# HEALTH CARE INDUSTRY MARKET UPDATE

Acute Care Hospitals

April 29, 2002

Dear Friends of CMS:

As the regulators of over $500 billion per year of Medicare, Medicaid, and S-CHIP funds, we believe it is incumbent on us to better understand the finances of our contractors, health providers, and other related businesses that provide services to the more than 70 million beneficiaries these programs serve. Health plans, hospitals, nursing homes, home health agencies, DME suppliers, medical device manufacturers, and pharmaceutical companies are just some of those whose finances are heavily reliant on these public programs.

I have always been surprised at how little Wall Street and Washington interact—and how companies often provide different financial information to each. I am a strong believer in adequate funding for our major partners in these programs, but I do not think they should be saying one thing to investors and another to regulators (as it is occasionally in their interest to do). If health plans or providers need help, we should have a thorough understanding of their real financial status to assess the true level of need.

Many investment banking firms conduct detailed analyses of major health providers, both for the equity investors in for-profit companies, and for the debt holders of for-profit and nonprofit entities. Health systems typically provide these investors with clear financial data. These data can be used by regulators and legislators to assess funding adequacy, or the need for regulatory reforms.

CMS' Office of Research, Development & Information (ORDI) has gathered research reports from the major investment firms, summarized their analyses, and condensed them into a short, and hopefully, understandable format. Our goal is to provide objective summary information that can be quickly used by CMS, HHS, Congress, and their staffs that oversee these programs. The primary person at CMS assigned to this task is Lambert van der Walde. Lambert previously worked for Salomon Smith Barney in New York and is experienced with corporate financial analysis and reviewing corporate research. We have also recently added Tatyana Daniels to the team. Tatyana previously worked at Salomon Smith Barney and J.P. Morgan in New York and is also experienced with financial analysis and writing corporate research.

This, our third report, focuses on acute care hospitals. In coming months, we will review the financial and market performance of home health agencies, device manufacturers, pharmaceutical companies, and virtually every other major provider and supplier sector. Though I am proud of this effort, and believe it will add to understanding of the programs, we welcome comments on the content and format of this report. We want to make this as consumer friendly as possible for everyone who reads it. Please provide comments to Lambert van der Walde at lvanderwalde@cms.hhs.gov or Tatyana Daniels at tdaniels@cms.hhs.gov.

Sincerely,

Tom Scully

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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# Wall Street's View of Hospitals

Hospital industry shows signs of recovery and stabilization, but continued cost pressures loom on the horizon.

- **Balanced Budget Act Medicare and Medicaid payment policies and managed care pricing pressures destabilized many hospitals in the late 1990s.**
- **Hospitals are recovering because of remedial legislation in 1999 and 2000 that led to a Medicare-induced recovery.**
- **Investors hope that Medicare payment stability will extend the sector's recovery.**
- **Current hospital profit margins are near the historical average.**
- **While credit ratings are stabilizing, nonprofit hospitals face a difficult and increasingly complex bond market.**
- **Generally, bond investors forecast increased revenue stability for nonprofit hospitals. However, financially strong hospitals are getting stronger and weak hospitals are getting weaker.**
- **The financial performance of for-profit hospital companies is solid. Investors expect strong growth from the sector, and the forecast is the brightest it has been in years.**

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# EXECUTIVE SUMMARY

## State of the Industry

**The Hospital Industry Experienced Turmoil in the Late 1990s**
The late 1990s challenged the hospital industry on three major fronts; the Balanced Budget Act (BBA) of 1997 significantly reduced Medicare payment increases, hospitals accepted low payment from managed care organizations (MCOs), and several major defaults and bankruptcies shook the investment community. These challenges caused performance problems (as profit margins contracted) and also limited access to capital (as investors left the sector).

**Balanced Budget Act of 1997 Slowed the Growth of Medicare Hospital Payments**
In 1997, the Congress enacted the Balanced Budget Act, which slowed the growth in Medicare payments to virtually all fee-for-service providers and managed care plans. The deceleration in Medicare hospital spending was accomplished by the BBA's slowing of the rate of fee-for-service inpatient payment growth for hospitals paid under the inpatient prospective payment system (PPS). This produced an actual payment decline of 1.2% in 1998 and an increase of 0.4% in 1999. As a result, hospital profit margins also declined because Medicare represents a significant portion of most hospitals' revenue. Following these declines in payment increases, the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000 were passed, moderating the impact of the BBA by providing more modest reductions in Medicare payment increases to the industry.

**BBRA & BIPA are moderating the impact of the BBA by providing more modest reductions in Medicare payment increases to the industry.**

**Low Managed Care Premiums Restricted Hospital Margins**
In the mid-to-late 1990s, many hospitals accepted low payments from MCOs, giving MCO's leverage to push down payment levels across the sector. As contracts have come up for renegotiation, and as the hospitals regained market power, hospitals have been able to secure significant rate increases. Concurrently, Wall Street analysts believe that the commercial pricing cycle for managed care has regained its strength—which is to say that price competition has been reduced, giving the MCOs the resources to increase hospital payment. (For a more thorough discussion on managed care, see the CMS Market Update, November 28, 2001.)

**Hospitals are succeeding in negotiating more favorable payment rates.**

**Investors Lost Confidence Due to Solvency Concerns**
Many debt investors lost confidence in the hospital sector after the July 1998 bankruptcy of the Allegheny Health Education and Research Foundation (AHERF), the largest default ever by a nonprofit health care organization. After AHERF defaulted on $1.3 billion in debt, several other bankruptcies followed.

In addition to these three challenges, some hospitals found themselves struggling with poorly performing non-core business acquisitions, such as physician practices and HMOs. Some hospitals responded by divesting these businesses.

**Some hospitals responded by divesting non-core businesses.**

## Wall Street's Outlook

In the January 2002 Moody's Investors Service Industry Outlook, Bruce Gordon reviewed his perspective on the not-for-profit health care industry. Based on the financial improvement for most of the hospital providers in its rated portfolio over the past 6 to 12 months, Gordon states in his summary opinion that:

**Moody's expects that hospitals will be able to maintain revenue growth at a rate equal to or in excess of expense growth.**

> "We believe the not-for-profit health care industry will continue to reflect stability over the next one to two years, though with a considerable level of uncertainty given a number of risk factors. We attribute this stability to our expectation that hospital providers will be able to sustain revenue growth at a rate equal to or in excess of expense growth."

This outlook was reiterated by Moody's in April 2002 when it stated, "…we remain cautiously optimistic that 2002 will represent a year of relative credit stability."

Investors are generally encouraged by the industry's recovery under the moderated BBA policies, though the possible extension of a BBA market basket policy that is substantially below the full update seems to be a concern. Deborah Lawson, a Salomon Smith Barney hospital research analyst, calmed concerned investors in a recent publication. The investors were alarmed about discussion of a potential Medicare payment rate increase less than inflation, or the full "market basket" update. She explained that since the implementation of the inpatient PPS in 1984, Medicare payment rate increases have, in fact, almost always been below the full market basket update. She says, "In fact, this year, fiscal 2002, hospital Medicare payment rates have been updated by 'market basket minus 0.55%.' This, in our opinion, is 'status quo' on hospital payments." She continues, "Of course, updates that are significantly below market basket, as was seen in the late 1990s would be harmful. We believe that the likelihood of updates slightly below market basket is high. And, again, we never expected that hospitals would receive full market basket in the out years."

**Medicare payment increases have almost always been below the full market basket update.**

Still, the struggle for many nonprofit hospitals is not over. According to Lori Price of J.P. Morgan, "Following the BBA cutbacks in 1997, nonprofit hospitals chose to hold onto cash instead of reinvesting capital back into their core facilities." She says that this underinvestment hurt the market-share of many nonprofits. Patients and physicians went to local competitors or to other markets for care, seeking the newer and more technologically advanced facilities of the for-profit chains. "This loss in market-share caused operating margins to compress, hurting the nonprofit hospitals' ability to raise capital which was sorely needed to invest in facility and technology upgrades. Thus, a vicious cycle began—without a strong market position, there is no capital available to increase market share."

**Many nonprofit hospitals find themselves caught in a "vicious cycle" of underinvestment and dwindling market share.**

# ACUTE CARE HOSPITAL INDUSTRY OVERVIEW

**Most hospitals are nonprofit.**

There are 4,915 acute care community hospitals in the United States (as of 2000).[1] Of these, approximately 85% of them are nonprofit. (Figure 1)

**Figure 1: Community Hospitals**

| (2000) | Number of Facilities | Percent of Facilities | Number of Beds | Percent of Beds |
|---|---|---|---|---|
| Nongovernment Non-Profit Community Hospitals | 3,003 | 61 % | 582,988 | 71 % |
| State & Local Government Community Hospitals | 1,163 | 24 % | 130,689 | 16 % |
| Total Non-Profit Community Hospitals | 4,166 | 85 % | 713,677 | 87 % |
| For-Profit Community Hospitals | 749 | 15 % | 109,883 | 13 % |
| Total Community Hospitals | 4,915 | 100 % | 823,560 | 100 % |

Source: American Hospital Association

## Revenue Sources

Hospitals generate their revenue from multiple (and variable) product lines. While a substantial portion comes from inpatient care and outpatient services, other income streams come from product lines including: skilled nursing, home health services, medical equipment sales, hospice, rural health clinics, physician office rental, gift shops, and parking garages. These revenues come from both public and private payors. Private funds come from commercial insurers, private donors, and patients. Public funds come from Medicare, Medicaid, and a number of other government programs. The United States total hospital expenditures for 2000 are listed in Figure 2 below.

