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Profit distribution in privately funded healthcare

Reallocating costs and setting up internal transactions in the organizational structure of a healthcare organization

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Preface

In front of you lies the final product of my study Industrial Engineering and Management. After working for half a year as an intern, in the exciting world that the privately funded healthcare is, my study has come to an end. I could not suspect it beforehand, but the healthcare sector opened up my eyes for all its dynamics. The complex playing field, touching legal, fiscal and social aspects in combination with the area of corporate finance made this graduation project an exciting experience.

I am grateful for the introductions that offered me the chance to work in this fascinating environment. Furthermore I want to thank my colleagues, that made my stay an unique experience. Because of their open attitude, enthusiasm and team spirit the one hour drive in the morning never started reluctantly. In particular I want to thank my external supervisor, for all the constructive feedback sessions, guidance and pleasant collaboration.

I also owe a lot of gratitude to my supervisors from the University of Twente. The support of Reinoud Joosten gave me the confidence that I was on the correct path to come to a solution. His linguistic skills of the English language helped improved mine further and he encouraged me to take credit for my work. I am Henk Kroon grateful for his clear insight and constructive remarks regarding the structure of my thesis.

Tim van Lent,

November 18th 2013

Management summary

Privately funded healthcare organizations offering insured healthcare are currently hindered by legislation preventing them to distribute profits directly to its shareholders. This was the main problem to be solved in our research. In this thesis we present a feasible solution to overcome it, applicable for many years to come. Not only is this thesis highly relevant for the organization where it took place, it also is very valuable for current and new privately funded healthcare organizations. It offers guidance and flexibility allowing an adequate solution that is viable for years.

We have reviewed this problem from a legal, fiscal and social perspective. An extensive research yielded the following boundaries and requirements for the solution:

- From a legal perspective the solution needs to be valid under current and future legislation. Also it should be taken into account that outsourcing of core activities means that the profit distribution restriction also applies to the entity carrying out the healthcare activities.
- From a fiscal perspective transfer prices should be in line with the market if internal transactions are considered. Also a fiscal unity should be formed for both the corporate income tax and the value added tax to prevent double taxation.
- From a social perspective the solution is only valid if no structural losses occur in entities and the profit level of the entity carrying out the healthcare activities should be in line with the market.
- Furthermore the solution should be durable, requiring no drastic changes in upcoming years. The amount of upkeep should be minimal.

The solution that fits best within these boundaries and requirements is to determine internal transactions within the holding structure. We considered multiple internal transactions, and reallocated activities and corresponding costs between the structure of legal entities.

I developed an Excel-tool that allows for much flexibility to optimize the amount of revenues free of the profit distribution restriction while still staying within the stated boundaries. Furthermore I devised a distribution model that makes a strong case towards the Dutch authorities regarding the type of internal transactions and the height of the financial result in the entity carrying out the healthcare activities. The model developed allows that all profits within the hospital group are eligible for distribution in approximately the next 12 years and shareholders are able to see a return in the form of dividends after 7 years.

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List of abbreviations

DBC	=	Diagnose-Behandelcombinatie
DOT	=	DBC's Op weg naar Transparantie
EBIT	=	Earnings Before Interest and Taxes
IGZ	=	Inspectie voor de Gezondheidszorg
NZa	=	Nederlandse Zorgautoriteit
ROI	=	Return on Investment
SLA	=	Service Level Agreement
VAT	=	Value Added Tax
VWS	=	Volksgezondheid, Welzijn & Sport
WACC	=	Weighted Average Cost of Capital
WTZi	=	Wet Toelating Zorginstellingen
ZBC	=	Zelfstandig Behandelcentrum
Zvw	=	Zorgverzekeringswet

List of tables and figures

1. Introduction

In this first chapter I will introduce my graduation project and provide background information about the environment in which the project took place. Given the sensitive nature of this graduation project, both from a competitive and a legal perspective, this thesis will not give any indication which healthcare institution is discussed nor the specific nature of healthcare it offers. The organization will be addressed as “The Hospital”. In this chapter I will describe its characteristics and provide information about the environment in which it operates. I will conclude with the organizational structure of legal entities.

1.1 Background

The Hospital was founded on the idea that the quality of healthcare offered for patients with a certain disease could be improved by specialization and patient-centered care. The lead surgeon and founder felt frustrated that this could not be realized in traditional hospitals. His vision was that by focusing on the patient’s needs and organizing all processes in a specialized ‘centre of excellence’, patients could be served much better. Although it is premature to prove its success, prospects look very promising. The Hospital classifies as a ‘Zelfstandig Behandelcentrum’ (ZBC), meaning that it offers insured healthcare under the Health insurance law (Zvw), involving multiple specialized medical areas. The main difference between hospitals and ZBCs is that ZBCs are commercial organizations and do not receive any subsidies as opposed to hospitals. Furthermore the range of healthcare offered is usually limited for ZBCs.

An important characteristic of the healthcare The Hospital provides is that it is not entirely free to determine its own prices. The healthcare can only be offered when the patients have a referral from their general practitioner. This applies also to other healthcare providers offering the same type of healthcare. The organization of the Dutch healthcare system will be discussed in more detail in Section 3.

The Hospital is privately funded. Private investors brought in capital in the form of shares and subordinated debt. The remaining capital is provided by a bank in the form of loans and equipment leases. The loan for remodelling the building is realized under the GO Cure arrangement, meaning that the government underwrites part of the loan.

1.2 The organization structure

It is important to declare that the graduation project is carried out for The Hospital as a whole, containing multiple legal entities. In the following figure the structure of these entities is plotted, using fictive names.

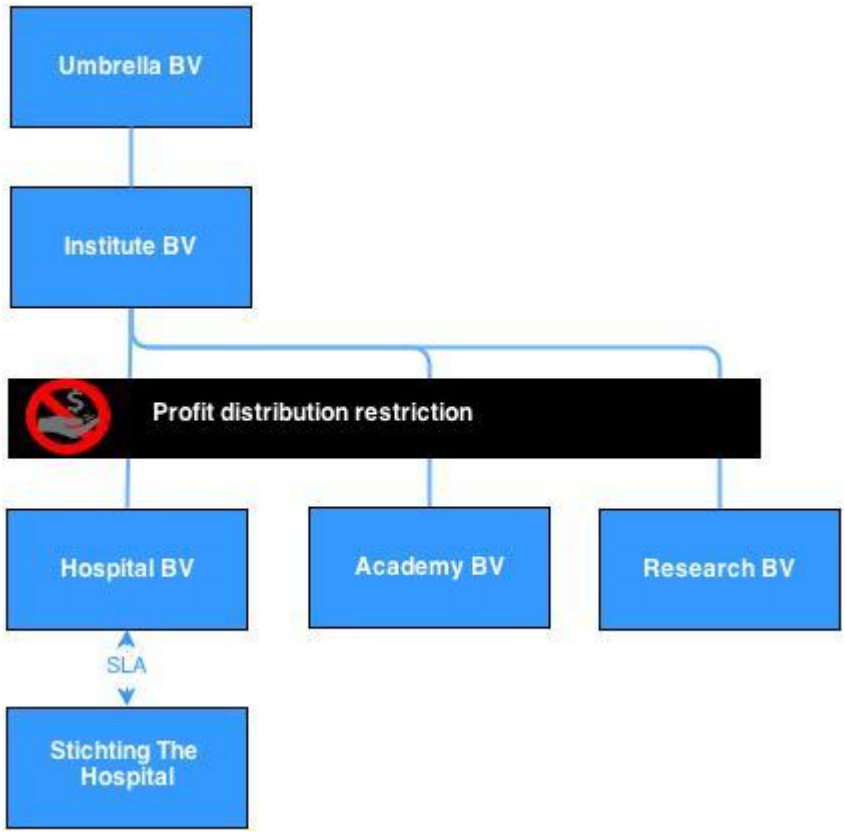


Figure 1: Organizational structure of legal entities.

Umbrella is owned by private investors; subsequently Umbrella fully owns Institute, which fully owns Hospital, Academy and Research . Healthcare contracts with insurance agencies are situated in Stichting The Hospital, as well as the license to offer specialized insured medical healthcare. Stichting The Hospital subcontracts its healthcare activities to Hospital BV regulated in a Service Level Agreement (SLA), specifying the resources and services exchanged between them. It also specifies the rights and requirements of both parties regarding the resources and services agreed upon.

Academy BV has been created to facilitate training of personnel. Research BV has been set up for research purposes. Both Academy and Research are not operational at this moment, therefore they are excluded from the scope of this research project.

2. Problem definition and research approach

In this chapter I will describe the problem in detail and will elaborate on the methodology I will use to come to a solution of this problem.

2.1 Problem definition

Under the current law 'Wet Toelating Zorginstellingen' (WTZi), it is not allowed for hospitals providing specialized insured healthcare to distribute profits to shareholders. A bill has been submitted to the Dutch Parliament to change this, however it is still uncertain whether this will pass and if so, when this will be coming into force. The position of the profit distribution restriction in the organizational structure of legal entities of The Hospital is illustrated in Figure 1. Given the fact that Stichting The Hospital contracts out all of its core activities to Hospital BV the Dutch healthcare authorities apply the profit restriction on Hospital BV as well, meaning that Hospital BV is not allowed to distribute its profit to Institute BV. This is where the main problem lies. Within the current structure the earnings from The Hospital's activities remain in Hospital BV, while the shareholders invested capital in Umbrella BV. Without the possibility of distributing results upwards in the structure of entities the private investors cannot make a return on their investment, both on their share capital and the subordinated debt.

Currently the constructions to facilitate distribution of profits, despite of the restriction, are often being tolerated. Therefore profit distribution in healthcare is a grey area in The Netherlands. Besides matters of a legal nature and the policies from the Dutch healthcare authorities (NZa), also the fiscal legislation plays an important role in executing this graduation project. Profit distribution of hospitals, especially private ones, currently receive much public attention. Mapping what position the Hospital takes regarding social responsibility is also incorporated in trying to realize shareholder return.

2.2 Research goal

The research goal will be to develop the possibility of shareholder's return for investors of The Hospital in a legally, fiscally and socially responsible manner.

2.3 Research questions

The graduation project consists of two parts: at first the legal, fiscal and social context is defined. The second part consists of questions related to the development of a profit distribution model. The reason that the legal, fiscal and social landscape are incorporated in the research questions instead using them as the boundary conditions is that the project is carried out in a rather complex playing field subject to many regulations, which requires extensive research.

The main research question is the following:

How can a sustainable shareholder's return be realized for the investors of The Hospital within the boundaries of the legal, fiscal and corporate social landscape?

In order to answer this question it is relevant to understand the concept of shareholder return and know what the boundary conditions of the playing field are. Therefore the following questions need to be answered:

a. *How is shareholder return described in the literature and what does it mean specifically for investors of The Hospital?*
b. *What boundaries regarding distribution of shareholder return are prescribed by legal regulation?*
c. *What boundaries regarding shareholder return distribution are prescribed by fiscal regulation?*
d. *What is The Hospital's position regarding the corporate social landscape and shareholder return distribution?*
e. *What constructions to facilitate the distribution of profits are currently in place in practice?*
f. *What are the requirements of the distribution model?*
g. *What types of models to facilitate the distribution of profit to shareholders are appropriate for The Hospital?*

When these questions have been answered an motivated choice can be made for a justifiable profit distribution model. Then the details of this model can be worked out further.

2.4 Problem owners

For the general problem of distributing shareholder return, the problem owners are the following: The private investors and the board of directors of the hospital. Currently the board of directors answer to the supervisory board, on which representatives of the shareholders serve. The investors want to know when they can expect return and how much.

2.5 Research approach

The research questions with be answered by making use of the following research methods and frameworks:

a. The shareholder value network of Rappaport (1986) is used to illustrate the meaning of the concept 'shareholder return' and how the latter can be realized. This is desk research.

Subsequently, by holding interviews with investors of The Hospital I will acquire specific knowledge regarding the amount of return they are aiming for.

b. The legal boundaries regarding shareholder return distribution are investigated by the PhD work of Plomp (2011), research documents from consultancy firms and documents from the NZa and the Dutch Ministry of Health, Welfare and Sports. This is desk research.
c. The fiscal boundaries regarding shareholder return distribution are found by examining documents of the Dutch tax authorities and tax lawyers. This is desk research.
d. The corporate social landscape in healthcare is mapped by reviewing research documents of consultancy firms. This is desk research.
e. The constructions that are currently being used in practice are found by conducting desk research, reviewing the annual accounts of ZBCs and examining the research by Plomp (2011).
f. Before choosing the distribution model the requirements of the model are drawn up from research of the dimensions and conducting interviews with the financial manager.
g. The terms and conditions the management of The Hospital have regarding the distribution model are found by conducting interviews. Both these preferences and developments in the legal, fiscal and social environments are incorporated to come to a motivated choice for a distribution model.

It is probably clear by now that this research project is of a practical nature and therefore relies heavily on research documents from the public domain, instead of academic papers. To give an indication on the depth and quality of these documents; many of the research documents studied also served as input for the Dutch government when drawing up new legislation.

The research questions will be answered in the following sections:

Question a	Question b	Question c	Question d	Question e	Question f	Question g
Chapter 5.1	Chapter 5.2	Chapter 5.3	Chapter 5.4	Chapter 5.5	Chapter 5.6	Chapter 5.7

The Dutch healthcare system is quite complex for people that are unfamiliar with it. Because of its relevance for this research project the basics of this system are explained in Chapter 3. In order to create a clear understanding of the complex playing field this research projected was conducted in Chapter 4 is added, which focuses specifically on private investments in healthcare.

2.6 Boundary conditions

The graduation thesis is subject to certain limitations at several areas: legislation, time, resources, IT.

Legislation

As mentioned earlier, current legislation (WTZi) forbids hospitals to distribute profit directly to investors. There is however much development and uncertainty regarding legislation. Therefore this field deserves considerable attention as a standalone research question.

Time

For this graduation project twenty weeks are scheduled. The target is to finish it within this timeframe. The amount of time that mentors, both external and internal, have available is also limited.

Resources

The Hospital is in its startup phase, so there are limited resources available to carry out, acquire or build the necessary activities and models.

IT

The model built should be compatible with the existing IT landscape.

