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Raleigh continues to lose HQ operations

By Amanda Jones Hoyle and Sougata Mukherjee

RALEIGH – North Carolina's capital city is losing much of the clout and prestige that comes with being the headquarters of a major national brand after Virginia-based Advance Auto Parts announced this week it is acquiring Raleigh-based General Parts International for $2 billion.

The deal marks a second major headquarters loss for the region in a month. The Raleigh-based Kerr Drug pharmacy chain announced in September that it was being acquired by competitor Walgreen Co. Kerr Drug has since notified state authorities that it will be eliminating 84 jobs in 2014.

General Parts has been a privately owned company since it was founded in 1961 by Raleigh entrepreneur O. Temple Sloan Jr., and its owners have always been private about the size and scope of the company's operations in the Triangle and across the country.

But according to data from Advance Auto Parts, General Parts generated $2.9 billion in revenue in

SEE **HQ SALE** PAGE 30

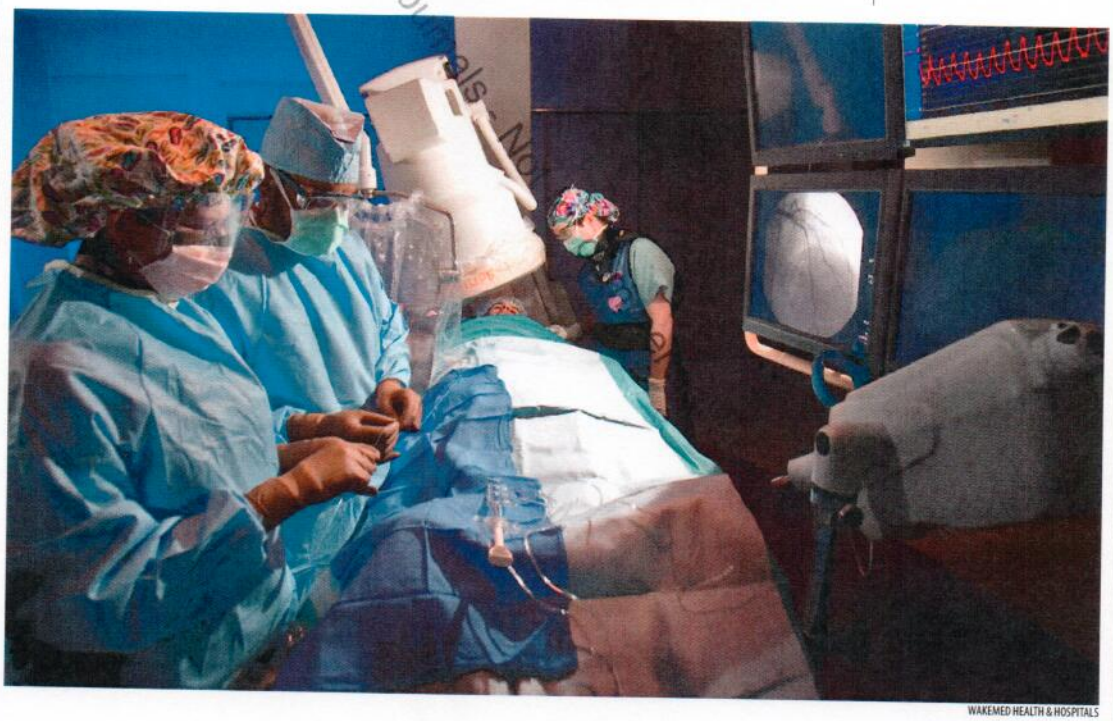
PHOTO C/O MARC BANKA

Raleigh's O. Temple Sloan Jr. founded General Parts.

HOSPITAL MERGERS

UNMASKED

Reporter Jason deBruyn delves into the world of hospital mergers. Where will the next one happen? Will there be more to come? Could WakeMed be a target? **P 12**



WAKEMED HEALTH & HOSPITALS

In the next decade, as many as one-third of all U.S. hospitals will either be acquired or have formed some sort of merger agreement with another health care system.

Most health care economists confirm this trend, which means the number of hospitals in the U.S. will shrink from about 6,000 in 2013 to roughly 4,000 as soon as 2020. While rural hospitals are the primary targets for acquisition or merger, the trend has some local health care leaders wondering if one of the Triangle's big three health care systems are ripe for the picking as well.