**Figure 2: Hospital Care Payor Segmentation**

| (Dollars in Billions, Calendar Year 2000) | Funds Expended | Percent of Total |
|---|---|---|
| Private Health Insurance | $ 133.9 | 32.5 % |
| Out-of-Pocket & Other Private | 35.0 | 8.5 % |
| Total Private Funds | $ 168.9 | 41.0 % |
| Medicare (Federal) | $ 125.7 | 30.5 % |
| Medicaid (Federal and State) | 70.1 | 17.0 % |
| Other Public | 47.4 | 11.5 % |
| Total Public Funds | $ 243.2 | 59.0 % |
| **Total Public & Private Funds** | **$ 412.1** | **100.0 %** |

Source: CMS, Office of the Actuary, National Health Statistics Group

### Commercial Insurance

**Commercial insurance pays for nearly one-third of the nation's hospital expenditures.**

The commercial insurance industry pays for nearly one-third of the nation's hospital expenditures. According to managed care analyst Charles Boorady of Goldman Sachs, health insurance premiums are expected to rise 13% in 2002. Moody's concurs with this estimate and expects that this will result in better-positioned hospitals being able to extract healthy rate increases in 2002. The softening labor market may cause this trend to slow as employers seek to shift some health insurance costs to employees by raising deductibles and co-payment amounts. In the short term, Boorady does not expect this to affect hospitals. In the long run, however, he believes there may be some incremental negative impact if added employee burden leads to more bad debt. Analysts also point to

[1] Community hospitals are nonfederal short-term general and special hospitals whose facilities and services are available to the public.

evidence that as health care costs have escalated, managed care organizations are beginning to use price incentives to direct patients to more economical providers.

## Medicare

**Medicare is the largest single payor of hospital services in the U.S.**

Medicare is the largest single payor of hospital services, paying for 30.5% of national expenditures in 2000. (Figure 2**,** above) Revenue from Medicare varies from hospital to hospital and in some cases is substantially higher than the average. Most Medicare funds for hospitals are now paid under several PPSs, which pay the provider on a per-case basis. (Further explanation of these systems can be found in the Appendix.) In the case of the inpatient PPS, these rates are updated by statutory cost factors based on a "market basket" of hospital costs that reflects hospital input price inflation. The "market basket percentage increase," or "market basket update," is the inflation factor applied each year to these prospective rates.

The Congress has typically set the payment update at a discount to the full market basket update. In fact, since the transition to full inpatient PPS in 1988, there has been only one year when the payment update was equal to the full market basket update. In Figure 3 below, the annual inpatient PPS updates are shown since 1988. The data points which show the trend in hospital funding are shown in the last column (Payment Update as a Percent of Market Basket Update). These show the relative increase in the level of Medicare reimbursement compared to inflation.

### Figure 3: Historical Inpatient PPS Payment Updates

| Fiscal Year | Annual Inpatient PPS Payment Update: Large Urban | Other Urban | Rural | Market Basket Update | Payment Update (Discount) / Premium to Market Basket Update | Payment Update as a Percent Market Basket Update |
|---|---|---|---|---|---|---|
| 1988 (1) | 1.50 % | 1.00 % | 3.00 % | 4.7 % | (1.70)% - (3.70)% | **21 % - 64 %** |
| 1989 | 3.40 % | 2.90 % | 3.90 % | 5.4 % | (1.50)% - (2.50)% | **54 % - 72 %** |
| 1990 (2) | 5.62 % | 4.97 % | 9.72 % | 5.5 % | 4.22 % - (0.53)% | **90 % - 177 %** |
| 1991 (3) | 3.20 % | 3.20 % | 4.50 % | 5.2 % | (0.70)% - (2.00)% | **62 % - 87 %** |
| 1992 | 2.80 % | 2.80 % | 3.80 % | 4.4 % | (0.60)% - (1.60)% | **64 % - 86 %** |
| 1993 | 2.55 % | 2.55 % | 3.55 % | 4.1 % | (0.55)% - (1.55)% | **62 % - 87 %** |
| 1994 | 1.80 % | 1.80 % | 3.30 % | 4.3 % | (1.00)% - (2.50)% | **42 % - 77 %** |
| 1995 | 1.10 % | 1.10 % | 8.40 % | 3.6 % | 4.80 % - (2.50)% | **30.6 %** |
| 1996 | 1.50 % | 1.50 % | 1.50 % | 3.5 % | (2.00)% | **42.9 %** |
| 1997 | 2.00 % | 2.00 % | 2.00 % | 2.5 % | (0.50)% | **80.0 %** |
| 1998 | 0.00 % | 0.00 % | 0.00 % | 2.7 % | (2.70)% | **0.0 %** |
| 1999 | 0.50 % | 0.50 % | 0.50 % | 2.4 % | (1.90)% | **20.8 %** |
| 2000 | 1.10 % | 1.10 % | 1.10 % | 2.9 % | (1.80)% | **37.9 %** |
| 2001 | 3.40 % | 3.40 % | 3.40 % | 3.4 % | 0.00 % | **100.0 %** |
| 2002 | 2.75 % | 2.75 % | 2.75 % | 3.3 % | (0.55)% | **83.3 %** |
| **Median (4)** | | | | | **(1.9)%** | **61.5 %** |
| **Mean (4)** | | | | | **(1.6)%** | **54.8 %** |

Source: CMS, Center for Medicare Management & Office of the Actuary

(1) Inpatient PPS was implemented in 1984, but was not fully-phased in until 1988. 1988 updates were in effect from April 1, 1988 to September 30, 1988. Prior to that, the updates were zero from October 1, 1987 to November 21, 1987, and 2.7 % from November 21, 1987 to March 31, 1988.

(2) 1990 updates were in effect from January 1, 1990 to September 30, 1990. Prior to that, the update was 5.5 % from October 1, 1989 to December 31, 1989.

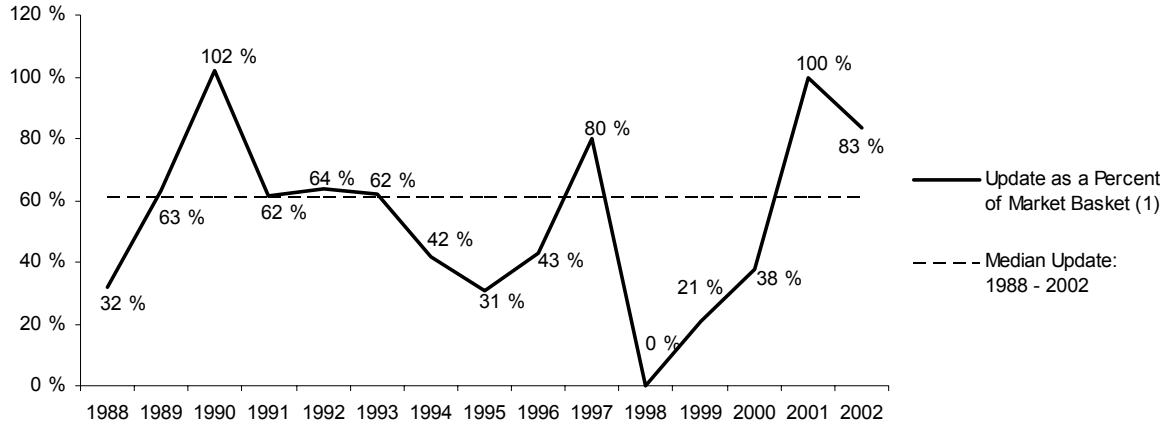
(3) 1991 updates were in effect from January 1, 1991 to September 30, 1991. Prior to that, the updates were 5.2 % from October 1, 1990 to October 21, 1990, and zero from October 21, 1990 to December 31, 1990.

(4) Median and mean for 1988 - 1995 Update as a Percent of Market Basket use the large urban payment update.

**Each time new PPS systems are introduced, the capital markets have become very nervous about the resulting financial performance of providers.**

The inpatient PPS phase-in began in 1984. Since then, the skilled nursing facility (1998), home health (2000), outpatient hospital (2000), and rehabilitation hospital (2002) PPS systems have also been implemented. Each time new PPS systems are introduced, the capital markets have become very nervous about the resulting financial performance of providers. Moody's, however, points out that, "Contrary to early opinions, the adoption of a case rate reimbursement system for outpatient procedures (APCs) in August 2000 has not had a material negative impact on most Moody's-rated providers. In fact, some believe they have profited from this change by becoming more efficient." It is not surprising that large policy changes affect the hospital industry. The graph below (Figure 4) demonstrates that in the case of the inpatient PPS, the update as a percent of the Market Basket, has vacillated dramatically above and below the median.

**Figure 4: Historical Update as a Percent of Market Basket**




Source: CMS, Center for Medicare Management
(1) The median for 1988 - 1995 Update as a Percent of Market Basket uses the large urban payment update.

## Medicaid

**Medicaid represents approximately 17.0% of national hospital spending.**

Medicaid represents approximately 17.0% of national hospital spending. Because Medicaid is administered by state governments and is only partially funded by the federal government (the federal contribution is 58.4% of total Medicaid funds), it is difficult for investors to forecast Medicaid trends on a nationwide basis. Investors are especially concerned about Medicaid rates in the wake of shrinking state budgets. According to Moody's, "In order to balance their budgets, many states are likely to reduce their Medicaid expenditures, which account for nearly 20% of most state budgets and represent the second largest expenditure after education."

## Rising Costs

**Health care costs are expected to rise 12.4% in 2002.**

Like other health care industry sectors, the hospital sector is experiencing dramatically rising costs. Goldman Sachs estimates that United States health care costs will rise 12.4% in 2002. Of this increase, half of the dollars are attributable to hospital expenditures and slightly over a quarter to prescription drugs.

### Prescription Drug Costs

CMS estimates that prescription drugs comprise approximately 5-6% of hospital costs. This cost component, according to Goldman Sachs, is expected to grow 20% in 2002.

### Labor Costs

A much larger portion of hospital costs than prescription drugs is hospital labor. One Wall Street analyst estimates that about 40% of a hospital's costs are labor and that nursing costs comprise about half of labor costs. This nursing cost is of particular concern to investors because of the nursing shortage. According to Deborah Lawson of Salomon Smith Barney, the existing nationwide shortage of registered nurses is being exacerbated by several factors: fewer nurses are in training programs and those who are, are more likely to be in non-baccalaureate degree programs (meaning they are less skilled), the existing nursing population is aging (the average age in 2000 was 45), and vacancy and turnover rates are also on the rise.

**The nationwide nursing shortage concerns investors.**

### Liability Insurance

Liability insurance also is a large concern for investors. Premiums are expected to continue to rise nationwide as St. Paul, the nation's second largest medical malpractice insurance carrier, has announced that it will be leaving the sector. This leaves fewer carriers and will likely further drive up costs to hospitals.