3. Healthcare in The Netherlands

This chapter is meant to give a brief overview of the part of the Dutch healthcare system that relates to the activities of The Hospital. First some distinctive characteristics of the Dutch healthcare market are highlighted, then the organization is laid out, after which important actors in the market are discussed.

3.1 Characteristics

The Dutch healthcare market is different from other markets in a number of ways. There is for instance no financial incentive for patients to switch to another healthcare supplier. There exists information asymmetry, meaning that the patient has no clue what the costs of his/her healthcare is. The costs are not a very relevant criterion for the patient, as long as the healthcare is covered by insurance. This means that patients will not come to a hospital because it offers lower costs than others. Therefore healthcare providers differentiate at different areas: quality, speed and customer satisfaction are examples of these. Even if healthcare organizations work efficiently and fast, while offering high quality, they are still dependent on the amount of healthcare the healthcare insurers purchase from them. A common contract states a fixed budget given by the insurer for which a provider can offer insured healthcare during a specific time period. If the costs in this time period rise above this budget, because more healthcare is offered for instance, the costs are for the provider's account. However, if the costs turn out to be lower than the specified budget, the provider should return the unused remaining part of the budget to the insurer. Therefore all risks lie with the healthcare provider.

3.2 Healthcare law

When institutions strive to offer insured healthcare a WTZi-license is necessary. The most important requirements are the accessibility of acute healthcare and the transparency in both governance structure and organization of operations. Institutions need to have an independent supervisory board and are subject to directives regarding the financial administration. Another characteristic that is highly relevant for this research is that profit distribution to shareholders, whether these are persons or legal entities, is not allowed for institutions holding a WTZi-license. Only in case of a ministerial exception is this possible, but this is only given when the accessibility of healthcare in a certain region is in severe danger. In The Netherlands it is not likely that this exception will be given at this point. In regions with high population density the distances to healthcare providers are already relatively small and in regions where people need to travel a long time for treatments the population density is not high enough to be economically interesting for providers to start an establishment there.

3.3 Insurance law

As mentioned earlier The Hospital offers insured healthcare under the Zvw. Healthcare insurances in The Netherlands consist of the following compartments(Ministerie VWS, 2011):

- AWBZ (Algemene Wet Bijzondere Ziektekosten) – general mandatory insurance that covers the long-lasting healthcare that is not individually affordable, such as handicaps, chronic illnesses and old age illnesses.
- Zvw (this category is also called “basispakket”)– general mandatory insurance package that covers necessary critical medical care, where the focus lies on curing patients instead of long-lasting care.
- Supplementary packages – voluntary insurance packages that cover a wide variety of medical care depending on the wishes of the policyholder.

Specialized healthcare in The Netherlands is for a large part organized in DOTs (‘DBC’s Op weg naar Transparantie’), which are single products in which activities from diagnosis to treatment are grouped. These DOTs can be invoiced to healthcare insurers. The origin of funding for these DOTs comes from contributions of civilians, employers, healthcare insurers and the government. The following scheme shows how the healthcare covered by the Zvw is financed.

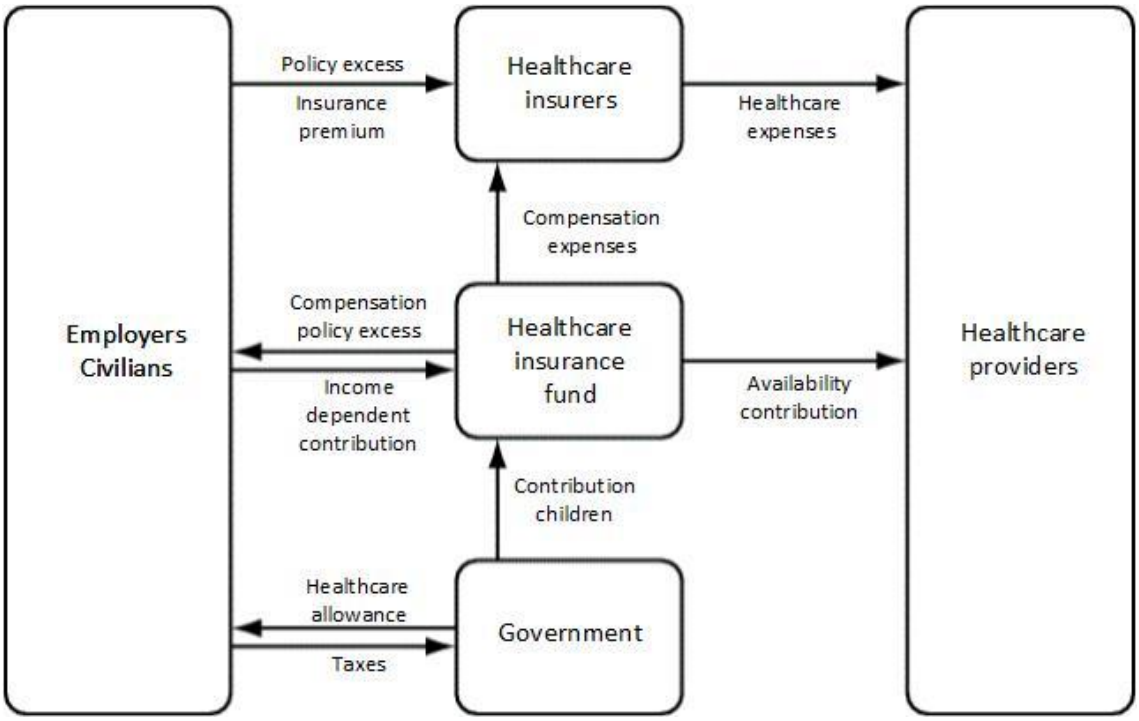


Figure 2: Finance scheme Zvw (translated from the Dutch state budgetary reports).

There are two categories of DOTs that are invoiced to the healthcare insurers, Segment A and Segment B. For DOTs in Segment A a tariff is set by the NZa. The prices of DOTs in Segment B consist

partly of a fixed tariff and the remainder of the price is free negotiable between healthcare providers and insurers. The government strives to make more and more DOTs freely negotiable to oppress the rising healthcare costs. Besides the prices of DOTs, also the quality and volumes are part of the negotiations. The idea is that by allowing competition between healthcare providers they are forced to work better and cheaper, which benefits the patients. The government also distinguishes a separate category of healthcare that is considered critical from a public perspective. These services are not funded based on performances, but from the national healthcare insurance fund via an availability subsidy. Examples of such services are trauma teams, donor transplantation units and academic activities.

3.4 Healthcare providers

In the Dutch healthcare system the following four types of healthcare providers that offer insured healthcare exist:

- General hospitals (research, treatment, nursing, training).
- Academic hospitals (all regular patient care plus highly specialized/expensive/rare diagnosis and care, scientific research and the development of new technologies/treatments).
- Categorical hospitals (diagnosis and treatments for only a specific category of patients).
- Independent treatment centers/ZBCs (privately funded, specialized care of mostly low-complex treatments that can be planned efficiently).

Especially the number of providers in the last category has grown significantly in the last decade. The following figure gives insight in the number of healthcare providers in each category between 2005 and 2011 (NZa, 2012):

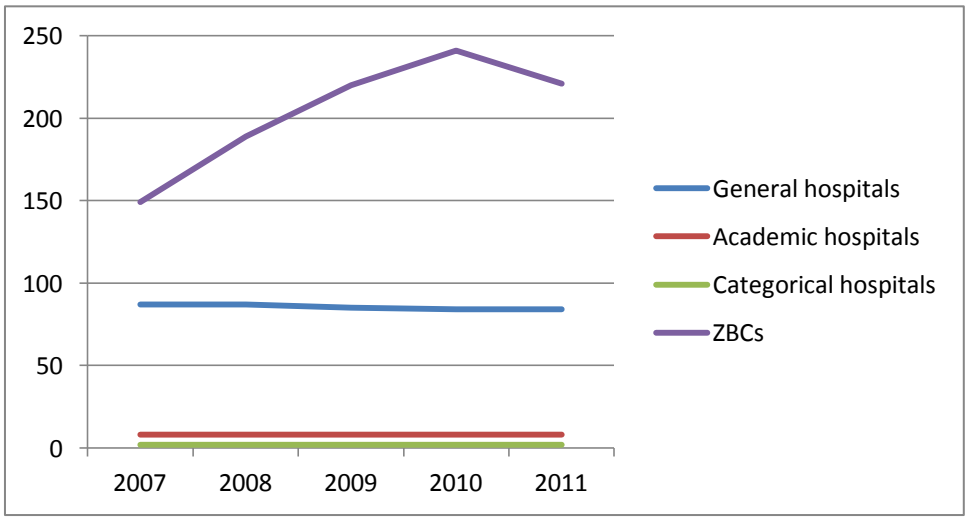


Figure 3: Number of WTZi-licensed healthcare providers per category (2007-2011).

3.5 Healthcare insurers

The Dutch market for healthcare is divided among approximately sixty healthcare insurers which are organized in the following five large insurance groups that purchase their healthcare at healthcare providers:

- Achmea.
- Uvit.
- CZ.
- Menzis.
- Multizorg.

The market can be characterized as a market with few buyers and many sellers, where the suppliers are highly dependent on the buyer. The buyers are the insurers and the sellers the healthcare providers. An effect of this is that insurance groups have considerable bargaining power in their dealings with hospitals and ZBCs. The government tolerates this market situation because it believes that this power can force healthcare providers to decrease costs and improve quality, hereby improving the entire health system.

The bargaining power of insurers is already visible; healthcare insurers use short-term contracts, resulting in uncertainty towards the future for healthcare providers. Furthermore the timing of contract negotiations is dictated by the insurers, resulting in situations where ZBCs for example have to operate for months without knowing the provided care will be remunerated. The insurers are also blamed for a 'take-it-or-leave-it' mentality; because providers are dependent on contracts and the insurers are aware of this the insurers can dictate the terms. Not agreeing to these would result in a large portion of patients whose care would not be completely compensated. This means that either the provider or the patients have to pay for this care. Patients generally do not see a healthcare provider if they have to pay for treatments that are insured in other facilities. This would result in a downfall in patients. Even if they do attend a hospital for uninsured healthcare the amount of credit risk for the provider increases. Unpaid invoices are more likely for individuals than large institutions, hereby increasing the costs for healthcare providers.

3.6 Dutch healthcare authorities

The Dutch healthcare authorities (NZa) is the supervisory body in healthcare that is in charge of following three points of public interest: transparent information, accessibility and affordability of healthcare. The NZa imposes transparency requirements regarding supply, quality and price of offered healthcare and enforces these regulations. It monitors the accessibility of healthcare per sector to ensure this is at a sufficient level. The NZa supervises both healthcare insurers and

healthcare providers to guarantee legal obligations are met and interests of consumers are protected. Besides disciplinary and monitoring activities the healthcare authorities also supply information and support to healthcare organizations that helps them to setup their processes according to the wishes of the authorities.

4. Private investments in healthcare

The healthcare sector receives a lot of attention and is often an important topic in elections. In the last few years much discussion was related to private investments in this sector. This chapter aims to create understanding of the social context of this graduation project.

4.1 Public opinion

The fear exists that by allowing private investors to invest actively in healthcare providers the focus shifts towards the most profitable healthcare activities and that other ones are discarded, as in regular shareholder value driven organizations would be the case. This would damage the accessibility of unprofitable healthcare (Kerste & Kok, 2010).

Others think that private investors in healthcare will encourage healthcare providers to work better and more efficiently. The idea is that healthcare insurers will purchase their specific healthcare at those providers that operate very well. Not only will the healthcare sector receive the necessary capital to make investments critical for its sustainability, it also acquires knowledge regarding risks, business processes and investment decisions. This will professionalize the organization of this sector(Boer & Croon, 2010). The amount of private capital also works as a buffer in hard times. The rate of return for investors depends on the financial result of the hospital. Therefore in hard times, when this return is next to nothing, the hospital can deploy its resources internally, which is not the case with capital in the form of loans for example. An inflow of equity will also increase solvability, which is favorable for the bank, currently the primary provider of capital. Equity works as a buffer regarding risks and results. Increasing this buffer reduces the risk for the bank.

4.2 Ministry of VWS

The Ministry of VWS attempts to put a stop to the rising healthcare expenses. The population in The Netherlands is aging and treatments of medical conditions are becoming increasingly advanced. Despite these rising costs the healthcare should remain affordable, also in the long run. The most important item for the government is the accessibility and continuity of healthcare. In order to bring the healthcare sector to a higher quality level without consuming public capital private investors are required.

4.3 Private investors

Private investors expect that in the near future it will be allowed for healthcare institutions to distribute profit to shareholders. Furthermore, in The Netherlands there is an ageing population and health problems that were fatal in the past are that not anymore(Keukens & Vissers, 2012). More people reaching higher ages while being treated for illnesses leads to a growing demand for

healthcare, independent on whether the economy thrives. In an uncertain economy investors seek for new durable investment opportunities and find that in the healthcare sector.

The returns private investors want for their investments depend on their social ideals. Investors who value that they contribute on a social level, like pension funds or insurers, will accept 8% on average, while most risk bearing investors demand at least 12%. Investors normally invest for at least five years, but generally they expect this horizon to be longer due to the perceived amount of time it takes to realize changes in a hospital environment (Boer & Croon, 2010). Investors of new enterprises focus mostly on value creation rather than dividends.

Risks that are currently identified by private investors are the low profitability of hospitals, the financial incentives of healthcare insurers to negotiate fiercely regarding prices, the limited political room for turnover expansion and the risk of governmental interference when profits are growing too strong (Plomp *et al.*, 2013). In order to really boost private investments in healthcare it should be clear that profit distribution is possible in the long run.

4.4 Healthcare providers

Private investments cannot be studied separately without also taking into account the factor control. In 2009 the government tried to overcome difficulties with the legal entity that almost all healthcare organizations adopted: 'the stichting'. This is a type of legal entity which has no profit orientation by law and is strictly bound by regulation not to distribute profits. The government constructed a new legal entity called 'Maatschappelijke Onderneming', meant for organizations in the semi-public sector, such as many hospitals. The idea was to give investors more control than was currently possible (Skipr, 2009). Although the proposal was revoked and the project is generally seen as a failure the idea behind it still stands: private investors demand a certain amount of control in exchange for the capital they bring in. Management of healthcare institutions is reserved in transferring control to private investors. An example of the type of control a private investor can have is illustrated by the interest of the MC Groep in IJsselmeerziekenhuizen. This hospital group had serious financial troubles and was saved by an investment of the MC Groep amongst others. The MC Groep was granted the right to propose 50% of the members in the supervisory board, which in turn elects the Board of Directors of the hospital. This led to the appointment of Loek Winter as CEO of the hospital, the founder of the MC Groep. Under his leadership the economic situation turned around and now the IJsselmeerziekenhuizen are performing in the top of their class (Winter, 2009).