Given its recent financial results, speculation has turned to WakeMed Health & Hospitals.

Last fiscal year, which ended Sept. 30, WakeMed posted its first operating loss in years, and it projects a best-case scenario of a break-even budget this year. In addition, the $1 billion system is looking for a new chief executive after it unceremoniously parted ways with Bill Atkinson in late September, citing a difference of opinion in the future direction of the hospital.

"I don't think WakeMed will be out there too long on their own,"

SEE **MERGERS** PAGE 12

COVER STORY

Hospital M&As flood health care landscape

DURHAM – One of the growth strategies for Duke University Health System, a nonprofit organization, has been to form a joint venture with LifePoint Hospitals Inc., a for-profit, publicly traded company that operates 60 hospitals in 20 states.

Formed in 2011, this venture is called DLP Healthcare and has pursued a variety of partnership models with health care organizations in and around North Carolina.

For example, the JV acquired a majority stake in the MedCath Partners division of MedCath Corp. for $25 million. That deal included the sale of property related to the operation of nine cardiac-catheteriza-

STEVE WILSON

Duke University Health has several joint ventures.

tion laboratories in North Carolina.

Similarly, DLP took an 80 percent ownership stake of Maria Parham Medical Center in Henderson. It agreed to infuse the system with $45 million for capital improvements over the next decade, as well as establish a new $30 million foundation.

Later, it acquired 110-bed Person Memorial Hospital in Roxboro, a hospital that generated $42.4 million in total revenue and $817,000 in profits in 2009. By comparison, Duke Health generated roughly $2.3 billion of revenue that year.

DLP also acquired 80 percent of Twin County Regional Healthcare, a hospital in Galax, Va., that generated $50 million in revenue annually. DLP committed $20 million for capital improvements at that hospital.

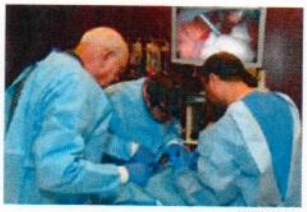


PHOTO C/O UNC

UNC pursues a variety of partnership models.

UNC Health Care, as a public entity, has a slightly different mission than its private, nonprofit counterparts in the area, even if those are still different from for-profit hospitals.

It, too, has a variety of partnership models, with the largest and most notable in the Triangle being the ownership of Rex Healthcare, the now 660-bed hospital it acquired in 2000. It also owns Chatham Hospital in Siler City, High Point Regional Health System and Caldwell Memorial Hospital in Lenoir.

Conversely, it has a 25-year management agreement with Pardee Hospital in

SEE **LANDSCAPE** PAGE 13

A helicopter arrives at WakeMed Health & Hospitals in Raleigh.

WAKEMED HEALTH & HOSPITALS

MERGERS: Regulatory pressures, balance sheets and mission all play a role

FROM PAGE 1

says Peyman Zand, a partner with Raleigh's Vaco, an executive search firm, who specializes in the health care industry.

Zand worked as the global director and divisional chief information officer for Dow Chemical Company for seven years before taking a job as director of planning at UNC Health Care from 2010 through early 2013.

WAKEMED'S NICHE

WakeMed officials insist such speculation is unfounded and that they have no interest in being acquired, with more than one executive saying such a suggestion is "off the table."

Board of directors chairman William "Wally" McBride explains that as a nonprofit hospital, WakeMed has a different set of stakeholders to whom it is accountable. Instead of shareholders who could be interested in a payout, WakeMed is responsible to carry out its mission of treating the county's low-income patients, the original mission WakeMed had 50 years ago when it was established as a county hospital.

"Our mission is to provide excellent, nondiscriminatory care for all who walk in the door," McBride says, adding that the stakeholders are patients, employees, the county, the mission and the physicians that work with WakeMed. "We can't conceive of any improved position to all of our stakeholders that would come from anything other than staying independent. We have the mission; we don't think anybody else will do the mission as well as we can. I think the county knows that. It's hard to see how the mission is furthered by any sort of agreement like we are talking about."

WakeMed, like many hospitals, has fallen on financial hard times.

For the fiscal year that ended Sept. 30, it posted a $7 million operating loss and is projecting only a break-even operating budget this year. The three prior years were stronger. The hospital posted operating gains of $20 million, $33 million and $55 million in 2010, 2011 and 2012, respectively. Overall patient revenue figures have grown steadily and are now at more than $1 billion annually.