**Premiums are expected to continue to rise nationwide.**

## INDUSTRY PERFORMANCE

One measure of hospital industry performance is financial and can be understood by examining a hospital's ability to generate sufficient revenues to cover expenses. To the extent a hospital earns more revenue than it needs to cover expenses, it generates a profit. Profit expressed as a percent of revenue is called profit margin. Profit margin is important because it is used to compare companies to one another.

### Operating and Net Income Margins

The definitions of profit margins may vary depending upon source. This report primarily focuses on two basic margin calculations that investors rely upon: operating income margin and net income margin for consolidated operations. This report does not attempt to address Medicare or Medicaid-only margins.

**Operating Income Margin (Operating Profit Margin or EBITDA)**
The operating income margin (also called operating cashflow margin) is calculated by dividing the operating income by net revenues and is expressed as a percent of revenue. Operating income is the amount of revenue that remains after all operating expenses have been paid. Operating revenues and expenses are those directly associated with the operations of the business, and not related to other activities such as the investment income that comes from endowments. Operating income gives an investor a good understanding of how much cash flow business activities are generating.

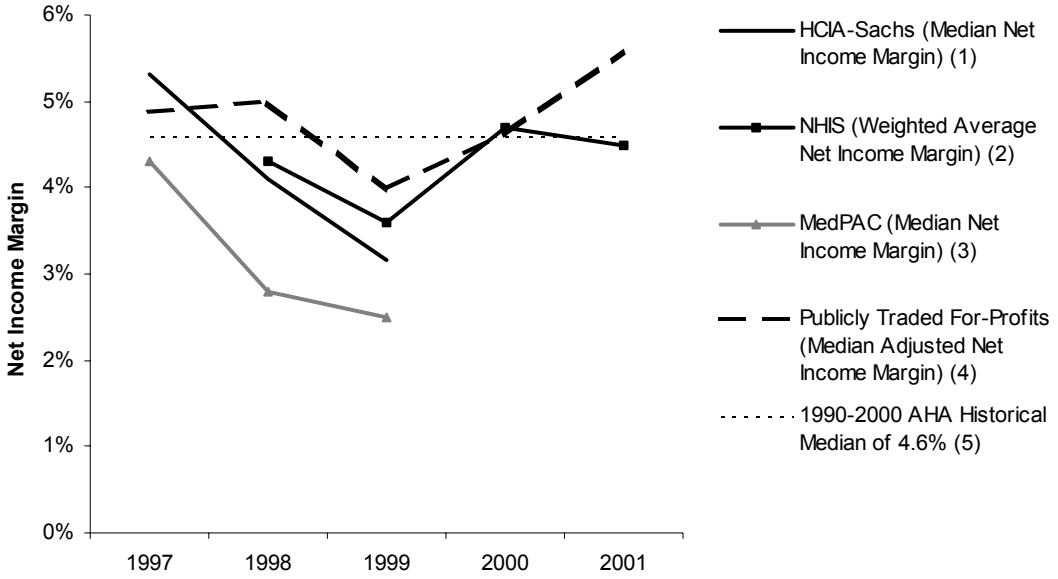
For the purposes of this report, hospital operating income includes the revenues and expenses associated with a hospital's non-patient care lines of business such as gift shops, cafeterias, and parking lots. This is to preserve the investor's point of view and the risk associated with the *entire* business. On the income statement and for the purposes of this report, operating income is also called EBITDA, or earnings before interest, taxes (if for-profit), depreciation, and amortization. In this analysis, one-time or unusual gains or losses were adjusted out of the calculation whenever possible. EBITDA is especially important to lenders as it tells investors how much cash the business is generating from operations and is available to pay financing costs (interest).

**Net Income Margin (Net Profit Margin)**
The net income margin (sometimes called the excess margin) is calculated by dividing the net income by net revenues and is expressed as a percent of revenue. Net income is the amount of revenue that remains after all operating expenses and non-operating expenses (such as interest, taxes, depreciation, and amortization) have been accounted for. This is the total profit or "bottom line." It is the amount that the business can reinvest in itself, and in the case of a for-profit company, may distribute to shareholders. Net income includes all revenue from investment income and any donations generated by a nonprofit. In this analysis one-time or unusual gains or losses were adjusted out of the calculation whenever possible.

Several studies of hospital net income margins are shown in the graph below (Figure 5). While methodology and sample selection differences create some variation, one can observe that most results fall in the 3-5% range. Despite these differences, the data are a good indicator on a directional basis. One will note that for the last two years, public for-profit companies appear to be increasing their profitability. Further, and not surprisingly, the publicly traded for-profit hospitals have outperformed the hospital group as a whole. This graph illustrates that hospitals are performing near the historical average.

**Figure 5: Hospital Industry Net Income Margins**

**Net income margins are trending above the historical median.**




Sources:
(1) HCIA-Sachs and Deloitte & Touche, for-profits and nonprofits, based on CMS cost reports through 1999
(2) National Hospital Indicator Survey, commissioned by CMS and MedPAC and conducted by the American Hospital Association and the Lewin Group, current methodology began in 1998. NHIS surveys nearly 1,900 community (for-profit and nonprofit) hospitals throughout the US
(3) MedPAC analysis of CMS cost reports through 1999
(4) SEC filings, Bloomberg, Wall Street Research. Adjusted net income margin reflects a company's net income adjusted for any extraordinary items (such as gains on sales of facilities, asset impairment charges, settlements with the Government, restructuring and investigation charges and charges from the extinguishment of debt)
(5) Lewin Group analysis of AHA annual survey, 1990-2000

In addition, it is important to note a recent memorandum that the Medicare Payment Advisory Commission (MedPAC)[2] issued on March 25, 2002, indicating:

> "In the 4th quarter of 2001, the NHIS total [net income] margin was 4.7%, slightly above the full fiscal year total [net income] margin of 4.5%—and significantly higher than we would have predicted, given the normal pattern of quarterly values and the potential for a financial impact from September 11th….We note that revenue per adjusted admission grew at a greater rate than expenses, despite no appreciable change in hospital discharges, days, outpatient visits or non-operating revenue. This would suggest that payments from private payers continue to increase….Either improvements in financial performance prior to September 11th were sufficient to offset problems that followed, or the financial impact on hospitals post-September 11th was less than generally expected."

[2] MedPAC is an independent federal body that advises the U.S. Congress on issues affecting the Medicare program.

## Nonprofit Margins

Investors divide bond issuers into two general risk-based categories: "investment grade" (relatively conservative) and speculative grade (relatively risky).[3] Rating agencies further subdivide issuers into twenty or so sub-categories. (Further discussion of credit ratings can be found on page 14.) In its September 2001 report, Moody's Investor Services reported median 2000 performance for a sample of hospitals.[4] The investment grade median net income margin[5] varied from 2.2% for the low-end (Baa) rated issuers to 7.2% for high-end (Aa) rated issuers. The investment grade operating cash flow margin median varied from 8.5% for Baa-rated issuers to 11.6% for Aa-rated issuers. On the other hand, hospitals considered to be speculative grade had median net income margin of a negative 2.2% and median operating income margin of 4.9%. (Figure 6)

**Figure 6: Nonprofit Hospital Margins**

| | Investment Grade | | | | Speculative Grade |
|---|---|---|---|---|---|
| Moody's 2000 Median Margins | All Ratings | Aa | A | Baa | Below Baa |
| Operating Cash Flow Margin (EBITDA) | 9.3 % | 11.6 % | 9.7 % | 8.5 % | 4.9 % |
| Net Income (Excess) Margin | 3.4 % | 7.2 % | 3.7 % | 2.2 % | (2.2)% |

Source: Moody's Investors Services
Note: Excludes multi-state hospital systems

### Urban vs. Rural performance

**Medicare payment differs for urban and rural hospitals.**
Medicare generally pays urban hospitals more than it does rural hospitals. This is due to a statutory formula, which results in "large" urban hospitals getting higher standardized base payments (reflecting higher input costs) as well as more disproportionate share (DSH) funds for both large and non-large urban hospitals. Urban hospitals are also more likely to have resident physician training programs, giving them access to graduate medical education (GME) funds. (For more discussion of these payment systems, see the Appendix.) This payment methodology provides fewer funds to rural facilities that often have lower volume than the urban hospitals. According to MedPAC, in spite of this lower Medicare payment rate, rural hospitals (as well as the "non-large" urban hospitals) had significantly higher net income margins than those in large urban areas. (See chart below.)

| Net Income Margin | 1999 |
|---|---|
| All Hospitals | 3.6 % |
| Urban (Large) Hospitals | 2.7 % |
| Urban (Non-Large) Hospitals | 4.6 % |
| Rural Hospitals | 4.8 % |
| For-Profit Urban (All) Hospitals | 8.9 % |
| For-Profit Rural Hospitals | 9.0 % |

Source: MedPAC

[3] Speculative grade bonds are also called "high-yield" or "junk" bonds.
[4] Moody's sampled 347 hospitals, each with at least five years of audited financial statements. Moody's excludes health maintenance organizations, physicians groups, human service providers, and specialty hospitals from its analysis.
[5] Moody's uses slightly different terminology than this report. Net income margin is what Moody's calls an "excess margin" which is (total operating revenue – total operating expenses + nonoperating income) / (total operating revenue + nonoperating revenue). Nonoperating revenues are principally the income streams generated from endowments and charitable donations.

## Access to Capital

**Access to capital is a key indication of how an industry is performing.** Without access to external sources of funds, a business is limited to only the net income it generates to fund its operations, maintain and expand its facilities, and invest in new tools and technology. The ability to access capital is critical for a hospital's future ability to serve its patients, build its market-share, and remain financially viable.

**The ability to access capital is critical for a hospital.**

Both for-profit and nonprofit hospitals have the ability to raise capital. Unlike for-profit entities, nonprofits do not have access to the stock (equity) markets and are not allowed to distribute their earnings (profits) as dividends to shareholders. Nonprofits are able to raise money through charitable donations and build endowments to fund operations and capital expenses and, like the for-profit sector, nonprofits may borrow money by taking loans from commercial lending institutions or by issuing debt securities to investors through the bond market. Nonprofit companies typically issue bonds in the public bond market. These bonds are often called municipal bonds because they are of the same type typically offered by municipalities to fund projects such as the construction of schools and roads. (Government-owned hospitals also have access to bonds backed by tax revenues: "general obligation" bonds.) Municipal bonds are also often "tax-exempt" bonds because the investor does not pay tax on the interest earned on the bonds. This is advantageous to the hospital because it can issue debt at a lower interest rate. The reduced tax burden on the bondholder subsidizes the lower interest rate.