4.5 Healthcare insurers

Healthcare insurers support the development of private investments in healthcare. Especially the accountability towards shareholders will urge the management of hospitals to operate efficiently and effectively. Healthcare insurers are also investors themselves by participating in investment funds that focus on young innovative healthcare companies. Also the government partakes in such funds, for example the Holland Venture Healthcare Innovation Fund. Healthcare insurer Menzis wants to found a new national investment fund for healthcare and appeals to banks, pension funds and other insurers to partake as well (Menzis, 2013). For healthcare insurers such investments yield a return, but also improve the healthcare sector. Therefore in the long run they gain as well from lower healthcare costs.

4.6 Private investments in healthcare abroad

When looking at European hospitals that are stock listed abroad it is clear that Dutch hospitals perform far worse than their European privately owned counterparts, from a financial perspective. When looking at the Earnings Before Interest and Taxes (EBIT) the European hospitals outperform the Dutch hospital by a factor 2 and the difference in solvability is a factor 3, ±30% to 10% respectively, in favor of the foreign hospitals (Winter, 2009).

Also the investments of private investors Cinven and 3i in hospitals in Sweden and England show that besides an improvement in service and quality, also an increase in financial return is realized (Boer & Croon, 2010).

5. Theoretical and practical framework

In this chapter the theoretical and practical framework is defined, which will help to find an appropriate distribution model realizing shareholder return. First the general concept of shareholder return is explained by making use of a framework from scientific literature, after which an analysis is conducted to yield the perspectives of the shareholders on this. Then the relevant forces in the playing field are researched, after which the distribution models used in practice are studied. This chapter concludes with options to facilitate profit distribution that meet the requirements of The Hospital.

5.1 Shareholder return

Shareholder return in literature

The goal of this research is to create a return for the shareholders of The Hospital. In order to realize this the following research question will be answered:

How is shareholder return described in the literature and what does it mean specifically for investors of The Hospital?

The return for shareholders can be in form of interest on subordinated debt, dividends or by an increase of the value of the stocks they hold. The return in the latter case is realized if the shares are sold, also called an 'exit'. Realizing return in the form of an exit is not a problem for The Hospital, as long as the majority of earnings is beyond the profit distribution restriction and therefore eligible to pay out. As mentioned earlier the investors of The Hospital expect to receive dividends after the start-up years. These cannot take place from Hospital BV, hereby forming the main problem of this research. To understand how shareholder return relates to shareholder value and business practices a framework is used for clarification.

Rappaport (1986) summarized the main relations within the shareholder value concept as displayed in Figure 4. In the network the shareholder return in form of dividends is highlighted to illustrate that there the major difficulty of this research lies. Despite the model's age it is still valued for its clear insight and it has been cited ever since. The model used here has been published in a paper by Largani (*et al.*, 2012). The framework is included to show where shareholder return comes from and how this can be realized. It is important to emphasize that shareholder return originating directly from healthcare activities is not eligible for distribution.

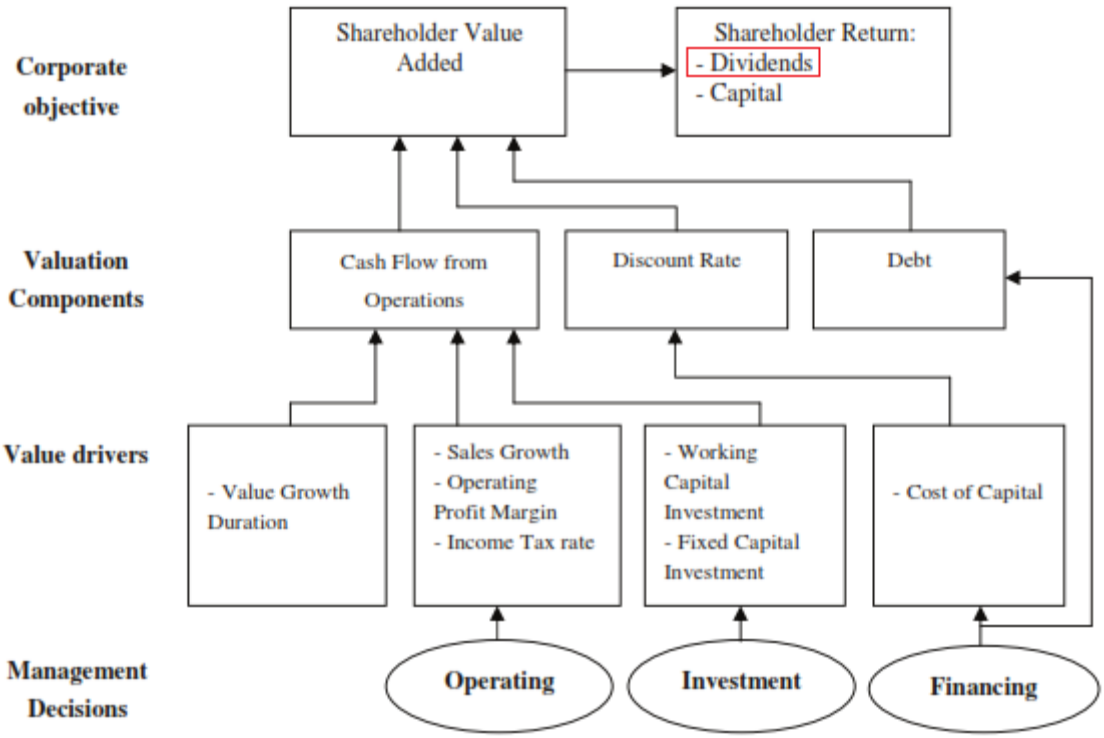


Figure 4: Rappaport's shareholder value network.

As the diagram illustrates the added shareholder value depends on many factors. Rappaport identifies three areas which contribute to value creation: operating, investment and financing management. Each of these individual areas have certain value creation factors.

The value drivers for operations speak for themselves. For investment value drivers there is a division made into working capital and fixed capital. An example of an investment in working capital could be inventories, and in fixed capital the expansion of capacity. The cost of capital includes the cost of both equity and debt finance. It reflects the amount of return that both lenders and shareholders demand in exchange for providing funds. The return these two parties demand is depended on the capital structure of the business, the amount of equity relative to the amount of debt. The cost of capital in the model of Rappaport (1986) is captured by Weighted Average Cost of Capital (WACC).

The value driver 'Value Growth Duration' describes the period of time in which, according to management estimates, the return will exceed the cost of capital (Largani et al, 2012).

The framework can be summarized into the following core sentence: the ability of a company to realize total shareholder's return, by dividends or share price appreciation, depends on its ability to consistently generate surplus cash well into the future (Rappaport, 1998). An important requirement

here is that this cash is eligible for distribution. This is incorporated when valuating shares in case of an exit.

Because shareholder return in the form of an exit is a large portion of the expected return for investors of The Hospital, the valuation methods for this are also considered in this thesis. The size of this research field alone would be material for multiple graduation projects. Therefore this subsection focuses on the matters relevant for execution of this thesis.

Share capital valuation can be done in numerous ways, mostly based on shareholder's equity, earnings and goodwill. A common problem in company valuations is that solely the income statement or solely the balance sheet is used. Even if both of these are jointly used, the valuation is still based on historic data alone. Therefore the most suitable method for valuing a company is to apply the discounted expected future cash flows as well, indicating the capability of generating cash for its shareholders. Given the uncertainty of future cash flows this is quite hard for new enterprises. Estimates of experts determining the value of the same company using the same data may vary enormously (Ge *et al.*, 2005).

In order to come to a thorough valuation the model of Fernandez (2007) proves an useful tool, which is displayed in the appendix. In my opinion this model excellently takes past performances and future benefits into account, while also incorporating the competitive environment and financing costs. The important lesson for The Hospital from these valuation techniques is that the value of its equity is largely determined by the expected future cash flows that are not restricted by the profit distribution restriction.

Shareholder return for investors of The Hospital

The major investor of The Hospital is an investment firm holding 63.90% of the share capital issued. This company strives to realize a return on investment of 25% per year after operating expenses. The investment horizon is estimated at 5 to 7 years. Two-thirds of the participation of the investment firm is in the form of subordinated loans, which are expected to be repaid after five years. During the first few years The Hospital does not make any repayments on these loans, but the interest builds up on the principal. When the solvability of the company exceeds 40% The Hospital is obliged to repay the loans. After five years the investment firm will apply an active dividend policy. Furthermore is it the aim of The Hospital to distribute all excess liquidity of Institute BV to the shareholders. The policy of The Hospital as a result of this would be to build up a solid and financially sound organization in the first years, after which the company focuses on growth in volume and profitability. In the long

run the ability of generating cash eligible for distribution should be strong enough to generate a significant return in case of an exit.

The other investors brought in share capital at par value. These investors benefit from a possible value increase of their shares and from dividend payments. Furthermore they have tagalong rights, meaning that in case of an exit these shareholders can join the major shareholder and sell their shares under the same conditions.

5.2 Legal environment and developments

Generating shareholder return is one thing, realizing the distribution of it is quite another. This subsection is divided into current legislation and upcoming legislation.

Current legislation

The legislation in place in The Netherlands restricts The Hospital's freedom of movement regarding the distribution of profits. Therefore the following research question needs to be answered to map the boundary conditions of this playing field:

What boundaries regarding distribution of shareholder return are prescribed by legal regulation?

When a healthcare institute wants to offer insured healthcare, according to the Zvw or the AWBZ, it needs a license that is regulated in the WTZi. In this law it is stated that a license can only be obtained if the institution has no profit orientation and does not distribute profits, unless they receive a ministerial exception. This is not given lightly. Exceptions can be made only in strong cases, where for instance the accessibility of certain healthcare is not yet guaranteed. It is important to emphasize that the profit distribution restriction also applies to dividend payments made to a parent company.

Upcoming legislation

We may anticipate several developments regarding private investments in healthcare and profit distribution. An important upcoming change in legislation that affects profit oriented healthcare organizations is Bill 33168, submitted to facilitate profit distribution and private investments. There are several restrictions that need to be met in order to protect public interests, these are the following (Rijksoverheid, 2013):

- The legal entity is a BV, N.V. or corporation.

- The healthcare organization should request the Inspectie voor de Gezondheidszorg (IGZ) once to perform an extra quality check. Only after the IGZ has given its approval it is allowed to distribute profits.
- The healthcare organization cannot distribute profit in the first three years and can only distribute profit after a positive net result for three consecutive years.
- The healthcare organization should satisfy a solvability criteria. Only if the equity relatively to the balance sheet total exceeds 20% and both the board of directors and the supervising organ approve, healthcare organizations are allowed to distribute profit.

The government aims to discourage short-term investors looking for a quick profit. However, due to the low profit margins in healthcare investors expect to receive the major part of their return through an increase in share value over time (Plomp, 2011). Also the solvability requirement makes it unlikely that in the first few years enough profit is earned for distribution. Besides, it is also unlikely that banks allow profit distributions if this endangers the continuity of the organization. Therefore some requirements seem redundant. A minimum investment term for new investors and requirements to prevent conflicts of interest in the governance structure would be improvements of the bill (Plomp *et al.*, 2013).

For this thesis both the NZa and the Ministry of public health, well-being and sports (VWS in Dutch) were approached to find out their point of view on profit distribution. The Ministry did not come up with a response. The correspondence with the Dutch healthcare authorities resulted in the following additional requirements of healthcare providers:

- The minimum solvency requirement also applies to the parent company of the health group; after profit distribution this should still be at least 20%.
- An adequate management safety system should be in place.
- The organization does not have a governmental guarantee as mentioned in ‘Garantieregelingen Inrichtingen voor Gezondheidszorg (GIG) 1958’.
- The organization has not received governmental support as mentioned in article 56a of ‘Wet Marktordening Gezondheidszorg’.
- There is no indication of command, obligation or coercion on the healthcare provider regarding its actions.

Furthermore the NZa emphasizes that investors looking for short-term gains have no place in healthcare and all requirements regarding profit distribution aim to guarantee the quality and affordability of healthcare. For many healthcare providers these additional requirements are not very

relevant. The presence of an adequate safety management system is already mandatory by the Inspection of Public Health (IGZ in Dutch). The GIG guarantee is a relic from the past, when the risk of purchasing and remodeling real estate lay mostly with the government. For recently founded healthcare organizations such as The Hospital this is not relevant. It is however very relevant that the solvency requirement also applies to the parent company of underlying entities. New healthcare providers have large startup costs and operate unprofitable at first, decreasing the equity position in the first few years. After the organization starts to make a profit, cumulative losses from the past are decreased, hereby strengthening the solvency position. Therefore it takes a few years to reach the required solvency for new organizations.

The upcoming legislation is not yet in effect however and there are no guarantees that this ever will and whether this change will be lasting. Politics cannot be anticipated in the long run and future parliaments might undo changes. Therefore for The Hospital it is important to find a solution that is currently valid and is also valid in the near future, regardless of upcoming legislation.

5.3 Fiscal environment

Also from a fiscal point of view it is important to investigate what the consequences of a certain distribution model are. Therefore the following research question needs an answer:

What boundaries regarding shareholder return distribution and internal allocation are prescribed by fiscal regulation?

Since 1969 organizations in healthcare have been exempt for corporate tax under the following restrictions: the organizations should deal exclusively (more than 90%) with providing healthcare and in case of any profits these should benefit the healthcare organization or the public interest. Therefore organizations that distribute profits to private investors no longer fall under the tax exemption. It is announced that the regulation regarding this tax emption will be changed, but it is still unclear in what direction (Belastingdienst, 2012).