The hospital is still on track to find an interim CEO by the end of October and a full-time CEO in six to nine months. It hired Doug Vinsel, a long-time chief operating officer of WakeMed who served in the chief executive post at Duke Raleigh for seven years before retiring in 2012, to help fill both of those roles. Vinsel says one or two down years do not make a trend, but acknowledges that financial realities across health care should be among the focal points of any new hire.

Why do hospitals merge?

Q & A with George F. Indest III, a health care mergers and acquistions lawyer in Florida.

How do hospital M&A deals get started?

These types of deals get started when one hospital identifies another hospital where it feels it can improve the operation or decrease operation costs or otherwise use the hospital to improve overall income for both hospitals. Sometimes it is merely matter of a hospital wanting to expand into a larger market or expand into a larger geographical area. In some states there are communities being serviced by a smaller hospital, but the community has grown to such a level that it needs the support of a larger hospital.

How do hospitals feel each other out before agreeing to an M&A?

It is our experience that usually this is done at the level of one operational officer or financial officer speaking to his or her

Of course, facilities like the new and soon-to-open healthplexes and especially the new WakeMed North hospital, which are projected to be more profitable than the main hospital on New Bern Avenue, will help the overall bottom line.

"This is a pretty crucial 24 months," McBride says.

THE PRESSURE IS ON

Other local hospitals are feeling financial pressures as well.

UNC Health Care adopted a budget that shows a slight operating loss. While Duke Health doesn't make its operating budget public, it just invested tens of millions of dollars to upgrade its electronic health records system, and Chief Executive Dr. Victor Dzau has said the system needs to look for ways to trim costs.

That systems are feeling pinched financially shouldn't come as a surprise. More than half of a hospital's patient mix comes from the government through Medicare and Medicaid; with the federal government looking to trim costs wherever possible, reimbursements to hospitals can land on the chopping block.

According to the Center on Budget and Policy Priorities, 21 percent of the federal budget, or $732 billion in 2012, went to major health programs. Medicare, which provides health coverage for the 48 million Americans 65 and older or with disabilities, accounted for $472 billion of that total. Even small cuts to that program mean millions lost to every hospital in the nation.

Dzau

In addition, hospitals now face penalties if patients come back to the hospital within 30 days of a discharge. Before these penalties, hospitals could treat the same patient repeatedly and charge a full bill each time – what was referred to as a "fee for service" model.

"Those factors make it very difficult to compete," says Russ Herakovich, managing director of GE Capital, health care financial services division, which recently analyzed M&A activity in the health care sector. "How do you grow when you are being paid less and seeing fewer patients?"

THE POWER OF COMBINATION

Answering his own rhetorical question, Herakovich says one logical way is by becoming larger. This gives the obvious economies of scale and stronger purchasing power, but also provides the health care system with a stronger bargaining position with private health insurance companies.

Hospitals and insurers negotiate reimbursements for every procedure. If the two sides can't come to an agreement, then the hospital goes on the insurer's "out-of-network" plan. That's not so bad for the insurer if the hospital is small and not a major player in a given market, but makes that insurer unappealing to health insurance customers if the out-of-network hospital is a major player. Consider if Duke Health or UNC Health Care were suddenly out of the network of Blue Cross and Blue Shield of North Carolina: Many Triangle residents would have to look for another insurance provider.

Consolidation gives hospitals a stronger bargaining position for higher reimbursement rates on those negotiated procedures.

"There is going to be a large amount of consolidation within the hospital industry," Herakovich says.

There are very few for-profit hospitals in North Carolina, though, and it is uncommon for a for-profit organization to buy a nonprofit hospital.

Herakovich

Duke Health has formed a strategy by which it partnered with the for-profit company LifePoint Hospitals Inc., a $3.5 billion for-profit, publicly traded company that operates 60 hospitals in 20 states. They formed the joint venture Duke LifePoint Healthcare and have acquired a majority stake in small, rural hospitals in and around North Carolina.

WakeMed has its own partnerships as well. The broadest arrangement is with Harnett Health, which WakeMed has managed since 2005 and which was a co-applicant in the successful Certificate of Need application to develop Central Harnett Hospital in Lillington, which opened in January. Many of its other partnerships are for specific aspects of a hospital, such as in pediatrics at Central Carolina Hospital, or for cardiac care at Wayne Memorial Hospital and Betsy Johnson Hospital. In most of these cases, the hospitals maintain a larger autonomy.