## Public Financing

Standard & Poor's rating agency believes that revenues for the hospital sector remain robust. S&P believes that, despite this, expense pressures will continue, and that these pressures may be the main concern for investors in the future.

**Standard & Poor's rating agency believes that revenues for the hospital sector remain robust.**

In a January 2002 publication, Moody's Investors Service reviewed its perspective of the nonprofit health care industry. Moody's states in its summary, "We believe the not-for-profit health care industry will continue to reflect stability over the next one to two years, though with a considerable level of uncertainty given a number of risk factors."

**Factors Supporting a Stable Industry Outlook**

Moody's lists the following factors to support its stable industry outlook:

1. Patient volume will continue to grow based on population growth, new clinical services, and technology.
2. Commercial premium rate increases will translate to higher hospital reimbursement. (Moody's estimates a 13% average managed care premium increase.)
3. Medicare is expected to reimburse hospitals at rates close to medical inflation.
4. The national recession is expected to end by the second half of 2002, limiting the negative impact of higher unemployment and subsequent uninsured patients.
5. Recent financial performance has shown that managers have learned how to maintain profitability by successfully eliminating unprofitable strategies and services.

**Risk Factors**

Moody's, however, suggests that there are also a number of risk factors to be aware of that could affect the sector beyond a one to two year time frame:

1. A prolonged economic recession could create federal budget deficits and result in lower Medicare reimbursement. (According to CMS, Medicare is approximately 30.5% of national hospital revenue.)
2. The current economic recession has caused a dramatic slowing in state revenues, which could lead to reductions in Medicaid reimbursement. (According to CMS, Medicaid is approximately 17.0% of total hospital revenue.)
3. An increase in debt issuance will result in higher leverage, leading to some rating downgrades. (See page 14 for a discussion of credit ratings.)
4. In addition to ongoing cost increases from staffing and pharmaceuticals, certain other expense items have shown recent acceleration, including malpractice insurance, utility costs, pension expenses, and bad debt provisions.
5. Future bio-terrorist activity could saddle hospitals with additional capital costs without a sufficient external funding source.
6. Physicians continue to pursue entrepreneurial activities, many at the expense of hospital financial performance.

The overall stable outlook contrasts with Moody's outlook in August of 2000:

> "Moody's believes that U.S. not-for-profit hospitals will continue to face a deteriorating credit environment over the next one to two years, reflecting continued pressures from both commercial and governmental payers; declining liquidity and higher leverage brought on by funding capital needs; and continued difficulties implementing and managing integration or dis-integration plans."

Several of these risk factors have since been mitigated (many avoided higher leverage by delaying or slowing capital expansion) or reversed (as in the case of commercial payers that are now paying more).

## Credit Ratings

Credit rating agencies such as Moody's, Standard & Poor's, and FitchRatings issue bond ratings. Bond ratings are tools that bond investors use in evaluating the risk in investing in these debt securities. The higher the risk, the greater the interest rate investors will demand. Bond ratings take into account both the localized business risks of the hospital issuer and the larger, industry-wide outlook for hospitals and health care providers. Credit ratings agencies categorize issuers of debt and their bonds into any one of approximately twenty categories based on the rating agencies' analyses of the ability of an issuer of debt to repay its obligation in a full and timely manner. (Figure 7)

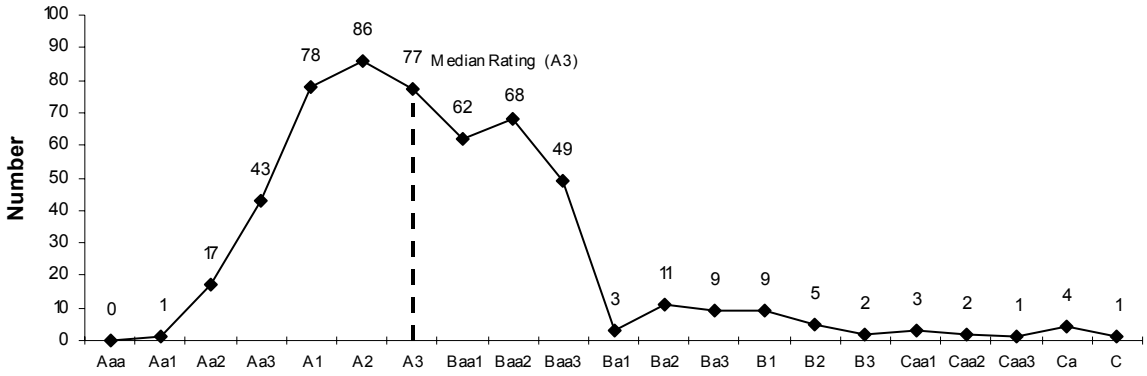
**Figure 7: Credit Rating Comparison**

| Investment Grade | | Speculative Grade ("Junk") | |
|---|---|---|---|
| **Standard & Poor's/ Fitch** | **Moody's** | **Standard & Poor's/ Fitch** | **Moody's** |
| AAA | Aaa | BB+ | Ba1 |
| AA+ | Aa1 | BB | Ba2 |
| AA | Aa2 | BB- | Ba3 |
| AA- | Aa3 | B+ | B1 |
| A+ | A1 | B | B2 |
| A | A2 | B- | B3 |
| A- | A3 | CCC+ | Caa1 |
| BBB+ | Baa1 | CCC | Caa2 |
| BBB | Baa2 | CCC- | Caa3 |
| BBB- | Baa3 | CC | Ca |
| | | C | C |
| | | D | |

Source: Rating Agencies

As of December 31, 2001, Moody's Investors Service rated 531 nonprofit health care issuers. Of these, 481, or 90.6%, were considered investment grade (relatively conservative). Moody's rates a company issuing bonds (an "issuer") investment grade if it believes the issuer is performing adequately enough to pay principal and interest to bondholders. As seen in Figure 8 below, Moody's distribution straddles a median A3 rating.

**Figure 8: Credit Rating Distribution**

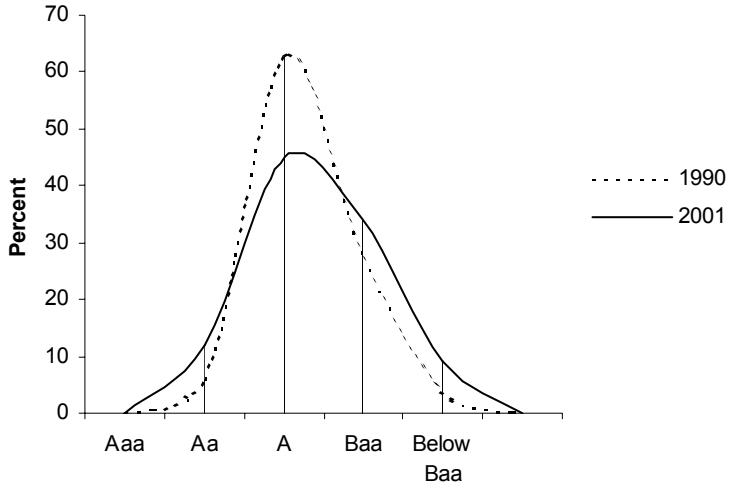



Source: Moody's Investors Services

**The stronger nonprofits are growing stronger and that the weaker issuers are growing weaker.**

While the graph above shows that nearly 80% of the ratings are single A or triple B, there is grave concern among issuers and bond investors alike about the potential for credit rating downgrades of issuers. As seen below in Figure 9, the last ten years have seen a flattening of Moody's rating distribution bell curve for tax-exempt health care bonds. Fewer bonds are rated at the median A3 level and more are distributed to the upper and lower regions. **This trend away from the median could indicate that the stronger nonprofits are growing stronger and that the weaker issuers are growing weaker—reflecting a dichotomy within the industry between hospitals that have the strength to issue and service debt and those who do not.** This split is part of a "vicious cycle" of underinvestment in core facilities and technologies that has eroded the market share of many nonprofits and left them unable to maintain investor confidence.

**Figure 9: Distribution Flattens and Shifts Toward Higher and Lower Ratings Over the Last Decade**



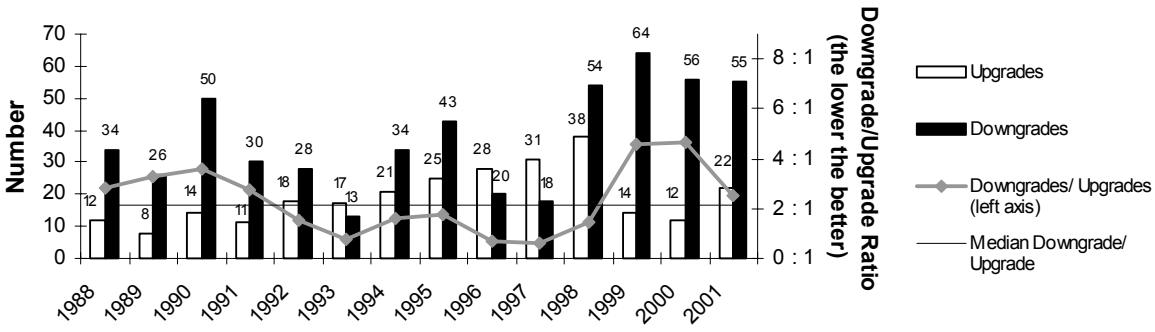

Source: Moody's Investors Services

Issuers are not required to obtain ratings in order to issue bonds. In order to better market a new bond transaction, however, a company with a strong financial and operating position will typically seek a rating from one or more of the credit rating agencies to validate its relative risk of default for its new bond issue. The issuer pays the rating agency a fee for this service. After the initial rating is established and the bond is issued, the agency will monitor the issuer's financial and operating position and is responsible for changing the rating due to an event or combination of events that have either weakened or strengthened the issuer's debt repayment ability. These rating changes are called downgrades or upgrades. (Issuers may also enhance a bond offering by purchasing bond insurance, which is described on page 21.)