Another tax exemption that healthcare organizations currently have is for Value Added Tax (VAT). A notion should be made that this exemption only applies to activities that are closely related to patient care. Also here it should be noted that this exemption is no longer in effect if the organization distributes its profits to shareholders. This VAT exemption does not apply to internal allocation of costs and non-medical services. The impact of this can be quite large, considering that on top of each transaction 21% of the amount has to be paid in taxes. In order to avoid this an organization can take the following countermeasures (Pauli, 2010):

- Fiscal unity, for organizations that are closely linked together both from an economical, financial and organizational perspective.
- Collaboration agreement, for healthcare related activities.
- Shared costs paid by one organization which allocates it to participating organizations (for example: the costs of research carried out for multiple hospitals).

Dutch tax authorities and the NZa require that costs are located transparently and economically justifiable, meaning that the origin of costs should be clear and the placement of activities among legal entities should be logical from an economical perspective. In case the current holding structure remains in place also transfer pricing should be taken into account. Transfer pricing is an internal allocation method. Dutch (and international) fiscal regulation requires of transfer prices that they are determined according to the 'arm's-length principle', this means that the price charged internally for certain services and/or products corresponds to the price charged for similar transactions in the market between independent organizations. Therefore it is not allowed to charge prices that are disproportionate compared to the market.

Currently there is a fiscal unity for both the corporate income tax and the value added tax, as displayed in Figure 5.

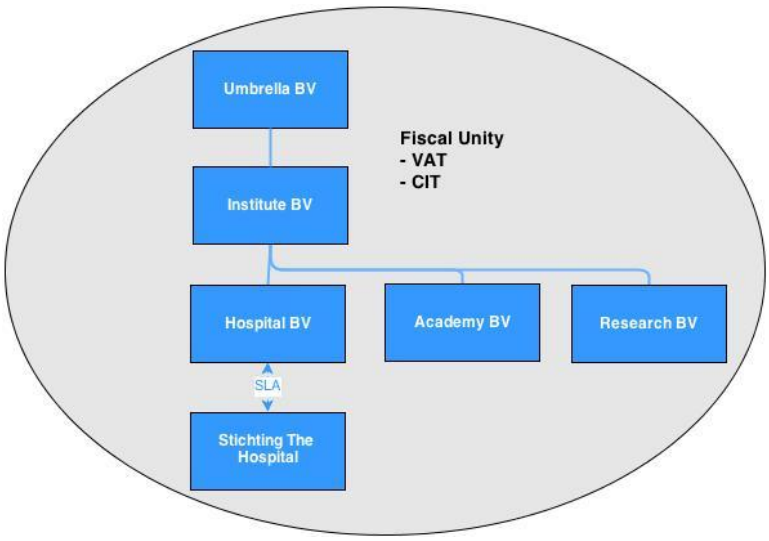


Figure 5: Fiscal unities in organizational structure.

When a fiscal unity is in place it is important that attention is paid to how the tax payments are dealt with internally. The Council for Annual Reporting ('Raad voor de Jaarverslaggeving' in Dutch) recognizes the following four alternatives (Franken & Litjens, 2009):

- The parent company pays the tax liability for the group.
- The tax liability is paid based on the fiscal result of the entities.

- The tax liability is paid based on the commercial result of the entities.
- The tax liability is paid as if there is no fiscal unity in place and the parent company acts as tax authority.

Choosing any of this methods may result in internal claims. Dividing the liability based on the commercial result is not appropriate according to the literature. It may harm creditors of underlying entities in favor of the parent company due to a difference in commercial and fiscal result.

In a successful holding the most common structure is to let the parent company pay all the taxes, which it can do by using cash received from dividend payments from underlying entities. This is however not possible for The Hospital, since dividend payments are not allowed for some of the underlying entities. In case of losses in underlying entities the last alternative is cheaper for the parent company, because the daughter company has no claim on the parent company regarding the fiscal benefits from its losses. This is the case in the second alternative. Therefore in the last option the head of the fiscal unity benefits from all the gains of horizontal loss compensation (Epe, 2010).

A company should document how it deals with taxes internally. A downside of the last alternative is that it requires more extensive documentation and agreements. In my opinion however this is worth the effort. During the startup period substantial losses will be made in Hospital BV. Compensating for this deferred tax asset conflicts with the aim of streaming earnings to Umbrella BV and subsequently the shareholders. Therefore in my opinion The Hospital should deal with taxes internally as if the head of the fiscal unity acts as tax authority, hereby benefiting from losses made in underlying entities. This way the entity that is not subject to the profit distribution restriction exploits the benefits from the horizontal loss compensation provided by the fiscal unity.

Transfer pricing within a fiscal unity is not very interesting from the tax authorities' perspective, unless the transfer prices result in losses in one or more entities and/or in case the fiscal unity is dissolved (Verberne, 2012). In other industries these internal transactions are not very relevant, because the holding company files its tax return based on consolidated statements where internal transactions are eliminated. In healthcare however it becomes relevant in my opinion when profits are distributed. Of dividend cash flows higher up in the tree of legal entities it should be made clear that these do not originate from healthcare activities directly. Then it becomes relevant to be able to show to the authorities that the amount of these cash flows is based on a 'fair' transfer price that corresponds to the price in the market for similar services. The determination of this price can be done by making use of the following methods, depending on the situation (Ministry of Finance, 2008):

- Comparable Uncontrolled Price method.
- Resale Price method.
- Cost plus method.
- Profit split method.
- Transactional Net Margin method.

Each of these methods will be briefly explained and the situations when these are appropriate to use. Later in this thesis these methods are used when determining internal transfer prices. It is important to notice that for every transaction an applicable method should be chosen.

Comparable Uncontrolled Price (CUP) method

The CUP method compares an internal transaction with a similar transaction in the market and uses the corresponding price. If comparable market prices are available this method is preferable in general, because it is direct and reliable.

Resale price method (RPM)

The resale price method takes the market price into account that a supplier demands for a certain product or service. The arm's length price that the internal supplier charges is determined by subtracting the gross margin from the market price. The gross margin consists of sales related costs and costs related to exerted functions on which an appropriate profit margin is added.

Cost plus (C+) method

The C+ method separates the direct and indirect costs of an organization that it can allocate to specific transactions with affiliated parties and overhead costs that cannot be allocated to specific transactions. A markup is added on the direct and indirect costs that covers both overheads costs and a profit margin. Therefore this method works with a gross margin. In general the C+ method is most reliable in situations where the exerted functions are less complex and the amount of value added by the involved party is small.

Profit split method

The profit split is used in situations where transactions are heavily intertwined making it difficult or impossible to review them separately. First the total profit of the transactions between the affiliated organizations is determined. Next this is divided in a way that approaches the arm's length principle as much as possible.

Transactional Net Margin method (TNMM)

The TNMM compares the operational net profit margin in relation to the costs, revenues or assets that a supplier in the market place realizes. This is a method that requires adequate estimation of costs made by external suppliers, which can be quite difficult.

5.4 Social environment

This section focuses on the position The Hospital occupies in the social landscape. In The Netherlands healthcare institutions are obliged to hand in their financial reports to answer for their performance. An important reason for this is that healthcare in The Netherlands is partly financed by taxpayers' money, causing public scrutiny on the profits these organizations make (see also Chapter 3). This means that financial information of The Hospital is accessible for the general public, therefore the public perception should be taken into account. In order to get a clear view on this the following research question will be answered:

What is The Hospital's position regarding the corporate social landscape and shareholder return distribution?

In The Netherlands the view exists that healthcare of sufficient quality should be available for the general public at acceptable costs. Many healthcare products/services are therefore merit goods, goods that an individual or society should have on the basis of a need, instead of the ability and willingness to pay (Thompson, 2011). This makes the healthcare sector somewhat different regarding the acceptability of profits. In most areas of business the view regarding profit is 'the more the better' and generating wealth for shareholders is incorporated in the organization's goals. In healthcare however, the focus should be on improving the quality of life for patients at acceptable costs. This is important to keep in mind when conducting a research like this.

Currently the public opinion regarding private hospitals is rather negative (see also Chapter 4). The view exists that the primary goal of these organizations is to make money at the expense of the patient. In order to find out what is socially acceptable regarding the amount of profit a hospital generates an analysis of the hospital branch in The Netherlands is reviewed. From this benchmark it follows that the average profit margin of all hospitals, defined as percentage of total revenues, is 1.9%. The differences in percentages differ for different regions, ranging from 1.5% in the Southern part of The Netherlands to 2.3% in the Eastern part. For small hospitals the average profit margin is 1.6%, but the spread is very large, ranging from -16% to 11%. These last figures are especially relevant, because this is the category The Hospital belongs to. They should however be corrected for incidental benefits and different accounting practices. This would mean that the two most profitable

hospitals of the category 'small hospitals' would fall back from 11% to 5% and 10% to 6% respectively. Looking at the Return on Equity (ROE) the most profitable hospitals realize approximately 26-54%, corrected for incidental benefits (BDO, 2012).

Given the portion of governmental funding hospitals are publicly accountable. Healthcare institutions are obliged to hand in their (consolidated) financial statements, which are made publicly available. Besides transparency purposes the financial statements also serve as input for benchmarks, allowing corrective action to be undertaken regarding prices and/or efficiency of operations.

5.5 In practice

To avoid valuable insights are being missed a study is conducted to find out how ZBCs currently realize the distribution of profits. Therefore the following research question needs to be answered:

What constructions to facilitate the distribution of profits are currently in place in practice?

First the type of legal entities holding the WTZi-license is investigated, after which special attention is paid to the holding structure.

Legal entity

In The Netherlands a BV is a common legal entity for private limited liability companies that are profit oriented. The liability of shareholders is normally limited to their capital contributions. In the law it is regulated that shareholders of a BV are entitled to part of the profits. It is possible to receive the WTZi-license as a BV, but given the private nature of BVs and its legal right to distribute profits this seems contradictory with the prescription from the WTZi. Therefore healthcare BV's that are providing insured specialized medical care need to address in their bylaws that the amount of profit distribution is limited. Also it should be clear that public funds are not distributed to shareholders (Plomp, 2011).

Therefore the type of legal entity that most institutions have when applying for the WTZi license is a 'Stichting' (foundation). This is a type of legal entity which has no profit orientation by law and is regulatory strictly bound not to distribute profits. Remarkably, both healthcare providers and investors find the stichting as legal entity unsuitable for effectively controlling a professional and complex organization like a hospital (Boer & Croon, 2010). It seems that the idea to use this entity is born out of necessity. Despite longstanding political ambitions to facilitate profit distribution in healthcare this is still not the case.

In practice many organizations that receive a WTZi-license subcontract their healthcare activities to BVs which subsequently distribute profits. Correspondence with the Ministry of VWS illustrated that

profits originating from providing specialized medical healthcare cannot be distributed. This also applies to subcontracting constructions.

For The Hospital the license lies with Stichting The Hospital, but all healthcare activities are contracted out to Hospital BV. This would mean that Hospital BV is also subject to the profit distribution restriction. Of the ZBCs in The Netherlands some are registered as BVs, but the vast majority as a stichting (NZa, 2012). These BVs holding licenses concern healthcare organizations that also offer uninsured healthcare. This allows a separation of public and private cash flows. Given the number of license holders that adopted the form of a stichting and the private nature of ZBCs this would suggest that currently ZBCs have found ways to distribute profit back to investors, despite the notion in the WTZi of no profit distribution. It is possible in practice, but the constructions used to facilitate this undermine transparency, control of annual accounts and accountability regarding the government (Plomp, 2011). On the other hand the Dutch healthcare authorities are not very strict in this. In 2008 they already advised the Ministry of VWS to allow an inflow of private capital in healthcare (NZa, 2010). So at this moment, it is still a grey area. In the following section I address how ZBCs manage to stay within the boundaries of the legislation while still finding ways to distribute profits.

Type of private capital

Due to the highly sensitive nature it is hard to determine how ZBCs distribute their profit exactly, but in general the holding structure is quite common for ZBCs. The Dutch Ministry of VWS (2013) states that the following ways of attracting private capital are used:

- Loans.
- Factoring.
- Sale-and-leaseback.
- Outplacement of certain services.
- Bonds.
- Subordinated debt.
- Donations and sponsoring.

Loans allow investors to earn interest. Factoring can be done in several ways. The invoices can be sold entirely, or a credit facility for the accounts receivables can be set up. The risk that a debtor defaults on its payment can be transferred to the factoring party or kept in-house. This also applies to the debtor ledger management. When decisions are made regarding these matters a certain fee is

paid to the factoring party which is usually a percentage that depends on either the turnover or the amount of accounts receivables.

Sale-and-leaseback constructions apply to real estate and medical equipment. The ownership is sold, but the building and equipment are still being used in return for a compensation. Buyers of bonds buy a portion of debt and receive compensation for this in the form of interest. Subordinated debt is an attractive alternative for investors because the amount of compensation can be significantly higher compared to other forms of providing capital. In the case of a default holders of subordinated debt are compensated after all other holders of debt are compensated, if there still are resources left. Therefore, the risk that they lose money on their investment is greater, allowing this kind of investors to demand higher compensation. Outplacement of services means that services or activities that were previously done in-house are now being outsourced to another entity. This can be done at market price, allowing room for a profit margin if this entity is part of the same group.

Research of annual reports of several ZBCs showed also other ways of redistributing earnings. The holding structure seems a common construction in which often personnel costs are charged internally between legal entities of the holding. Although from these annual accounts the identity of the investors of the ZBCs cannot be identified, there are indications that for some they were also involved as a manager. This way they were able to collect management fees from several entities in the holding. This scenario seems only viable if investors perform a dual role as an investor and employee or consultant. Otherwise it is likely to result in conflicts with investors not receiving wages, since these external investors will not appreciate funds are being diverted from the company.

Holding structure

A way to organize profit distribution is to create a holding structure where a holding company determines the strategy of the entire holding and where operational activities, support functions and facility management are assigned to different legal entities. Internally these entities charge each other for their services and by doing this revenues are redistributed in the holding. According to Plomp (2012) the holding structure has the following advantages:

- The influence of investors is limited.
- Exploitation and liability risks are limited.
- Prevention that private investors gain voting rights and profit claims over activities that have no profit orientation.
- Guarantee that public resources are used exclusively for healthcare activities.