UNC Health Care has taken a two-pronged approach. In some instances, it acquires a hospital outright and folds it into its own system. It has done this with Rex Healthcare in Raleigh and Chatham Hospital in Siler City, for example. Elsewhere, like Pardee Hospital in Henderson County, it has a long-term operating agreement under which the hospital still has some autonomy, but UNC Health Care runs the operations.

THE ROLE OF MISSION

When a hospital is considering a merger or acquisition, Zand confirms that a facility's mission – such as WakeMed's – also plays a role. Before it was taken private in the late 1990s, WakeMed served as Wake County's community hospital with the express mission of treating the county's poorest patients. Even after going private, it has largely maintained that goal.

For example, in 2012, the N.C. Hospital Association estimated its total community benefit at $190 million, a figure which includes $77 million the hospital wrote off as costs of treating charity care patients, those patients which don't have insurance and cannot afford to pay for medical care.

Conversely, Rex Healthcare had a community benefit $73 million, including $26 million in charity care.

When a nonprofit hospital is acquired, it's common to see the acquiring company establish a foundation, or promise other kinds of community investments to keep that mission alive. DLP Healthcare established a $30 million foundation with Maria Parham Medical Center in Henderson, for example.

In a larger example, Colorado-based Catholic Health Initiatives contributed more than $1 billion to create a new Episcopal Health Foundation when it acquired St. Luke's Episcopal Health System in Houston. Those are both nonprofit hospital systems.

Wally McBride chairs WakeMed's board of directors.

counterpart at the other hospital if that hospital is not part of a big chain. Sometimes members of a hospital's board of directors may talk to the board of directors at other hospitals to ensure that their philosophies are similar and will not conflict.

How does the patient mix of a hospital play into this?

A hospital might be looking to obtain more patients with certain illnesses or conditions to come into its program. Some hospitals also have the ability or desire to specialize in providing different services such as cardiac surgery, wellness programs, labor and delivery, or other such programs.

One hospital may be located in an area where there are more patients in a certain category that the other hospital would like to capture and bring into its program.

Do you expect to see more of these deals in the future?

Yes, larger hospital chains are buying up smaller independent hospitals. I also expect that more independent hospitals will merge or be acquired by other smaller hospitals that provide a similar level of service to keep larger chains out of their markets.

LANDSCAPE: Hospital M&As take many forms

FROM PAGE 12

western North Carolina. The Henderson County Board of Commissioners still has some autonomy over the health care system there, but UNC Health Care is responsible for the operations.

The health care system is also in exclusive talks with Johnston Memorial for a partnership in Johnston County. Although talks are not finalized, UNC Health Care will partner with Johnston Health by taking a minority stake. Johnston Health will retain majority ownership in the new partnership and also retain control of the board.

"New affiliates to UNC Health Care have accessed the same pricing yielding millions of dollars in annual savings," according to the UNC Health Care annual report. "Adding their purchasing power, in turn, will further reduce acquisition costs for all of UNC Health Care."

PHOTO C/O DENVER BUSINESS JOURNAL

Catholic Health Initiatives inked a $2 billion merger.

In April, Colorado-based Catholic Health Initiatives (CHI) announced it would buy St. Luke's Episcopal Health System, a group of Houston-area hospitals, in a deal worth more than $2 billion. This one involved nonprofit entities and was one of the largest deals to involve faith-based hospital systems, which have similar missions.

Here, CHI said it will contribute more than $1 billion to create a new Episcopal Health Foundation, which will focus on the unmet health needs of the area's underserved population. It agreed to contribute another $1 billion for future investments at the hospital.

When first approaching a merger or acquisition, health care systems perform a tricky dance, says Lisa Phillips of Irving Levin Associates, which publishes health care merger and acquisition reports.

Hospitals don't get to look at each others' books, largely because each side wants to protect the proprietary insurance reimbursements they negotiated with health insurers.

Instead, they will give their financials to a third-party firm like PricewaterhouseCoopers for what Phillips called a "black box review," in which the third party will assess the financial viability prior to merger negotiations get underway in full.

How these negotiations begin, however, vary widely.

Sometimes members of boards have a previously established connection, or maybe chief executives know each other. In some cases one hospital openly shops itself, or in other cases one hospital makes an unsolicited or even hostile bid for another hospital.

– Jason deBruyn