**The ratios of credit rating upgrades to downgrades within an industry are often used to evaluate an industry—especially by the credit rating agencies that give them.** During 2001, Moody's downgraded 55 ratings and upgraded 22, a ratio of 2.5:1. This is an improvement compared to 2000, the worst year in over a decade, when 56 ratings were downgraded and 12 were upgraded, resulting in a ratio of 4.7:1. In the fourth quarter of 2001, downgrades and upgrades were equal at seven each, this was the first time in 15 quarters that upgrades were at least equal to downgrades. (Figure 10) Standard & Poor's is also seeing an increasingly favorable trend in its ratings distribution.

**Figure 10: Number of Rating Downgrades vs. Upgrades 1988 - 2001**

**Downgrade/upgrade ratios are still an investor concern, but are showing signs of returning to historical norms.**



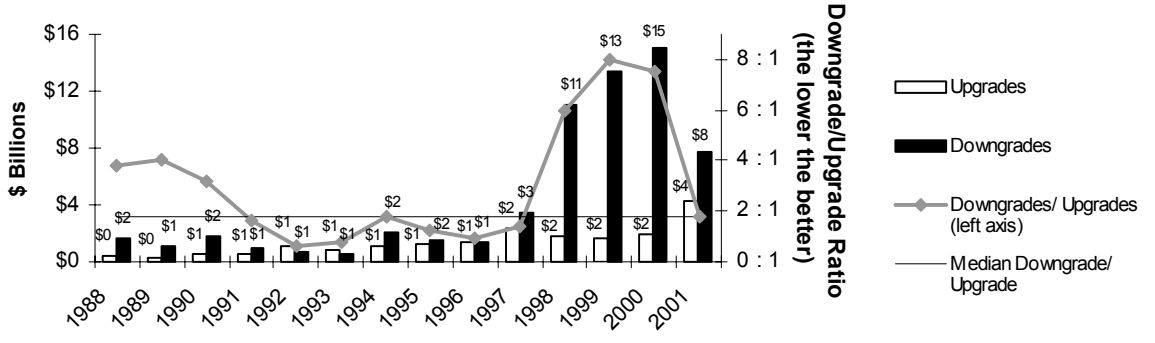

Source: Moody's Investors Services

**In the ten years before BBA, Moody's downgraded a combined total of $15.0 billion in nonprofit hospital debt…in the four years following BBA, Moody's downgraded $47.2 billion in debt.**

The ratio improvement from 2000 to 2001 looks better when looking at debt figures on a total value basis. Moody's believes that the improvement in the downgrade/upgrade ratio is supported by an improvement in financial performance of the sector. For 2001, Moody's downgraded debt totaling $7.6 billion and upgraded debt totaling $4.3 billion, resulting in a ratio of 1.8:1. This is a significant improvement over 2000 when downgrades totaled twice as much at $15.0 billion and upgrades totaled $2.0 billion, a ratio of 7.5:1. To put a more historical perspective on this, for the ten years leading up to the BBA, a total of $15.0 billion in debt was downgraded by Moody's. In the *four* years following the BBA, Moody's downgraded $47.2 billion in debt. (Figure 11)

**Figure 11: Total Value of Rating Downgrades vs. Upgrades 1988 - 2001**

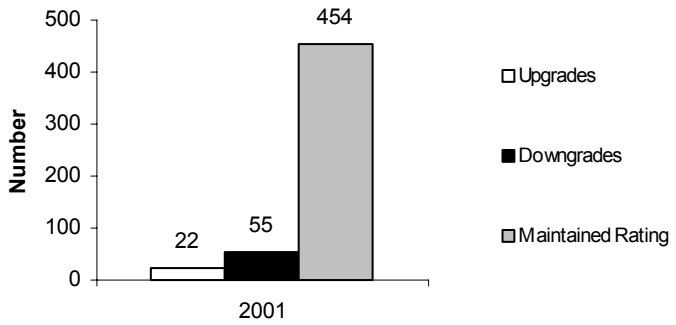
**Total value of downgraded debt was cut in half and upgraded debt doubled in 2001—the downgrade/upgrade ratio returned to the historical median.**




Source: Moody's Investors Services

The ratio of downgrades to upgrades remains a large concern to the industry and investors alike. It is a ratio of those companies that have become more able to repay their debt obligations versus those that have become less able to repay their debt obligations. This ratio is only one measure of an industry's performance. The ratio, however, does not acknowledge the borrowers (85.5% in 2001, see Figure 12) that maintained their level of ability to meet their debt obligation and thus their bond rating.

**Figure 12: Ratings not Affected by Ratings Changes**




Source: Moody's Investors Services

## Trends in Debt Issuance

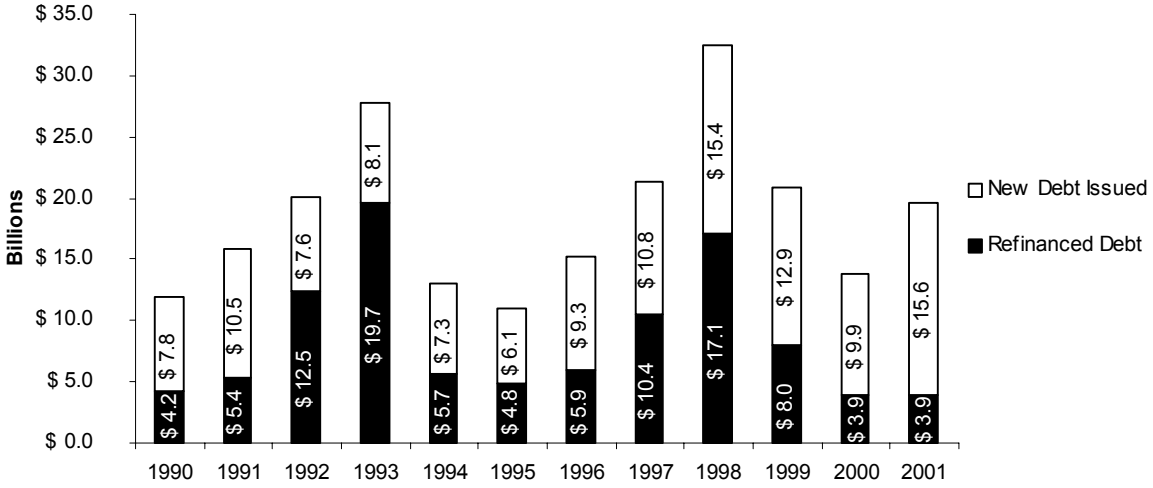
It is important to understand that upgrade and downgrade ratios are not necessarily an indication of an industry's access to capital. Rather, they are an indication of a change in the cost of any new debt financing to industry participants that happened to have a ratings change. In other words, a company that has experienced a downgrade will have to pay a higher interest rate on any newly issued bond than it would have had to pay if its credit rating stayed the same. [6] This increased interest rate translates into a higher "cost of capital."

**The amount of new debt issued is an indication of how confident the market is in the sector's financial condition.**

One measure of an industry's access to capital is the volume of new debt it issues in a given period. New debt issuance contrasts with the refinancing of old bonds, much in the same way homeowners refinance existing mortgages when interest rates decline. According to Gary Taylor of Banc of America Securities, the amount of new debt issued is an indication of how confident the market is in the sector's financial condition and its ability to take on new debt versus simply continuing to service existing obligations. The following graph (Figure 13) shows the total amount of debt financing issued by nonprofit hospitals since 1988 and the portion of it that is new.

**Figure 13: New Debt & Refinanced Debt Issued**

**New debt issued increased 57.6% in 2001.**



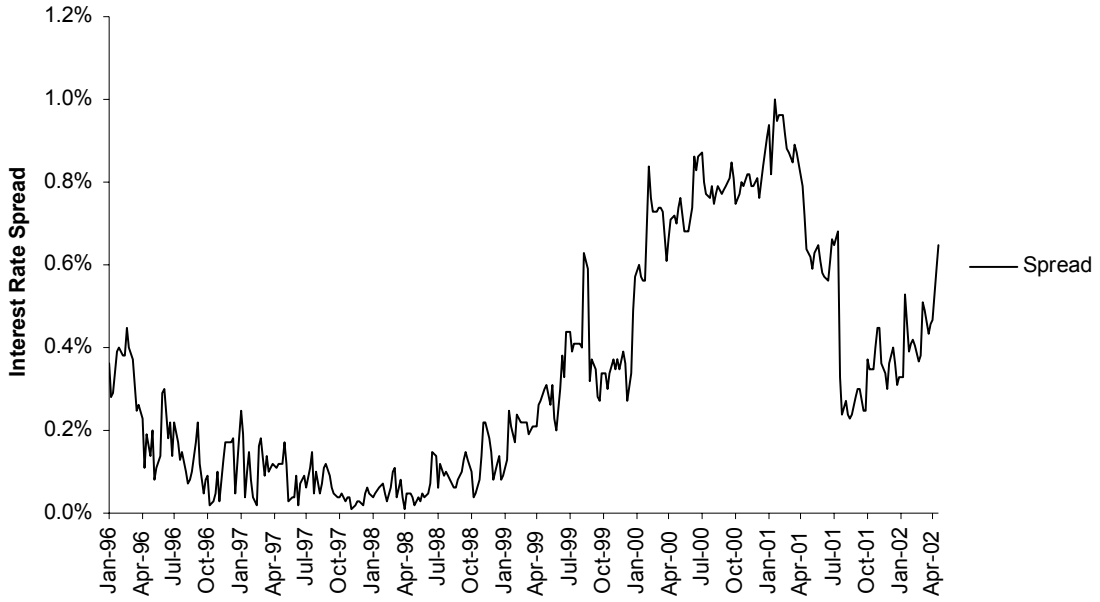

Source: Banc of America Securities and Thomson Financial

A measure of an industry's cost of capital in the debt market is the difference between the interest rate for that industry's debt and the interest rate for the market at large, or the "interest rate spread." Below, in Figure 14, the cost of issuing tax-exempt debt for hospitals is compared to the cost of issuing tax-exempt debt in the rest of the market.

[6] If an issuer is downgraded from investment grade (BBB-/Baa3 and above) to speculative ("junk") grade (BB+/Ba1 and below), the issuer will have difficulty issuing debt in the tax-exempt market.