There are also some disadvantages:

- By using a holding structure debt financers might object that losses in certain entities are not automatically compensated by profits from other entities of the holding.
- Entities that are part of a holding are generally not entitled to financial support in case of distress.
- The holding structure requires significant administrative costs.
- The Healthcare Governance Code (ZGC), the governance code for healthcare institutions, is not adequately set up for holding structures. The ZGC might recognize a conflict of interest if the management of the holding also governs the entity holding the healthcare services and determines that in case of members of the board holding shares, these should be held for the long term.

A way to overcome this last point is by explicitly stating in the bylaws what the social goal of the healthcare institution is and what the additional goals are, regarding profit orientation for example. Furthermore is should be stated how the different interests and goals relate to each other (Plomp, 2011).

5.6 Requirements on distribution model

In order to clarify which requirements the distribution model should meet in this subsection the following research question will be answered:

What are the requirements of the distribution model?

From examining the different dimensions the following requirements were drawn up that the distribution model should satisfy:

- From a legal perspective the solution needs to be valid under current and future legislation. Also it should be taken into account that outsourcing of core activities means that the profit distribution restriction also applies to the entity carrying out the healthcare activities.
- From a fiscal perspective transfer prices should be ‘at arm’s length’ if internal transactions are considered. Also a fiscal unity should be formed for both the corporate income tax and the value added tax to prevent double taxation.
- From a social perspective the solution is only valid if no structural losses occur in entities and the profit level of the entity carrying out the healthcare activities should preferably be in line with the market.
- Furthermore the solution should be durable, requiring no drastic changes in upcoming years and preferably little upkeep.

5.7 Appropriate distribution models

In this subsection the following research question will be answered:

What types of models to facilitate the distribution of profit to shareholders are appropriate for The Hospital?

From the previous subsections it is clear that The Hospital can choose from several alternatives regarding the distribution of profits to private investors. Loans, bonds and subordinated debt allow investors to realize a return on the capital they provided and can be applied regardless of which alternative is chosen.

Profit dependent loans, or profit participating loans, were also briefly considered. These types of loans however have characteristics that closely resemble equity. Assigning part of the profits to holders of these loans seems a direct violation of the profit distribution restriction. These type of loans were not found in research among Dutch healthcare providers.

Furthermore The Hospital can choose to apply for the WTZi-license as a stichting or a BV. Currently the stichting entity is used for this and changing this to the BV requires that the entire application procedure is followed again. Converting the license requires expertise from accountants, notaries, lawyers, fiscal consultants and the Ministry of VWS, and is therefore a substantial project (Keukens & Vissers, 2012). It requires a strong case and it is uncertain if the government allows some form of limited profit distribution and if so how much.

Leaving the license with Stichting also requires effort however. Within the holding structure that is already in place, activities need to be redeployed. Which activities are suitable for this en how compensation can be arranged in a justifiable manner requires research. Besides redeployment of activities also factoring and sale-and-lease back constructions are options to redistribute cash flows in a justifiable manner. The Hospital is in its start-up phase, so when evaluating the alternatives it should be kept in mind that the turnover is going to increase significantly in the coming years.

5.8 Conclusion

To summarize the content of this chapter, the answers to the research questions are given.

Research question	Answer to research question
a. How is shareholder return described in the literature and what does it mean specifically for investors of The Hospital?	Shareholder return can be in the form of dividends or capital in case of an exit. Only the former is currently not possible and is the crux of this research project. Investors of The Hospital aim for an annual ROI of 25% and expect dividends after the start-up phase.
b. What boundaries regarding distribution of shareholder return are prescribed by legal regulation?	Distribution of profits is forbidden for healthcare institutions that offer insured healthcare under the WTZi-permit, unless a ministerial exception is given.
c. What boundaries regarding shareholder return distribution and internal allocation are prescribed by fiscal regulation?	VAT and CIT exemptions for healthcare organizations are no longer in effect if profit is distributed to shareholders. Internal transactions are subject to transfer pricing rules.
d. What is The Hospital's position regarding the corporate social landscape and shareholder return distribution?	The Hospital offers merit goods, therefore financial results are reviewed critically. Profits of healthcare providers are low, just a few percent relative to their turnover.
e. What constructions to facilitate the distribution of profits are currently in place in practice?	Most privately funded healthcare providers seem to have adopted the holding structure in which profit distribution is realized using subcontracting and internal allocation of activities. Also loans, factoring, sale-and-leaseback constructions, bonds and subordinated debt are used.
f. What are the requirements of the distribution model?	The model should be valid under current and future legislation. Transfer prices should be at arm's length and fiscal unities for CIT and VAT should be formed. No structural losses should occur in entities and the result of the entity carrying out the healthcare activities should be in line with the results in the market.
g. What types of models to facilitate the distribution of profit to shareholders are appropriate for The Hospital?	There are several options; forms of debt and internal subcontracting and allocation within the holding structure.

6 Realization of the distribution model

This chapter contains the development of the model that facilitates profit distribution and elaborates on the choices made that lead to these. Firstly it is discussed which alternative has been chosen to facilitate the distribution of profits in a legitimate way for the coming years. Then the development of this distribution model is discussed step by step.

6.1 Choosing the distribution model

From a legal perspective the first step is to deal with current and future legislation, where the main choice is whether to change the legal entity to BV or adopt a holding structure, because the current situation does not suffice.

Changing the legal entity holding the WTZi-license is a complex and multidisciplinary problem. Distributing profit under the current legislation does not seem feasible and it is still unclear whether future legislation comes into effect. Preliminary research of the annual accounts show high projected earnings in comparison with other healthcare organizations. Even if it is possible to change the legal entity holding the WTZi-license it is highly likely that the cap on profit distribution allows none or only a small fraction of profits to be distributed to shareholders.

A solution that is feasible now and in the near future is internal redistributing activities in the holding structure. If the upcoming legislation passes and will be implemented, then The Hospital can decide at that moment to shift its WTZi-license to Hospital BV. This will most likely be much easier to realize than currently, because the government knows that many institutions will have to make the transition from stichting to BV and is likely to be more accommodating. An additional advantage is that changing the license to Hospital BV has no effects on the distribution model worked out in the holding structure, because Stichting the Hospital and Hospital BV currently subcontract completely. When using the holding structure it is important to keep in mind that direct outsourcing of healthcare activities is still subject to the profit distribution restriction.

A holding structure is also valid from a fiscal point of view. Hereby it is important to form a fiscal unity for both corporate income tax and value added tax to avoid double taxations. Also the transfer prices should be taken into account when internal transactions are devised, these should be at arm's length (see also Chapter 5.3).

From a social point of view the holding structure is very suitable, because it allows for a distinction between entities performing healthcare activities and entities carrying out supporting functions. Group earnings can be redistributed over entities, hereby ensuring that profits do not accumulate in

entities subject to the profit distribution restriction. It is important that entities do not operate continuously under a loss.

Furthermore it is relevant that the distribution model is durable, meaning that is valid for the coming years. It should therefore take into account that the revenues are going to increase rapidly in the years to come.

The holding structure allows for profits from internal transactions that are not subject to the profit distribution restriction. It requires that costs or activities are rearranged over different legal entities and transfer prices are charged for internal transactions. Taking the requirements from a legal, fiscal and social perspective into account the maximum profit not subject to the restriction is dependent on the number of internal transactions and the height of the transfer prices, while satisfying the condition that entities do not operate continuously under a loss.

Now the details should be further worked out. First of all it is important to determine which internal transactions can be applied. This is discussed in the next subsection.

6.2 Defining internal transactions

When searching for internal transactions a franchise structure was considered. This looked very promising, because of the amount of flexibility regarding the fees Institute could charge Hospital BV. Many of these fees can be turnover or profit-dependent and investments done by Institute could be retrieved using an entree fee. When investigating the possibility of a franchise structure it was found there is no legislation in The Netherlands regarding franchising. However it is common practice to use the European Code of Ethics for Franchising, provided by the European Franchise Federation. According to this code entities need to be financially and legally independent entities. Furthermore the business concept of the franchise agreement should be successfully implemented for a reasonable amount of time in one pilot establishment (European Franchise Federation, 2003). Because no pilot has taken place, The Hospital just started operating, and Hospital BV and Institute BV are economically intertwined, according to the code a franchise construction is not possible. Although this code is not binding, it will be taken into consideration when a dispute is taken to court. Taken these point into consideration the franchise constructing was rejected.

Royalty fee

Certain aspects of the franchise structure could still be used though. A franchise fee consists partly of compensation for the right to make use of the trade name, the domain name, the logos, etcetera. Within the holding structure Institute could charge compensation of Hospital for these aspects, as long as these kinds of intellectual property are owned by Institute. In business this compensation is

called royalties or royalty fee. Marketplace transactions showed royalty rates for logos and trademarks in the range of 0.5% to 3.0% of net sales (Anson, 2005). The fact that the fee is dependent on turnover makes it an interesting option for the coming years, in which the turnover is expected to rise significantly. Because of the availability of market prices, the CUP method can be used to come to a transfer price for the intellectual property compensation. A transfer price of 3.0% seems the maximum amount of justifiable compensation.

Marketing fee

Another aspect of the franchise structure that looks promising is the way marketing activities are remunerated. The (parent) company providing all promotional activities receives a compensation from the company that is benefiting from these activities in the form of a percentage of its turnover. The more effective marketing campaigns are, the more customers (patients) subsidiaries or franchises receive, the more compensation the parent company collects. Marketing activities are critical for new companies to create awareness and grow their clientele. It is hard to determine the exact amount of turnover that can be directly attributed to the marketing activities. The fee franchise organizations use consists on average of 2% for national promotional activities and 2% for local activities (International Franchise Association, 2006). These figures are also used to come to a marketing fee for The Hospital, leading to a fee of 4% of the turnover of Hospital BV. A different approach would be to take the marketing costs into account and apply the gross profit margin in the advertising industry as a markup. This would not capture the value possible under a turnover-dependent solution. When considering markups on marketing costs it is important to keep in mind that these costs are already at market prices. A markup would be for the labor hours managing the process. This can be done in the form of a management fee which is discussed later.

Factoring

Another interesting turnover-dependent option is factoring. Factoring is traditionally a financing option to make receivables liquid, in other words to change invoices to cash immediately. There are two types of factoring: traditional factoring and American factoring. Companies offering traditional factoring offer a cash facility which size is defined as a percentage of outstanding invoices. Interest is charged over the amount that is withdrawn from the cash facility. In case of American factoring invoices are sold directly in exchange for a percentage of the outstanding amount received in cash immediately and the rest after collection of the invoice. Both types of factoring take a fee into account, for which also the debtor ledger management is carried out. There is also a distinction to be made regarding the credit risk of both alternatives. In non-recourse factoring the credit risk is transferred to the factor, where in case of recourse factoring the company bears the risk that debtors

do not pay their invoices. Non-recourse factoring is therefore more expensive than recourse factoring. The fee for traditional factoring ranges according to a Dutch factoring agent from 0.1% to 1.0% relatively to the turnover plus interest on the withdrawn amount. American factoring fees range from 2% to 8% respectively (Factoringvergelijken.nl, 2013). Advance payments and cash facilities would mean that cash is provided by Institute to Stichting The Hospital, which is not desirable. Stichting has no need for cash, because it subcontracts all healthcare activities.

The entities are grouped together in a cash pool with the bank, meaning that any entity in the group can borrow at a specified interest rate up to a certain limit. Also the possibility of intercompany loans makes it redundant to use factoring as a finance option. It is however perfectly acceptable to transfer the credit risk and the debtor ledger management in exchange for a compensation. Basically the form of factoring proposed for The Hospital can be seen as traditional factoring where the cash facility corresponds with the intercompany current account. In factoring, the 'solidness' of the invoices is relevant; meaning the possibility that an invoice is not paid. Stichting The Hospital has invoices to healthcare insurers drawn up under specified contracts. As mentioned in Chapter 3.5 the market for healthcare insurers is divided among just a few very large players, therefore the invoices of Stichting The Hospital to contracted insurers are reasonably solid if no mistakes are made in the invoicing process. The invoices that will not be remunerated by insurers and need to be paid by patients do have significantly more credit risk. It is expected however that these invoices will form a minor part of the total number of invoices. The credit risk on the invoices is estimated at 1%. For the ledger management an additional 0.5% is charged. Adding to these a profit margin of 2.5%, a total factoring fee of 4% is used. Because the contracts with the healthcare insurers lie with the entity holding the WTZi-license, Stichting The Hospital, Stichting pays the remuneration. The total invoice amount is subcontracted to Hospital BV minus the costs for factoring.

Service fee markup

Costs are being transferred down the tree of legal entities while revenues are streamed upwards. The costs for supporting activities carried out by Institute should be compensated by Hospital. A justifiable transfer price should be charged for this, so that the profit component for Institute is as large as possible. A way to facilitate this is by merging the costs for office supplies, ICT, quality control, human resource management, building management, equipment maintenance and advisory services into a single service fee. This service fee consists of all costs that Institute had to make to perform corresponding services plus a markup. This means the cost plus method was applied for the transfer price. The reason for this is that Institute subcontracts most of these services to outside contractors at a market price. The markup is justified because Institute handles contract

management and coordinates between end users and suppliers. However, there is limited room for a justifiable markup. Setting this too high would raise questions why Hospital BV would not deal with the suppliers in the market directly. Discussions with the finance manager of The Hospital resulted in a markup percentage of 10%. A notion should be made here that the additional value charged on top of market prices stems from the factor management. Therefore a consideration should me made whether to apply a markup on services or to apply a management fee.

Turn-key markup

Two very important categories of costs are the leasehold improvements and the investments in equipment, because these involve millions of Euros. Both investments are done on behalf of Hospital BV, but paid for by Institute and Umbrella. In order to come to a justifiable markup, in this section many financial documents of The Hospital were studied extensively, such as financing contracts, lease agreements and budgetary reports. For every investment the corresponding financing costs were calculated from the financial statements and a review of the financing agreements. Because investments are considered, also a return on these investments is justifiable in the form of a markup. The investment costs, corresponding financing costs, and markup (percentage on the investment costs) are internally charged to Hospital BV in the form of a yearly turn-key premium, calculated using a time horizon of 10 years. This horizon corresponds to the length of the building lease, as specified in the contract. The annual return on the turn-key investment was set on 7% per year.

