonds, exempts nonprofit hospitals from federal taxation, and increases the probability that they will be exempted from state and local taxation.[14]

The magnitude of this investment by the public must be calculated on a hospital-by-hospital basis. However, considering the decades of investment involved, in many instances the properly discounted value of society's investment could be much greater than six times EBITDA or some other market calculation. The question is whether society should expect some return on its investment if society built the hospital using Hill-Burton funds, allowed donors to have a tax deduction to pay for expanding the hospital, permitted the hospital to fund expansion through earnings that were not taxed, and allowed the hospital to issue tax-free bonds to renovate its plant. In cases in which the properly discounted societal investment in a hospital is greater than a hospital's market value, the public should examine the terms of the sale to make sure that it is receiving an adequate return on its investment.

How Should New Foundations' Assets Be Used?

Hollis presents two different scenarios when nonprofits are acquired by for-profits. Under one scenario the hospital enters into a joint venture; in the other scenario the hospital is sold. A foundation can be created in either circumstance, although it is more likely to be created when the hospital is sold. There are several policy issues related to the creation of such foundations.

Endowments are created based on the value of the hospital, its existing debt, and the terms of the agreement. No public policy determines when a foundation is created or how large it should be. In 1994 the sale of Denver's Rose Health Care System to Columbia/HCA created an endowment of $150 million.[15] When Columbia/HCA and HealthONE negotiated a fifty-fifty for-profit joint venture in the same city that year, no new foundation was created, although the value of the assets was much greater in the HealthONE transaction than in the Rose transaction.[16]

In many cases, the purpose of the foundation is to continue to be able to provide the services that the nonprofit hospital provided. These include charity care, subsidies for medical research and medical education, and other hospital-related services. An investigation of foundations created by sales of nonprofit hospitals to for-profit hospital chains found that the payouts would not be sufficient to allow the foundation to provide the level of charity care that the hospital was providing and for the foundation to remain in existence in perpetuity.[17]

When the public examines a transaction, it also should examine what services will be provided by the foundation. The tax exemption and societal investment was based on a set of assumptions about the value of the services provided by the nonprofit hospital. In some instances, the purpose of a newly created foundation has little to do with hospitals

or even health care. For example, the Rose Foundation, created by the sale of the Rose Health Care System, has decided to focus on preserving Jewish identity, education, the elderly, children and families, and other topics. The Jackson Foundation, created by the sale of Goodlark Regional Medical Center, is considering financing a sports training complex, an arts center, and a foreign language program.[18] Although these are laudable objectives, they are not based on the original reason that society invested in these nonprofit hospitals. The public policy question is whether the objectives of the foundation should reflect the original reasons for society's investment in nonprofit hospitals or whether the foundation can use the money for other purposes.

Conclusion

The investment banking community is having a major influence on hospital ownership. By giving for-profit chains a price earnings multiple that is three times greater than the multiple it gives nonprofit hospitals, it is fostering the sale of nonprofit hospitals. With only two for-profit hospital chains purchasing nonprofit hospitals, it is possible that nonprofit hospitals are not receiving the full economic value for their assets. Without full disclosure, it is difficult for the public to assess if it is getting full value for its historical investment in nonprofit hospitals. At a minimum, society should know what it has invested in each nonprofit hospital that is for sale to make sure that it receives an adequate return on its investment. Finally, society should examine whether the endowment created by the sale is sufficient to maintain the services the hospital has historically provided. The public should investigate the mission of a foundation that is created from a nonprofit conversion, especially if the foundation wants to provide services that do not reflect society's reasons for investing in the hospital in the first place.

NOTES

1. D.M. Fox and P. Isenberg, "Anticipating the Magic Moment: The Public Interest in Health Plan Conversions in California," *Health Affairs* (Spring 1996): 202–209.
2. H. Meyer et al., "Selling or Selling Out: The Lure," *Hospitals and Health Networks* (5 June 1996): 22–28.
3. S.R. Hollis, "Strategic and Economic Factors in the Not-for-Profit Hospital Affiliation Process," Draft Copy (San Francisco: Cain Brothers and Company, September 1996), 12 (chart).
4. *The Washington Post*, 1 February 1997, K3.
5. R. Kuttner, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business" (Part 1), *The New England Journal of Medicine* (1 August 1996): 362–367.
6. American Hospital Association, *Hospital Statistics, 1995* (Chicago: AHA, 1996), 2–3, table 1.
7. Ibid.
8. Kuttner, "Columbia/HCA and the Resurgence of the For-Profit Hospital Business" (Part 1).
9. J.M. Watt et al., "The Comparative Economic Performance of Investor-Owned Chains and Not-for-Profit Hospitals," *The New England Journal of Medicine* 314, no. 2 (1986): 89–96; and B.H. Gray, ed., *For-Profit Enterprise in Health Care* (Washington: National Academy Press, 1986).
10. *AHA Hospital Statistics, 1995*; and B. Arrington and C.C. Haddock, "Who Really Profits from Not-for-Profits?" *Health Services Research* 25, no. 2 (1990): 291–304.
11. VHA, Inc., *Florida Hospital Analysis* (Irving, Tex.: VHA, 1995).
12. L. Miller, "When Your Community Hospital Goes Up for Sale: A Guide to Understanding the Sale and Conversion of Not-for-Profit Hospitals to For-Profit Corporations and What You Can Do about It" (Washington: Volunteer Trustees Foundation for Research and Education, 1996).
13. M. Freudenheim, "California Challenges Deal on Nonprofit Hospital," *The New York Times*, 9 November 1996, A35.
14. F. Cerne, "Frugal Philanthropy," *Hospitals and Health Networks* (20 September 1994): 31–34; and M.A. Potter and B.B. Longest Jr., "The Divergence of Federal and State Policies on the Charitable Tax Exemption of Nonprofit Hospitals," *Journal of Health Politics, Policy and Law* (Summer 1994): 392–419.
15. Meyer et al., "Selling or Selling Out."
16. Ibid.
17. G. Anderson et al., "Investor-Owned Chains and Teaching Hospitals: The Implications of Acquisition," *The New England Journal of Medicine* (18 July 1985): 201–204.
18. Meyer et al., "Selling or Selling Out."