**Figure 14: Historical Interest Rate Spread Between the Salomon Smith Barney Hospital Bond Index [1] and the Bond Buyer Revenue Bond Index [2]**

**Hospital interest rate spreads declined to the lowest level in over a year by the end of 2001, but have since risen.**




Source: Salomon Smith Barney
(1) Theoretical yield for a community hospital, $25mm, A/A, 25 year bond.
(2) The Revenue Bond Index consists of 25 various revenue bonds that mature in 30 years. The average rating is roughly equivalent to Moody's A1 and S&P's A-plus.

## Public Debt Market Dynamics

**Health care providers have been encouraged to return to the public debt markets by historically low interest rates.**

Moody's says that, "A number of rating downgrades recorded in 2001 were solely the result of large debt increases, in some cases a doubling and even tripling of the hospital's total debt outstanding. After a multi-year period of capital deferment, evidenced by flat expenditures in 2000 relative to 1999, health care providers have been encouraged to return to the debt markets by historically low interest rates and a more stable health care outlook. In the absence of a corresponding increase in cash flow generation, many of these hospitals can expect to see their credit ratings come under pressure following large debt issuance." According to Banc of America Securities, of the $22.7 billion in tax-exempt health care sector bonds issued in 2001, general acute care hospitals issued $19.5 billion, or 86.1%. This is an improved 41.8% increase over 2000 issuance. Moody's expects the surge in debt issuance that occurred during the fourth quarter of 2001 to continue well into 2002.

**General acute care hospitals issued 41.8% more bonds in 2001 than in 2000.**

**Management struggles with a paradox between maintaining its credit rating and accessing sorely needed capital.**

The downside to this borrowing opportunity is the increased leverage and credit risk for the issuer—possibly resulting in a rating downgrade. In this circumstance, management can find itself in a quandary. The paradox is a trade-off between the higher credit ratings and the long-term returns on worthwhile projects in the current low-interest rate environment. Carsten Beith and Matthew Goldreich of Cain Brothers, a tax-exempt specialist investment bank, describe the paradox: "What many outsiders may consider the most prudent management of a hospital from a long-term perspective may run counter to the incentives of current management. What manager wants to tell the board that the implementation of a costly project, with terrific long-term financial prospects, could result in a rating downgrade when the project is funded?"

## Bond Market Difficulties

**Investors lost confidence in the tax-exempt bond market.** The July 1998 bankruptcy of the Allegheny Health Education and Research Foundation (AHERF) was the largest ever by a nonprofit health care organization. AHERF defaulted on $1.3 billion in debt. Investor concerns regarding the Balanced Budget Act of 1997 also squeezed the market as decreased Medicare payments to hospitals ushered in a new era of unpredictability.

Cain Brothers notes that:

> "The AHERF bankruptcy and the increasing number of hospital bankruptcies announced since then have been a further catalyst for increasing investor concern. As a result, over the past several years, the spread between high investment grade, (including AAA-insured health care debt issues) and low investment grade debt (BBB) has widened from about 0.30% to about 1.20%, reflecting the increased risk perceived by investors in hospital debt."

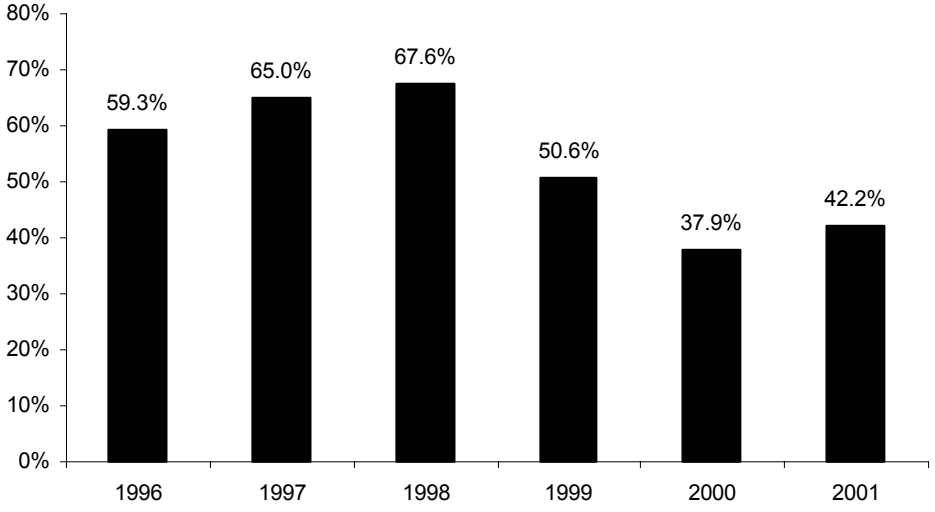
### Bond Insurance

**The willingness of bond insurers to insure hospital debt has declined in recent years.**

Bond insurance companies guarantee some nonprofit hospital bonds. This is a common enhancement to bond issuers that enables issuers to offer bonds at a lower interest rate. The willingness of bond insurers to insure hospital debt has declined in recent years.

According to Carolyn Tain of MBIA Insurance Corp., the combination of short-term financial volatility and long-term uncertainty has pushed bond insurers like MBIA away from the health care market, even from large, well-established systems. "With the exception of those in the strong "A" or "AA" category, there are few systems in this country that I feel really comfortable with," Tain says. MBIA, it should be noted, lost nearly $200 million dollars on the AHERF bankruptcy. Insured bond issuance dropped in 1999 and 2000 but increased in 2001. See Figure 15 below.

**Figure 15: Fewer New Tax-Exempt Hospital Bonds Carry Bond Insurance**




Source: Merrill Lynch and Thomson Financial

Frederick Hessler, a tax-exempt bond analyst at Salomon Smith Barney, says that bond insurers are reluctant to provide bond insurance to health care organizations with credit ratings in the "A" rating category or below. While there may have been reluctance on the part of bond insurers to underwrite hospital bonds in recent years, there may also have been less demand as issuers chose to go it alone in an interest rate-friendly environment where the cost of buying the insurance simply was too high.

### Investor Disclosure Concern Further Limits Access to Capital for Nonprofit Hospitals

Unlike the Securities and Exchange Commission (SEC) requirements, which require publicly traded companies to disclose material events to shareholders, there were no disclosure requirements for municipal bonds other than those included voluntarily in bond documents by the underwriters until 1994. In 1994, the SEC stepped in, enacting amendments to a rule requiring the borrower to file audited financial statements annually through a national registry. For many bond investors, these annual financial statements are not enough. Despite investor pressure, however, many borrowers have been reluctant to accept proposals that would further expand reporting.

Tom Weyl of Eaton Vance Mutual Funds believes that as the market for hospital tax-exempt bond securities shrinks and borrowing becomes more costly, hospitals that resist expanded reporting will have difficulty accessing needed capital. Investors are even selling existing bonds of issuers that decline to disclose sufficient data. "We have pruned people out of our portfolio who refuse to share information with us." Weyl says.

Andrew Matteis of Putnam Investments argues that much of the information that investors are seeking is not really the encumbrance that hospital executives would have investors believe it is—it is information that hospitals already produce and make available to management and to their boards.

It is possible that when the nonprofit hospitals disclose as much to their bondholders as the for-profits do to their investors, they will have better access to capital than they currently have now.

Quarterly disclosure of financials and key operating statistics would go a long way toward satisfying the information needs of investors trading in the secondary market, Frederick Hessler of Salomon Smith Barney says. "Investors are screaming for it."

## Bank Loans

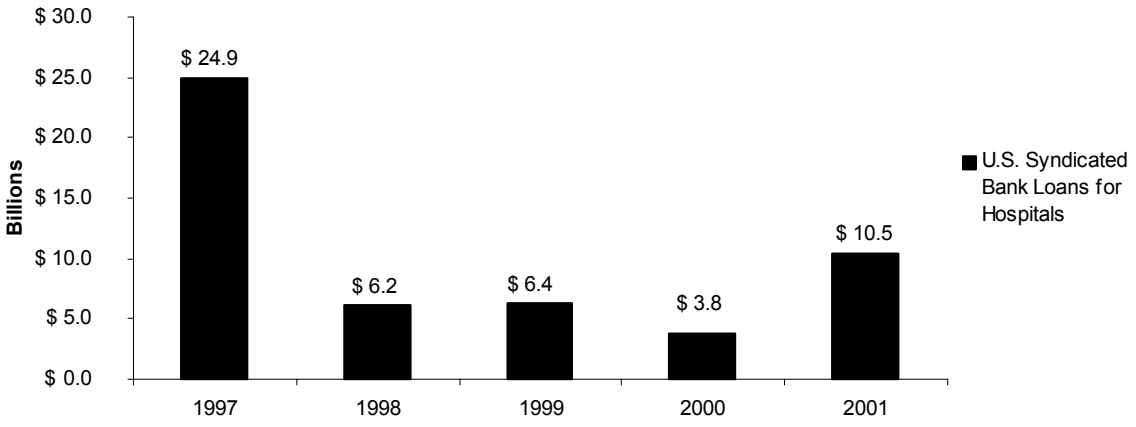
In addition to accessing the bond market for capital, hospitals have also historically looked to commercial banks for loans, letters of credit, and similar products. According to Bank of America, one of the largest commercial lenders to hospitals, the availability of capital from commercial banks has been reduced in recent years for a variety of reasons:

- Bank consolidations in the last decade have resulted in less available capital—fewer lenders
- Bankruptcies in the broader health care industry have resulted in banks abandoning the industry, regardless of the specific sector
- Volatility in government payments
- Declining operating margins
- Vertical integration, diversification and merger difficulties

Bank of America says that the market for bank loans and letters of credit was relatively robust as recently as 1997 (see Figure 16). Historically, many banks extended credit commitments to hospitals at attractive rates to maintain relationships with local hospital systems. As a result of the reasons mentioned above, as well as banks' increasing focus on risk capital, portfolio management, and client profitability, hospitals face increasing cost of capital.

**Figure 16: Hospital Bank Loans 1997 - 2001**

**Bank loans dropped in the late 1990's and showed marginal improvement for 2001.**




Source: Thomson Financial

Lenders believe that there is no broad market for hospitals with credit agency ratings lower than a Moody's A (the median). As of December 31, 2001, 56.9% of Moody's rated bonds had ratings of A or better. This, of course, does not reflect the majority of hospitals that are unrated.