Management fee and personnel placement

Another possibility to create internal profit is the management fee. Assigning managers from Institute to Hospital allows for a compensation that can be given in the form of a management fee. This fee covers the salary of the managers, plus a margin. Besides the financial consequences for The Hospital, there are several matters that require consideration. For the holding company employing managers to lead subsidiaries would result in complete control of the course of its subsidiary. However, it also means that the legal liability for these managers' actions also shifts to the holding company. This cancels the risk diversification of the holding structure. Furthermore from a labor law perspective the employment agreement of the managers with the holding coexists with the employee's mandate as legal representative of the subsidiary. A consequence of this is that a dismissal as general manager of the subsidiary does not automatically dissolve the employee agreement with the holding company. When there are no grounds for a discharge at the holding level this could result in high costs. There are also fiscal conditions determining whether or not the management fees are tax deductible, but in light of the consolidated tax groups in place these are irrelevant for The Hospital. These groups for that matter already made the participating companies

of the unity liable regarding claims from the tax authorities of the company as a whole (David & Gaucher, 2012).

On the other hand, separating the workforce in medical functions versus supporting functions also offers flexibility towards the future. If other branches are opened the organization remains the same; supporting functions lie with Institute, where underlying entities focus on the core (healthcare) activities. Legal liabilities can only be separated if independent managers are in place. In a small organization like The Hospital this is not the case, therefore the matter of legal liability does not play a role here. Placing strategic personnel into Institute also offers opportunity regarding the possible opening of new subsidiaries.

Internal discussions resulted in the choice for a markup, consistent with the cost plus method, of 10%. An important consideration is whether both a service fee and a management fee can be charged. The markup on service costs was justified from the perspective that a certain amount of management was involved. There is some overlap, making it harder to justify to apply both. Later in this thesis this is incorporated when coming to a distribution model.

Intercompany financing

When a company consists of multiple legal entities it is common that internal financing takes place. This includes internal loans for instance. If there is a liquidity need in one entity, this might be resolved by offering a loan from another entity. Another way to do this is via an intercompany current account. These internal finance agreements however should be at arm's length, meaning that terms and conditions, such as interest rates, should be at a market transaction basis.

At first Hospital BV is expected to have a negative result, due to the fact that The Hospital has just started operating. These losses are compensated through the intercompany current account. To come to a justifiable interest rate for this account other types of debt present in The Hospital were considered, stemming from the idea that The Hospital needed to attract funds in order to offer this facility internally. Therefore the cost of debt was calculated. The interest on the intercompany current account was set equal to this, resulting in an interest rate of 5.25%.

Summarizing, the following internal transactions were considered to be applied within the holding structure:

- Royalty fee.
- Marketing fee.
- Factoring fee.

- Service fee.
- Remuneration turn-key investments.
- Management fee.
- Intercompany finance.

Applying these internal transactions affects the placement of costs and internal profits. As mentioned earlier it is not clear that all internal transactions will be accepted by the Dutch authorities. There might be overlap between some transactions. Furthermore it is uncertain how franchise-like fees are accepted by the authorities. Therefore in the following section several scenarios were worked out in which certain internal transactions are incorporated or not, allowing flexibility towards possible solutions.

6.3 Different scenarios

Several internal transactions are well justifiable and are likely to be applied in any case. These are: a factoring fee, a turn-key fee, a management fee and interest on the intercompany current account. This is considered the base scenario and is incorporated as Scenario 4. The scenarios are ranked, where Scenario 1 takes all internal transactions into account. This scenario therefore realizes the most internal profit. Scenario 2 takes all transactions into account minus the royalty fee and Scenario 3 all transactions minus the royalty and the marketing fee. Table 1 summarizes the scenarios and their internal transactions:

Internal transaction	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Service fee	x			
Marketing fee	x	x		
Royalty fee	x	x	x	
Factoring fee	x	x	x	x
Management fee	x	x	x	x
Turn-key fee	x	x	x	x
Interest I/C account	x	x	x	x

Table 1: Different scenarios and their characteristics.

These four scenarios allow for maximizing the internal profit under the conditions that the authorities accept the internal transactions and no entities operate under a loss. In order to find out what the financial consequences of each scenario are a model was built, which is discussed extensively in the following subsection.

6.4 Developing the Excel-tool

In order to calculate the financial results under each scenario the costs and revenues should be divided over the different legal entities. A model needed to be drawn up that meets the following requirements:

- Clear insight in internal transactions and financial consequences.
- Variable input parameters for transfer prices.
- Possibility of adjusting the turnover.

Microsoft Excel satisfies all of these needs. The program is currently present in the organization and end users, such as the financial and general manager, are experienced with this software.

It was decided to realize the model in the form of different income statements for each entity. Income statements give a clear insight in costs and revenues and allow for clear insight in internal transactions. I incorporated all transfer prices as input variables, allowing to test effects of changes in these. Also a variable was added that can change the turnover by a certain factor. The assumption was made that the relative change in turnover applies to the direct costs and personnel costs as well. Under these conditions it can be tested what effect turnover changes have on the financial result of scenarios. Because interest from the intercompany current account plays an important role in the internal transactions the balances to date are incorporated as an input field. This leads to the following control panel with variables of the model that can be adjusted:

Turnover percentage	100%	I/C balances			
Service fee markup	10%	Stichting	Hospital	Institute	Umbrella
I/C interest rate	5,3%				
Factoring fee	4%				
Royalty fee	3%				
Marketing fee	4%				
Annual return turn-key investments	7%				
Management fee	10%				

Table 2: Control panel Excel-model

The top variable “Turnover percentage” corresponds to a sensitivity analysis that is discussed later to investigate the effect of a change in turnover. It is important to state once again that the variables

used for transfer prices have to be ‘at arm’s length’, meaning that for each variable a minimum and maximum determine the range which a variable can take.

Drawing up income statements for each entity required substantial effort. Only the consolidated financial statements present took estimates for coming years into account. For the Excel-tool these statements were used as input, allocating costs and revenues over different entities.

In the financial documents the projected turnover is going to increase by a fivefold in just a few years. The government, healthcare insurers and healthcare providers however have agreed that the costs of healthcare cannot grow more than 2.5% in the period 2012-2015 (Rijksoverheid, 2011). Some money (65 Million) has been reserved by the healthcare authorities for ZBCs that are new and growing rapidly. Further growth is only possible at the expense of the budget of other healthcare providers in the region. In this light it is kept in mind that the projected turnover numbers might turn out to be lower than projected for the coming years.

Another comment regarding the figures from the balance sheet is that projected future revenues are based on the number of patients, but also the case mix. This is the mix and frequency of treatments during a year. The Hospital has been operating for a few months and it appears that the case mix will vary somewhat from the business case. The percentage of new patients where the disease is found is far greater than in other hospitals. This can be explained by the high number of second opinions that are being carried out. Also patients that are already being treated switch to The Hospital for continuation of their treatment. All these changes affect the case mix and therefore the earnings. Also a relative change from surgery to diagnostics might affect projected earnings. Taking all these points into consideration it is wise to be somewhat reserved regarding these figures. After pointing out the issue of unrealistic turnover numbers several discussions took place with the management of The Hospital. This led to a revision of the numbers by taking the data related to the first months of operating into account. Both the turnover, direct costs and personnel costs were adjusted.

The Excel-tool is structured like a waterfall of income statements for the different legal entities, where internal remunerations are colored red if outgoing and green if incoming. The different scenarios were positioned next to each other to allow for a quick comparison. The timeline for each scenario corresponds with the horizon of the financial statements, namely four years (2013-2016). After this period the results are assumed to be stable. All costs stem from the budgetary reports.

An important assumption of the model is that financial results of entities are settled using the intercompany current account. In case the financial result of an entity is negative, the balance on its intercompany current account grows more negative, and in case of a profit the balance amount is

reduced with the profit. The results in Institute BV are not subject to the profit distribution restriction. Therefore after its loss position on the internal current account is repaid, the assumption is made that excess results are distributed to Umbrella BV via dividend payments.

6.5 Results

From the perspective of The Hospital the desired situation would be that the earnings in Institute and Umbrella combined, without results from Hospital BV, relative to the total earnings of the group are as large as justifiably possible. The profit that is eligible for distribution is maximized this way, meaning that also the value in case of an exit will be maximized.

When reviewing the results it became clear that in all four scenarios both Institute and Umbrella will start operating profitably right away and continue to do so in the coming years. The bottleneck in this case therefore would be preventing that Hospital BV operates unprofitably. The financial result of Hospital BV and the combined results of Institute and Umbrella are displayed in Figure 6.

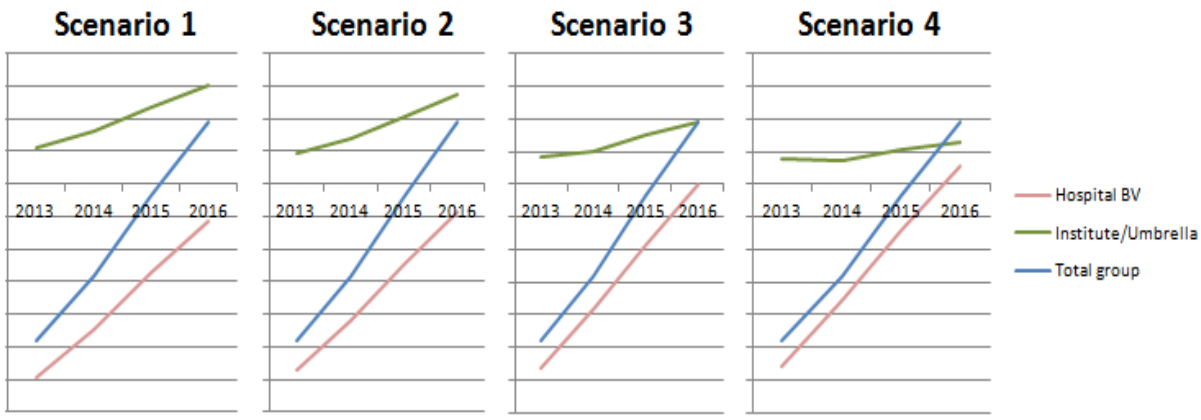


Figure 6: Financial result per year for each entity.

Internal transactions do not affect the financial result of the entire group, because earnings are merely repositioned. Figure 6 shows that Scenarios 1 and 2 would result in significant continuous losses for Hospital BV, while for Scenario 3 a small loss is anticipated. In order to repay the startup costs Hospital BV needs to be profitable. The loss position from these startup costs offers the possibility of distributing earnings to Umbrella BV without violating the profit distribution restriction. Profits are merely used to repay the outstanding amount of debt on the intercompany current account. For The Hospital it is favorable if this loss position is repaid very slowly, because it would mean that for a long time profits in Hospital BV can be distributed. However, it should be kept in mind that the model needs to be justifiable. Realizing a miniscule profit compared to turnover does not make a strong case towards the authorities. Figure 7 shows how the results look cumulatively. Only in Scenario 4 the loss position of Hospital BV is gradually repaid.

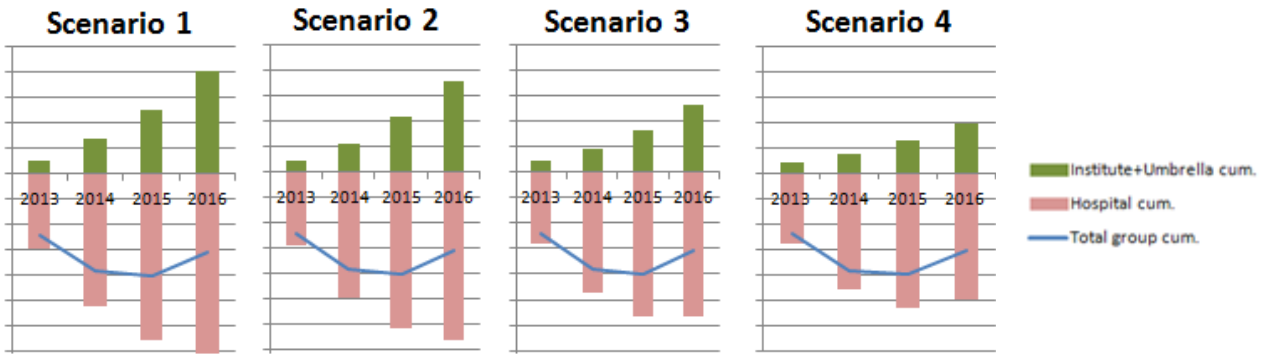


Figure 7: Cumulative yearly financial results.

There are two options for The Hospital to realize the distribution model: adjusting the transfer prices in Scenario 3 downwards or apply the internal transactions as in Scenario 4. The latter makes a stronger case towards authorities, so first of all it is investigated what the consequences of Scenario 4 are in the long run. Assuming that the turnover remains stable as of 2016, in Figure 8 can be seen that the cumulative result of the group becomes positive in 2019.

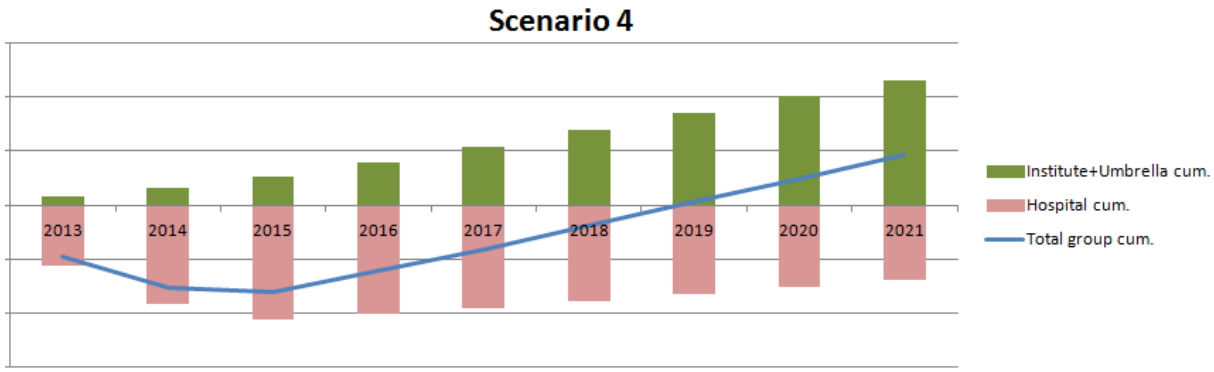


Figure 8: Cumulative results under scenario 4.

Until 2019 the solvability is recovering from the startup losses and after 2019 it becomes positive. Because a large portion of the loans is repaid at that point and the financial result is substantial, the solvability improves very fast. The loss position of Hospital BV is reduced to zero in approximately 2025. The amount of profit Hospital BV makes after four years will be 2.7% relatively to its turnover. This is a quite common percentage for hospitals (see also 5.4). These results show that Scenario 4 meets the requirements adequately:

- It is a strong case towards the Dutch authorities regarding the type of internal transactions.
- Hospital BV starts to make a profit in 2016 that is market comparable.
- The profit in Hospital BV is small enough to ensure that internal debts due to startup losses are repaid slowly. This leads to a situation that until 2025 approximately all profits are not

subject to the profit distribution restriction. So applying this scenario is suitable well into the future.

To clarify the internal organization of activities under Scenario 4 the following figure was drafted to summarize the internal situation for the entire group:

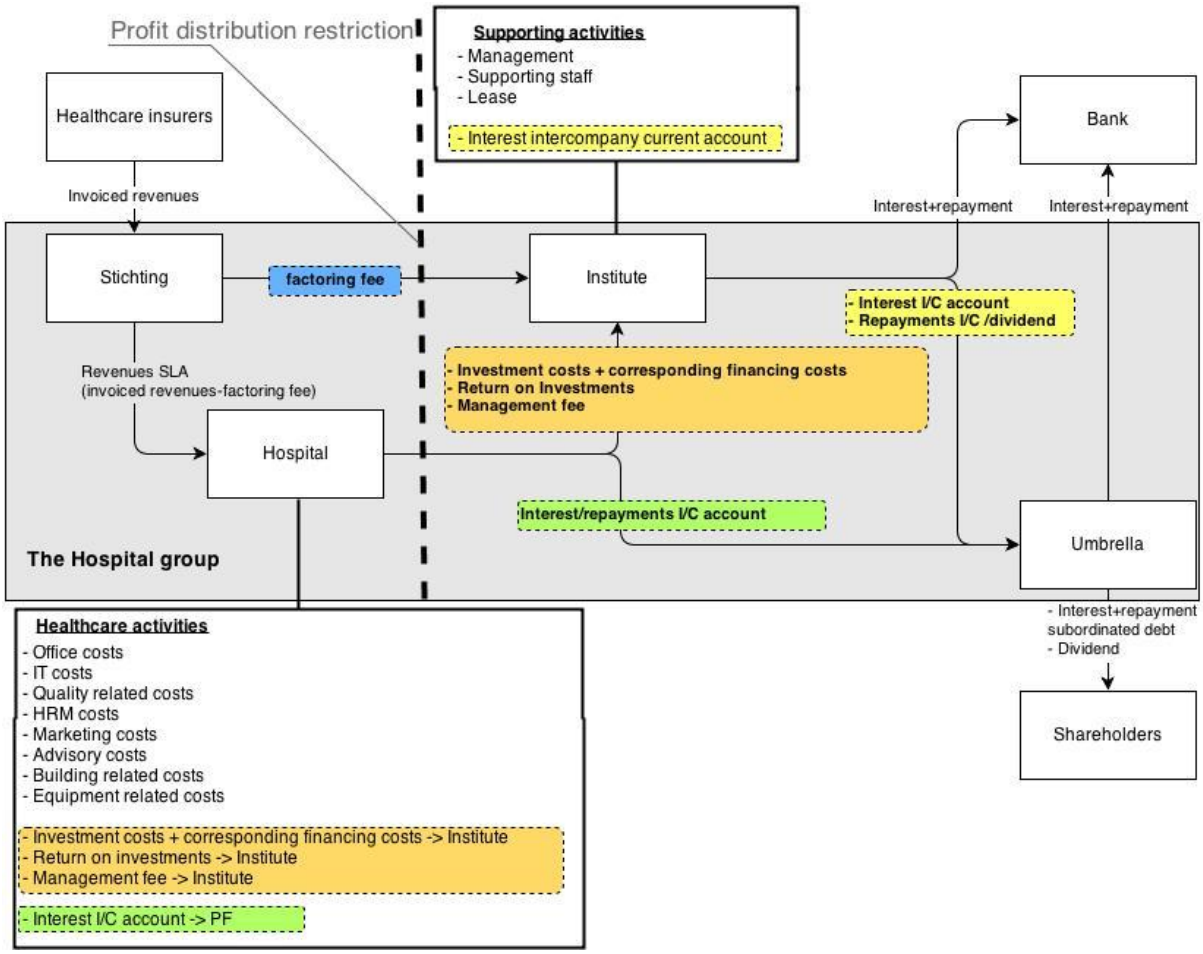


Figure 9: Internal transactions in The Hospital under Scenario 4.

It is important to keep in mind that the results of all scenarios are based on projections. Therefore The Hospital needs to be able to adjust its internal model in case of deviations from the financial projections. In case a situation occurs where a large portion of the profits cannot be distributed due to the restriction, the amount of internal transactions can be increased according to the different scenarios provided. Therefore this thesis not only provides a strong solution to deal with the original problem, but also offers flexibility to deal with changes that might occur in the future. In order to find out how Scenario 4 would be affected by turnover changes a sensitivity analysis was conducted.

6.6 Sensitivity analysis

To find out how Scenario 4 responds to changes in turnover the variable 'Turnover percentage' is altered for several different turnovers. When conducting this analysis the assumption was made that the gross margin and personnel costs changed relatively the same as the turnover. In order to avoid repetitive actions a macro was coded that automatically changes variables and fills in tables with the click of a button. Whether or not Hospital BV operates profitably after four years will be the bottleneck, since Institute and Umbrella start operating profitably right away. As can be seen in Figure 10 the viability of Scenario 4 strongly depends on the condition the financial projections are met.

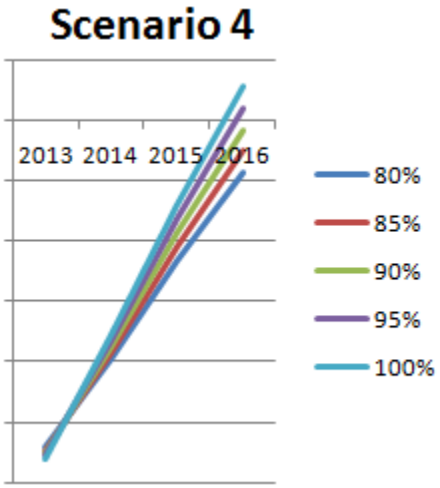


Figure 10: Financial result Hospital BV.

In the other scenarios the effect of a lower turnover is even greater, since more earnings are being diverted from Hospital BV. The Hospital can deal with lower revenues by adjusting the height of the transfer prices downwards in Scenario 4. In case the turnover will be greater than projected The Hospital cannot adjust the transfer prices upwards much, because of the 'arm's length restriction'. Then the course of action for The Hospital would be to incorporate additional internal transactions, meaning one of the other scenarios is adopted. This shows that the model has great flexibility, offering a plan of action for any future development.

6.7 Dividend prospects

The bank, which is the major contributor of debt capital, offered capital for the group as a whole. Therefore it would only allow dividend payments if the group as a whole is healthy enough to meet its current and future financial obligations. Besides this liquidity requirement, an important requirement for the allowance of dividend payments is that the total amount of equity is greater than the total amount of debt.

When Scenario 4 is implemented the group as a whole starts operating profitably in 2016. Before that year the equity position of the group is decreased by the losses of each year, resulting in a negative equity position. In 2019 the group is expected to have made up for losses from the startup years, meaning that a positive equity position will be reached. The solvency of the group increases rapidly, because both the financial result is strong and the amount of debt is greatly reduced. Therefore in 2020 the amount of equity is expected to have surpassed the amount of debt. By then the solvency is strong enough to make dividends payments to shareholders.

In order to test whether the liquidity of The Hospital group is strong enough for dividend payments insight in cash flows is required. The only cash flow statement present was the consolidated one, from before operating. This did not give information on the individual entities and also was based on the original turnover numbers. Therefore cash flow statements were drafted for each entity for the coming years. These show that as of 2016, when the financial result of the group turns positive, positive net cash flows start to occur. These continue to grow stronger, due to decreasing repayments on debt. Even when possible reinvestments are incorporated still a substantial positive cash flow is generated. This cash flow is of course greatly influenced by the financial result of The Hospital and therefore its turnover. Previous subsection showed however different countermeasures to ensure a strong financial result. Therefore the liquidity test, to ensure the company is still able to meet its obligations after dividend payments, should not be a problem. The prospect of significant dividends combined with the fact that the majority of earnings is free to distribute boosts the value of The Hospital group, allowing shareholders to make a significant return after seven years.

An important notion should be made that these expectations rely on certain assumptions, such as that the financing structure does not change radically and projected earnings are realized. Therefore these rough estimations should be annually reevaluated in order to come to a more reliable prediction on the moment dividend payments start to take place.

6.8 Conclusions

In order to deal with the profit distribution restriction the holding structure was chosen. Several applicable internal transactions were identified. For each of these transactions a justifiable transfer price was determined. Several scenarios were drafted that presumed incorporation of different internal transactions, ranging from the strongest justifiable case to the maximum amount of internal transactions. Income statements were developed for each entity under each scenario. This was realized in an Excel-tool that incorporated transfer prices as variables and also allowed for sensitivity analyses regarding turnover changes. This tool and the drafted scenarios offer The Hospital great flexibility regarding the future. Scenario 4 excellently meets all of the requirements and is a good solution for the original problem. It allows for a strong case regarding the authorities. Both the justifiability of the type of internal transactions, the market comparable profit of Hospital BV and the long term possibility of distributing The Hospital's profits makes the proposed scenario very suitable. Furthermore future developments can be adequately tackled by adopting one of the other scenarios or adjusting the transfer prices downwards.

Cash flow statements were developed and after four years a positive net cash flow is generated, which continues to be strong for the years after. Therefore liquidity will not form a major hurdle for dividends. The solvency of The Hospital is expected to turn positive in 2019. Due to strong financial results and declining debt the solvency increases rapidly. Therefore in 2020 both the solvency and liquidity positions are expected to be strong enough to allow for dividend payments to shareholders.

7 Conclusions and recommendations

In this chapter the main conclusions of our research are summarized. Furthermore I give advice to improve the model and anticipate on what future actions are necessary to keep it operational. The chapter ends with recommendations regarding strategic developments to be anticipated.

7.1 Conclusions

At the start of this research project the following research question was drawn up:

How can a sustainable shareholder's return be realized for the investors of The Hospital within the boundaries of the legal, fiscal and corporate social landscape?

The main problem The Hospital had, is that it could not distribute profits to investors, because profit distributions are not allowed for organizations offering insured healthcare. The aim of enabling this distribution led to research incorporating knowledge from different fields and combining this into a single solution viable for years to come.

I mapped the complex playing field from legal, fiscal and social points of view. I studied current and future legislation extensively, including research documents that served as input for this legislation. Fiscal regulations relevant to the current situation and possible future solutions were reviewed. At some point this concerned highly specialized areas. I viewed upon the problem from a social perspective as well. Due to the public discussion around privately funded healthcare and the consequences it has on the political course of the country, it was essential to take social currents into account as well. All of these dimensions took place in the dynamic complex environment of the Dutch healthcare sector. Although I am schooled primarily for the financial sector I did incorporate all of these dimensions to the best of my abilities.

The strongest solution to the problem that stemmed from this research was the holding structure. Therefore the decision was made to facilitate profit distributions using the holding structure. This was done for the following reasons:

- The structure is viable for the aim of the research. By setting up internal transactions in a justifiable way revenues can be moved past het profit distribution restriction.
- The holding structure is also viable in case future legislation comes into effect. It requires only minimal changes to the internal distribution model if this is the case.
- The holding structure offers flexibility in applying different internal transactions. This flexibility is especially valuable in light of the substantial changes in turnover that are to be expected.

- The holding structure allows for fiscal optimization.
- The structure of legal entities is already in place, but lacks refinement and internal transactions in its current form.
- The structure offers flexibility towards the opening of new subsidiaries in the future. These can be incorporated quite easily and according to the same distribution model.

A range of feasible internal transactions was defined and market comparable transfer prices were established. Four different scenarios were drawn up, each applying a different number of internal transactions. This offers The Hospital great flexibility towards future developments.

The entire distribution model is developed in Microsoft Excel. Income statements and cash flow statements were drawn up for each entity. Special attention was paid to the internal transactions. These are highlighted in the Excel-tool and its value depend on the height of the transfer prices. The markups and fees of the transfer prices are the input variables in the control panel of the model. Effects of changes in transfer prices can be seen immediately for each of the scenarios, which are displayed clearly next to each other. Every scenario considers four years, which is the time horizon of the consolidated financial projections. The turnover can be adjusted as well, allowing for sensitivity analysis of changing turnovers. The Excel-tool offers a unique tool to improve the revenues free of the restriction, while satisfying the boundary conditions. These latter are:

- The height of the transfer prices should be at arm's length, meaning they should be comparable to similar transactions in the market place. The variables for the transfer prices in the base model do not leave much room for adjusting these upwards.
- Hospital BV should make a justifiable profit in the long run. This profit should be large enough to make a strong case towards the healthcare authorities. If the entities within the group were independent of each other the management should strive to make at least a market comparable profit of 1,6% relatively to its turnover. A profit much larger than common in the market would result in profits that cannot be distributed, which is not desirable. This shows that determining feasible scenarios is a delicate business.

After the financial numbers were adjusted for lower revenues and higher personnel costs the model and scenarios were built in Excel. This rendered only Scenario 4 as a viable option. This is however not just an acceptable option, but an excellent one:

- It is a strong case towards the Dutch authorities regarding the type of internal transactions.
- Hospital BV starts to make a profit in 2016 that is market comparable.

- The profit in Hospital BV is small enough to ensure that internal debts due to startup losses are repaid slowly. This leads to a situation that until 2025 approximately all profits are free of the profit distribution restriction. So applying this scenario is suitable well into the future.

The liquidity position of The Hospital looks strong for the future. The solvability position improves quickly after The Hospital starts to make a profit in 2016. In 2020 this position is expected to be strong enough to allow dividend payments to shareholders.