This shortage of credit is further compounded by the tremendous consolidation of the commercial banking industry that has reduced the number of lenders. Among the banks that have remained in the market, many are demanding increased fees to enhance profitability, and have become much more selective in maintaining relationships with hospitals. In addition, fewer banks are willing to participate in a secondary role on a syndicated loan transaction (where multiple banks share the risk of the loan). This means that with fewer banks to share the risk, fewer loans are available.

## Alternate Financing Methods

To the extent that traditional 30-year tax-exempt bonds and commercial loans have become more difficult to obtain, hospital companies are looking to non-traditional types of capital, such as short-term debt.

According to Frederick Hessler, the short-term borrowings of Salomon Smith Barney's AA hospital clients typically account for 30-50% of their overall debt structure. But even with strong financial plans and controls in place, investors are leery of huge, long-term investments, Hessler says. Providers should be as well, he adds. "The world is changing so fast, and delivery is going to change in such dramatic ways that I'm not sure anyone can begin to imagine. With all the technology changes that are coming, I would be scared to make the investment in bricks and mortar to replace existing facilities. You're making a 30 or 40-year bet on the delivery cycle," Hessler says. Instead, alternate financing structures should be examined.

In August of 2000, Moody's stated that it believes it will see more of these alternative debt structures, some of which include:

- sale-leaseback arrangements of office buildings;
- greater use of lines of credit for short-term capital needs;
- off-balance sheet financings secured by accounts receivable, and/or the pledge of an asset;
- off-balance sheet financings with third parties for projects that do not qualify for tax-exempt financings

## HOSPITAL ACQUISITION ENVIRONMENT

**Hospitals are often sold to benefit from the acquiror's better access to capital.**

Consolidation continues in the hospital industry. Wall Street analysts believe that one of the reasons for this activity is access to capital—both in terms of improved capital costs for the (mostly for-profit) acquirors and the need for a strong partner for the (mostly nonprofit) acquired hospitals in order to maintain their access to capital. Other drivers for consolidation are the growth strategies of the rural for-profit companies, the desire of hospital systems to shed non-core facilities, the financial distress of some nonprofit hospitals, and gains in efficiency.

**Nonprofit Acquisition Environment: Nonprofits Provide a Robust Pipeline of Acquisitions**

Deborah Lawson of Salomon Smith Barney believes that, "Hospital consolidation has been steady over the past three calendar years, and, despite an improving fundamental environment, we expect these sales to continue at the same pace, or at an accelerated one, despite an improvement in the environment."

Lawson cites three factors as principal drivers of hospital consolidation:

- *Portfolio Rationalization:* A number of systems that grew too rapidly were adversely affected by the BBA and other factors and are now looking to shed facilities that are not in core markets. Catholic Health East and Catholic Health Initiatives, for example, traded a number of hospitals during calendar 2001 to tighten up their respective geographies.

**Despite general stabilization in the industry, many hospitals remain weak.**

- *Distressed Hospitals:* Despite general stabilization in the industry, many hospitals remain weak, and we have seen continued sales of distressed hospitals, sometimes through prepackaged bankruptcy deals.
- *Access to Capital:* Many facilities, while generally stable, are determining they will need a strong partner in order to maintain their access to capital. Often such facilities are opting to sell while they are financially stable and can command an attractive price, rather than waiting until they are up against a wall. This is more a driver for not-for-profits buying other not-for-profits. A case in point is in the Nashville, Tennessee market, where the No. 4 hospital, St. Thomas (owned by Ascension), bought the No. 1 hospital, Baptist, for aggregate consideration of approximately $340 million. The transaction was announced in April and closed at the end of calendar year 2001.

Lawson further believes that nonprofits, "…are shedding non-core assets, and, despite an improved reimbursement climate, one-third of the hospitals in the U.S. have negative EBITDA. While credit quality appears to be improving, the aggregate amount of debt downgraded dramatically improved, to $7.7 billion in 2001 from $15 billion in 2000."

## For-Profit Hospital Acquisition Environment

For-profit hospital companies announced eleven transactions in the fourth quarter of 2001 and three in the first quarter of 2002.

**Figure 17: Announced Hospital Acquisitions by For-profit Hospital Companies**

| | Total Acquisitions | Companies (Number of Deals) |
|---|---|---|
| Q3 2001 | 6 | Community Health (2), LifePoint (1), Province (2), Tenet (1) |
| Q4 2001 | 11 | Community Health (3), HMA (4), LifePoint (1), Province (1), Universal (2) |
| Q1 2002 | 3 | Community Health (1), HMA (2) |

Source: Lehman Brothers

Adam Feinstein of Lehman Brothers believes that for fourth quarter of 2001 and the first quarter of 2002:

> "…the acquisition environment remains robust. HMA has made the most announcements with six deals, followed by Community Health with four transactions. Improved borrowing costs were a key driver to the recent acceleration. Also, most companies suggested that valuations remain reasonable in most circumstances, but there are some instances of price creeping. One of our biggest concerns over the past year was that acquisition multiples would move higher, reflecting easy access to capital. However, it appears that most companies have exercised a high level of discipline thus far. Lastly, the average deal size increased over the past three months to 179 beds from 127 beds in the previous three-month period."

**Improved borrowing costs were a key driver to the recent acceleration.**

Salomon Smith Barney's Deborah Lawson adds that "Community, Province, and Tenet have been the most active acquirers of distressed facilities and have nimbly brought many of these hospitals to profitability. As such, despite eight publicly traded hospitals and two private systems (i.e., Vanguard and Ardent) that have been quite active, acquisition pricing has not escalated, but has remained disciplined, in our view."

## OPERATING DYNAMICS & OPPORTUNITIES

Bond investors are, more than ever, scrutinizing hospital business practices, management teams, and boards of directors. Investors are much more eager to invest in companies that are led by managers who keep the business solvent with strong strategic and capital planning, are divesting failing lines of business, and communicate effectively with core financial constituents.

Frederick Hessler of Salomon Smith Barney says that, "Traditional providers of capital to the health care industry will certainly be more discriminating in the future. They will look at health care organizations possessing strong fundamentals most favorably." A lack of clarity on future payments and cash flows to fund operations is a big negative. Investors need a degree of comfort that earnings from operations will be stable in order to cover debt obligations. Hessler points out that traditional tax-exempt bond investors will be wary of markets with a number of aggressive managed care plans that will squeeze pricing in that market. He believes that hospitals with a sound strategy and a dominant market position will be most successful at attracting investors. "Organizations that have a solid management team and focus on core businesses—and doing them well—will attract investors. All of those core strengths must, however, result in sustained profitability."

**Hospitals with a sound strategy and a dominant market position will be most successful at attracting investors.**

### Leadership

Dennis Farrell, of Moody's Investor Services says that one of the key differences between the "haves" and the "have-nots" is the quality and depth of senior management:

> "We used to look at management, and if the same people were there for 20 years we'd say 'Good, stable management team.' [If] I see somebody who's been there 20 years now…I get a little nervous. Do they have the tools and equipment to make the decision they are being faced with today, or are they just some[one] that the rest of the team would like to get rid of?"
>
> "Today, rating agencies and investors are more likely to look for specific management experience and skills needed to cope with today's market, either in the person of top managers or among individuals they have hired to run their organizations. Experience in managed care, mergers, acquisitions, and network development are highly prized. So are managers capable of operating new ventures."

**Management is the key factor in a hospital's performance.**

M. Craig Kornett of credit rating agency FitchRatings agrees. "Some organizations that used to be 'haves' but today are 'have nots' got that way because they got into ventures and operations that they didn't have the managerial talent to operate….Long-term care and physician practice management are two examples," he says.

In addition to additional scrutiny of management, investors and rating agencies are looking more closely at boards of directors. "On the [debt] side, what people are looking for first and foremost is a board that puts the financial equilibrium of the organization first," says Mark Hall, a partner with health care financial advisors Kaufman Hall in Northbrook, Ill. "Unless the organization is in financial equilibrium over the long run, there can be no mission."

**"Unless the organization is in financial equilibrium over the long run, there can be no mission."**

**Outsourcing of non-core functions is an option for cutting costs.**
Efforts to reduce capital expenditures by outsourcing functions such as information systems are applauded by investors. Hessler thinks hospitals could become even more efficient by farming out other services such as labs and pharmacies. He says:

> "We believe that outsourcing will be viewed as a potential capital source. Historically, health care organizations have outsourced truly non-core operations such as food service and housekeeping. Now, health care organizations will begin to look to their non-core operations and businesses and enter into partnering arrangements with others, principally for-profit companies, to provide these services collaboratively. In doing so, health care organizations will be able to tap their partners' equity capital. Certainly, concerns regarding the quality of service, sustainability of the outsourcing partner, and the economies and efficiencies realized are just a few of the issues that must be addressed before implementing an outsourcing arrangement."

### Improving Efficiency of Operations

Many investor concerns with the hospital sector arise in regard to their efficiency in operations. A recent article published by Paul Mango and Louis Shapiro of McKinsey & Company, a management consulting firm, highlights some of the operational problems afflicting this sector.

**A Logistical Anachronism**
McKinsey suggests that the cure for ailing hospital income statements is that managers pay serious attention to operating inefficiencies. McKinsey observes that the rampant bottlenecks in a hospital are a "true logistical anachronism" and that other industries refined these inefficiencies decades ago. McKinsey notes that through the mid-1980s insurers paid the fees demanded by hospitals and the federal and state government payors subsidized expansion of capacity by adding what McKinsey calls a "capital pass-through term" to Medicare and Medicaid payments.

**Corporate Culture**
The corporate culture that developed from this generous payment environment and lack of competition did not change when faced with the pressure of aggressive negotiations by managed care organizations in the late 1980s and then in the Balanced Budget Act of 1997 for government programs. Instead, hospital response to this "more austere environment" included mergers, "slash and burn cost cutting," and even hospital-based insurance plans. McKinsey believes that these measures, especially the mergers, neither helped achieve improved productivity or local-market bargaining power to offset the leverage that managed care and the government wielded.

McKinsey believes that the answer to hospital problems remains detailed day-to-day attention to operations and logistics in order to gain operating efficiencies. Hospitals that eliminate bottlenecks and use their assets efficiently will drastically improve both operations and the bottom line.