The main result of this report is a model that effectively tackles the profit distribution restriction, while offering flexibility towards future changes in regulation and/or turnover. The effect of changes in transfer prices or turnover can be seen immediately, hereby offering the possibility to determine when the shareholders can expect to see return and how much.

7.2 Discussion

The model requires some fine-tuning to make it fully operational. This should be done via expert knowledge from different fields. From a legal perspective any vulnerabilities regarding the legal liability of the different entities should be investigated. Furthermore, the internal contracts should be drawn up, in order to document any internal transactions. Fiscal lawyers should examine the holding structure and define contracts to deal with taxes optimally. Management agreements should be researched further from a labor law perspective to find out if it is possible to unify liability for an employee of the holding and subcontracted manager of the subsidiary.

The amount of upkeep for the model is relatively small. Transfer prices should be investigated periodically to ensure these are still at arm's length. Furthermore the financial results should be regularly evaluated to see whether the internal parameters of the model need to be adjusted. Both of these reviews may be done annually.

The proposed model is valid for the coming years and is justifiable regarding the Dutch healthcare authorities. In case the future legislation comes into effect several options are possible for The Hospital. It can shift its WTZi-license to Hospital BV. Factoring costs are then charged to Hospital BV instead of Stichting The Hospital, because the contracts and revenues shift to Hospital BV. Everything else remains the same. A more drastic approach would be to converge all activities into a single legal entity, hereby cancelling any internal transactions. This option should only be considered if the terms of profit distribution are favorable and durable.

The contribution of this thesis is very practical in nature. Privately funded healthcare providers are growing rapidly in The Netherlands and all of these encounter the problem The Hospital had regarding the distribution of profits. This thesis offers current and future privately funded healthcare

providers a lot of guidance. The way the distribution model is constructed can be duplicated in any of these organizations. It offers a range of internal transactions to choose from and things to keep in mind when implementing the model. By structuring the Excel-tool in the same manner, all current and future privately funded healthcare organizations can gain immediate insight in financial consequences of certain internal transactions, hereby offering the possibility to optimize their individual model according to their wishes.

7.3 Recommendations

When the financial projections are realized and considerations arise to expand the current business model the franchise construction should be taken into account. Expanding the business under the current business model offers opportunities to realize franchise revenues.

Another recommendation would be to anticipate on developments that already begin to take shape, such as a higher number of malignant patients, due to more second opinions. Also the amount of inflow of patients that want to continue treatment in The Hospital after already being diagnosed at another hospital is disruptive to the original business case. Investigate what the financial impact would be of a relative shift of types of patients. Relatively more patients in need of surgery for example, or on the contrary a larger share of diagnostic activities. See whether it is worthwhile to increase the capacity of certain healthcare processes.

References

Anson, W. (2005), *Fundamentals of Intellectual Property Valuation: A Primer for Indentifying and Determining Value*, American Bar Association.

BDO (2012), *Benchmark Ziekenhuizen 2012* - http://www.bdo.nl/nl/publicaties/documents/bdo-benchmark-ziekenhuizen-2012.pdf

Belastingdienst (2012), *Belastingplan 2012.*

Boer & Croon (2010), *Investeringsbereidheid in de curatieve zorg* – Een onderzoek in opdracht van het Ministerie van Volksgezondheid, Welzijn en Sport - http://www.boercroon.nl/uploads/tx_rkpublications/2010_03_25__rapport_investeringsbereidheid_in_de_zorg_-_finaal.pdf

Boer & Croon (2011), *Zelfstandige Behandel Centra – Kwaliteit van zorg, efficiëntie en innovatiekracht*, research in behalf of Zelfstandige Klinieken Nederland.

Butler Consultants (2012), *Free Industry Statistics – Sorted by Highest Growth Margin* - http://research.financial-projections.com/IndustryStats-GrossMargin.html

David, R. & Guacher, C. (2012), *Intra-group management agreements: beware the pitfalls* - http://www.internationallawoffice.com/newsletters/detail.aspx?g=14ed882b-498a-48a8-9e9e-2e1bdda58fac

Epe, P. (2010), *Winstbelasting in de bedrijfseconomische jaarrekening (Proefschrift)*, Nyenrode Business Universiteit.

European Franchise Federation (2003), *European Code of Ethics for Franchising* - http://www.eff-franchise.com/spip.php?rubrique13

Factoringvergelijken.nl (2013), *Debiteurenfinanciering* - http://www.factoringvergelijken.nl/

Fernández, P.(2007), *Company valuation methods - The most common errors in valuations*, University of Navarra – IESE Business School.

Franken, R. & Litjens, H.J.R. (2009), *Fiscale eenheid en draagplicht: Oppassen, zeker in crisistijd!*, Accountancy Nieuws (22) - http://www.accountancynieuws.nl/actueel/vaktechniek/fiscale-eenheid-en-draagplicht-oppassen-zeker-in.87970.lynkx

Ge, D., Mahoney, J.M., Mahoney, J.T., *New Venture Valuation by Venture Capitalists: An Integrative Approach*, University of Illinois.

International Franchise Association (2006), *The Profile of Franchising 2006: Series III – Royalty and Advertising Fees* - *http://www.franchise.org/files/Systems%20with%20Ad%20Programs;%20Avg.%20Advertising%20Fee%20for%20Program.pdf*

Kerste, M., Kok, L. (2010), *Winst in de eigendomsstructuur – Eigendom, winstbestemming en zeggenschap binnen ziekenhuizen*, SEO Economisch Onderzoek.

Keukens, Q. & Vissers, L.B (2012)., *Winstuitkeringen aan private investeerders in de zorg – De omzetting van een 'zorg-stichting' in een 'zorg-bv'*. Onderneming en Financiering 2012 (20) - www.banning.nl/download.html?id=1903

Largani, M.S., Kaviani, M. & Abdollahpour, A.(2012), *A review of the application of the concept of Shareholder Value Added (SVA) in financial decisions*, Procedia – Social and Behavioral Sciences 40.

Menzis (2013) – Persbericht 6-5-2013 – *Landelijk investeringsfonds voor de zorg nodig* - http://www.menzis.nl/web/Artikel/Persbericht/LandelijkInvesteringsfondsVoorDeZorgNodig.htm

Ministerie van Financiën (2008), *Verrekenprijzen, toepassing van het arm's-Lengthbeginsel en de Transfer Pricing Guidelines for Multinational Enterprises and Tax Administrations (OESO-richtlijnen)* - http://mijnwetten.nl/verrekenprijzen-toepassing-van-het-arms-lengthbeginsel-en-de-transfer-pricing-guidelines-for-multinational-enterprises-and-tax-administrations-oeso-richtlijnen

Ministerie VWS (2011), *Ziektekostenverzekeringen in Nederland.*

Ministerie VWS (2013), *Nota naar aanleiding van verslag – wetswijziging 33168.*

NZa (2010, *Advies: Experiment met winstoogmerk in de ziekenhuiszorg – Private winst voor het publieke belang.*

NZa (2012), *Marktscan medisch specialistische zorg – weergave van de markt 2006-2011.*

NZa (2012), *Monitor Zelfstandige Behandelcentra – Een kwalitatieve en kwantitatieve analyse.*

Pahud de Mortanges, C. & Van Riel, A. (2003), *Brand Equity and Shareholder Value*. European Management Journal Vol.21, No.4.

Pauli, C. (2010), *Ondernemen in de zorg – De 50 meest gestelde vragen*, Ernst & Young - http://www.slideshare.net/charlottepauli/ondernemen-in-de-zorg-50-meest-gestelde-vragen

Plomp, E. (2011), *Winst in de zorg – Juridische aspecten van winstuitkering door zorginstellingen*, Sdu Uitgevers bv.

Plomp, E., Schut, E. & Varkevisser, M. (2013), *Winstuitkering bij ziekenhuiszorg*. ESB 98, edition 4667

Rappaport, A. (1986), *Creating Shareholder Value: The new standard for business performance*. New York Free Press.

Rappaport, A. (1998), *Creating Shareholder Value: A Guide for Managers and Investors*. New York Free Press.

Skipr (2009), *BoZ tegen nieuwe wet maatschappelijke onderneming* - http://www.skipr.nl/actueel/id2622-boz-tegen-nieuwe-wet-maatschappelijke-onderneming-.html

Verberne, L.A.M.W. (2012), *Een onderzoek naar de gevolgen van transfer pricing in de omzetbelasting*. University of Tilburg – Business Faculty.

Wetvoorstel 33168 - Wijziging van de Wet cliëntenrechten zorg en enkele andere wetten om het mogelijk te maken dat aanbieders van medisch-specialistische zorg, mits zij aan een aantal voorwaarden voldoen, winst uitkeren (voorwaarden voor winstuitkering aanbieders medisch-specialistische zorg).

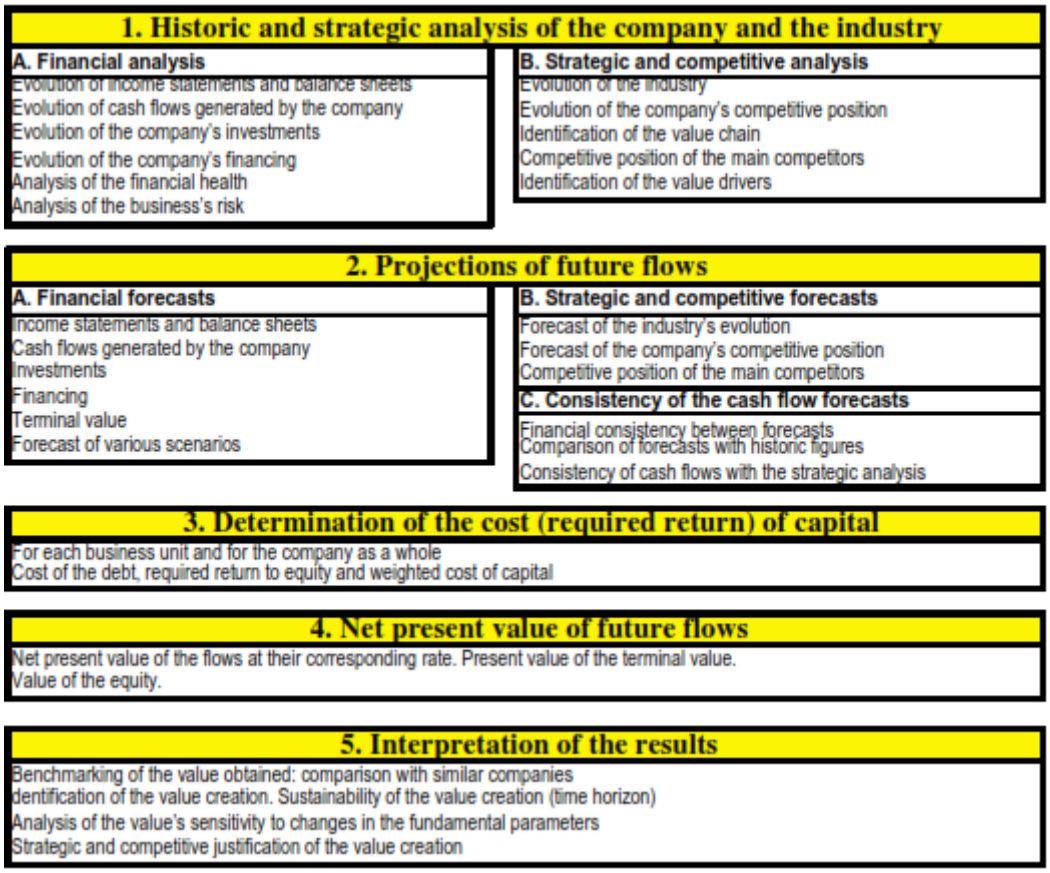
Rijksoverheid – 05-07-2011 – *Bestuurlijk hoofdlijnenakkoord 2012-2015 tussen de Nederlandse Vereniging van Ziekenhuizen, de Nederlandse Federatie van Universitair Medische Centra, Zelfstandige Klinieken Nederland, Zorgverzekeraars Nederland en het Ministerie van Volksgezondheid, Welzijn en Sport* - http://www.rijksoverheid.nl/documenten-en-publicaties/besluiten/2011/07/05/bestuurlijk-hoofdlijnenakkoord-2012-2015.html

Rijksoverheid - Nieuwsbericht 15-02-2013 – *Schippers stelt nadere voorwaarden aan winstuitkering* - http://www.rijksoverheid.nl/nieuws/2013/02/15/schippers-stelt-nadere-voorwaarden-aan-winstuitkering-ziekenhuizen.html

Thompson, W. (2011), *The city as distorted price system*, City Reader, 274.

Winter, L., (2009), Presentatie oktober 2009 | Ministerie van Volksgezondheid, Welzijn en Sport, voor minister Klink. "Ziekenhuizen vanuit een Privaat Perspectief Bezien"

Appendices


1. Historic and strategic analysis of the company and the industry
A. Financial analysis
Evolution of income statements and balance sheets
Evolution of cash flows generated by the company
Evolution of the company's investments
Evolution of the company's financing
Analysis of the financial health
Analysis of the business's risk
B. Strategic and competitive analysis
Evolution of the industry
Evolution of the company's competitive position
Identification of the value chain
Competitive position of the main competitors
Identification of the value drivers
2. Projections of future flows
A. Financial forecasts
Income statements and balance sheets
Cash flows generated by the company
Investments
Financing
Terminal value
Forecast of various scenarios
B. Strategic and competitive forecasts
Forecast of the industry's evolution
Forecast of the company's competitive position
Competitive position of the main competitors
C. Consistency of the cash flow forecasts
Financial consistency between forecasts
Comparison of forecasts with historic figures
Consistency of cash flows with the strategic analysis
3. Determination of the cost (required return) of capital
For each business unit and for the company as a whole
Cost of the debt, required return to equity and weighted cost of capital
4. Net present value of future flows
Net present value of the flows at their corresponding rate. Present value of the terminal value.
Value of the equity.
5. Interpretation of the results
Benchmarking of the value obtained: comparison with similar companies
dentification of the value creation. Sustainability of the value creation (time horizon)
Analysis of the value's sensitivity to changes in the fundamental parameters
Strategic and competitive justification of the value creation