## FOR-PROFIT HOSPITAL COMPANIES

**For-profit hospital companies differ from their nonprofit peers in that they focus more on profitability and are often quicker to adapt their strategies to environmental factors.**

Although the for-profit segment of the hospital industry comprises only 15% of the total industry, it is growing somewhat faster than, and gaining market share from nonprofits, the remaining 85% of the sector. Wall Street analysts believe that for-profit hospital companies differ from their nonprofit peers in that they focus more on profitability and are often quicker to adapt their strategies to environmental factors. Wall Street has identified some clear winners in the more competitive and challenging environment that hospitals are facing. There are eight publicly traded for-profit hospital management companies, and, of these, HCA and Tenet Healthcare comprise nearly 75% of the sector's value. These eight companies together operate approximately 550 hospitals.

**Figure 18: For-Profit Publicly Traded Hospital Companies**

| Company | Firm Value ($Millions) |
|---|---|
| HCA | $32,404 |
| Tenet Healthcare Corporation | 28,817 |
| Health Management Associates | 6,209 |
| Triad Hospitals | 4,773 |
| Community Health Systems | 3,798 |
| Universal Health Services | 3,292 |
| LifePoint Hospitals | 1,417 |
| Province Healthcare Company | 1,183 |

Source: Morgan Stanley Healthcare Facilities Weekly Comps as of 4/19/02
Note: Firm Value = equity market capitalization + net debt + minority interest – unconsolidated assets

### State of the Industry

**Wall Street believes the publicly traded hospital companies are doing well.**

**All of the publicly traded hospital companies met or exceeded Wall Street's expectations in the first quarter of 2002.**

The for-profit hospital management companies outperformed the S&P 500 Index for the majority of the last year. The sector's ability to outperform Wall Street's expectations for quarterly earnings is healthy. All of the publicly traded for-profit hospital companies met or exceeded Wall Street's earnings expectations during the first quarter of 2002. Profitability has increased within the sector as the companies have reemerged from weakened financial performance and are stabilizing following the implementation of the BBRA and BIPA. Increased profitability has allowed for-profit hospitals to generate more cash flow. This cash is reinvested in hospital facilities and new technology, and allows hospitals to have strong access to capital.

**For-Profit hospital companies responded to BBA by cutting costs, divesting ancillary businesses, and changing their corporate strategy.**

**For-profit hospital companies responded to BBA strategically.**

Following the BBA, many hospital companies implemented focused strategies by divesting ancillary businesses such as home health agencies, ambulatory surgery facilities, and physicians practices. In addition to focusing on costs, companies sharpened their focus by exiting from markets in which they could not achieve dominance and by spinning-off poor-performing rural hospitals. The for-profit hospital sector separated into companies focused on competitive urban markets and those focused on rural markets where a hospital is often the only one in the market. The companies that focus on urban and suburban markets are HCA (NYSE: HCA) and Tenet Healthcare Corporation (NYSE: THC). The rural companies include: Community Health Systems (NYSE: CYH), Health

Management Associates (NYSE: HMA), LifePoint Hospitals (NASDAQ: LPNT), and Province Healthcare Company (NASDAQ: PRHC). Triad Hospitals (NYSE: TRI) focuses on hospitals in small urban and suburban markets. Examples of this urban/rural sector segmentation are the HCA divestiture of both Triad and LifePoint in 1999, turning these divisions of HCA into independent publicly traded companies, and the very successful initial public offering of Community Health Systems in 2000.

**Urban Hospital Companies**

**Urban hospital companies have significant market share in a number of markets.**

Large urban hospital companies, such as HCA and Tenet, have significant market share in a number of urban and suburban markets, especially in the South and West. Their strategy is to increase their competitive position in specific geographic regions by owning multiple hospitals in those regions. This allows them to enhance their negotiating position with managed care companies as well as enjoy general economies of scale. HCA's and Tenet's primary strategy is to invest free cash flow into existing operations in order to add capacity and expand higher-acuity services.

**Rural Hospital Companies**

**Rural hospital companies acquire hospitals that are either the sole provider or have dominant share in a market.**

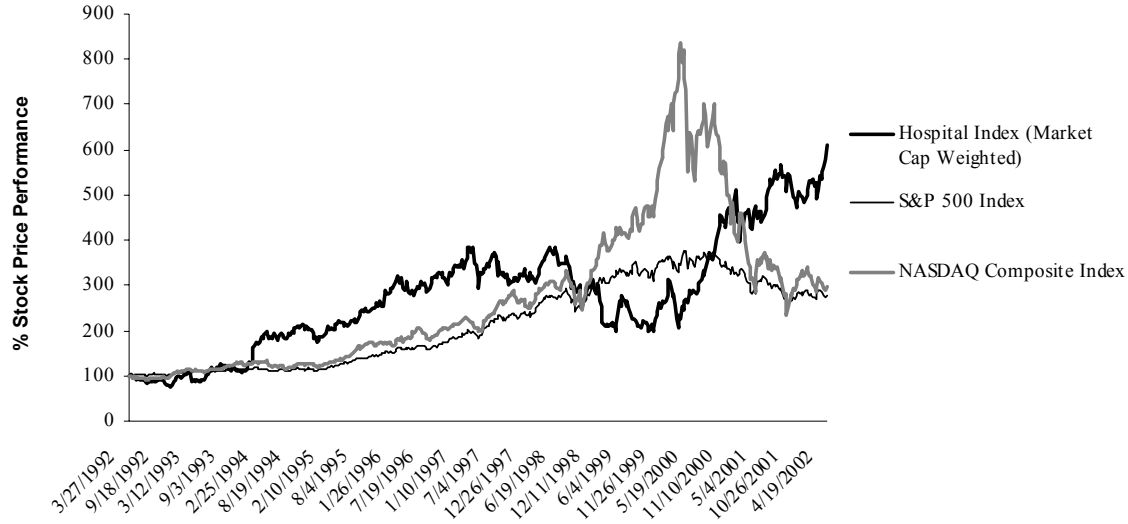
Rural hospital companies typically try to gain significant market share in a region by purchasing hospitals in markets where one hospital is the sole provider for that area. The growth strategy for most rural companies is based on two primary goals: acquisitions in underserved markets and the improvement of existing and acquired facilities. Rural hospitals also recruit physicians to increase their ability to offer broader services to patients. Generally, if a rural town does not have high caliber physicians, patients will travel to the nearest large town for medical care. To increase the number of physicians in the rural community, many for-profit rural hospitals recruit physicians by guaranteeing a new physician's income for a period of time while the doctor builds a new practice. Hospital volume increases when these physician's practices are established. While the physician self-referral provisions of the Social Security Act (commonly referred to as the Anti-Kickback Statute and the "Stark Law") prohibit hospitals from guaranteeing physicians' income, exceptions are sometimes made if a hospital can prove that it is in a medically underserved market.

## Stock Market Performance

**For-Profit Publicly Traded Hospital Companies Outperformed the S&P 500 Index for the Majority of the Last Year as well as the Majority of the Last 10 Years.** According to Goldman Sachs' Andrew Bhak, strong hospital stock price performance, "…has primarily been driven by the group's ability to deliver ongoing upside to consensus earnings expectations against a backdrop of downward estimate revisions across the broader market." The graph below (Figure 19) compares the group's performance over the last decade to the S&P 500 Index and the NASDAQ Composite Index, benchmarks of the broad equity market.

**Figure 19: Stock Performance of the Hospital Companies vs. the S&P 500 and the NASDAQ Composite—Last Ten Years**

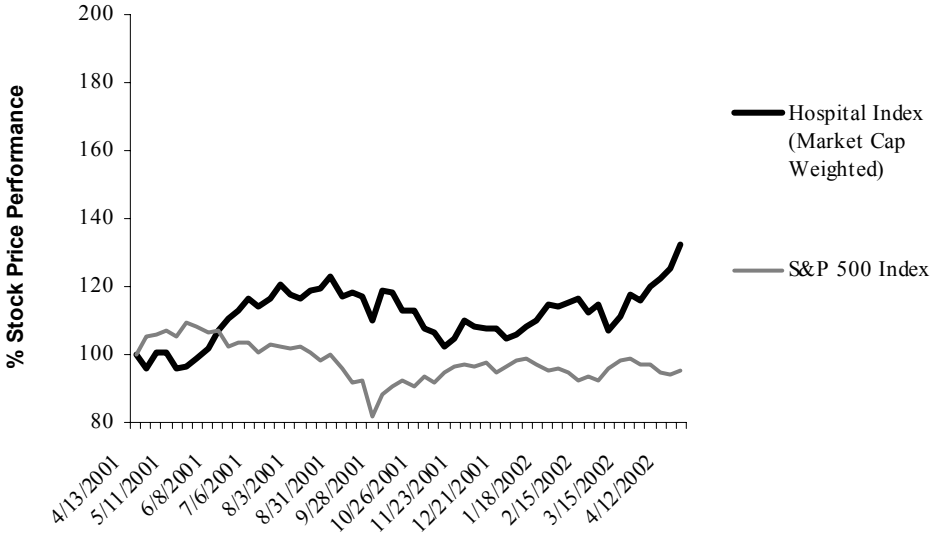
**Hospital companies outperformed the market over the last ten years.**




Source: Bloomberg
Hospital Index: Community Health Systems, HCA, Health Management Associates, LifePoint Hospitals, Province Healthcare Company, Tenet Healthcare Corporation, Triad, Universal Health Services

**Figure 20: Stock Performance of the Hospital Companies—Last Twelve Months**

**The hospital companies outperformed the S&P 500 Index over the last twelve months.**




Source: Bloomberg
Hospital Index: Community Health Systems, HCA, Health Management Associates, LifePoint Hospitals, Province Healthcare Company, Tenet Healthcare Corporation, Triad, Universal Health Services

## Industry Performance

**For-profit hospital financial performance is very strong.**
EPS, or earnings per share, is a key metric investors use to measure quarterly financial performance. A.J. Rice of Merrill Lynch believes that:

**Merrill Lynch believes that very strong EPS growth was the result of exceptional performance.**

> "…fourth quarter 2001 EPS results demonstrate continued strong trend within the hospital group….Significantly, year-over-year EPS growth in the fourth quarter averaged an exceptionally strong 50% (EPS jumped 76% year-over-year for all of 2001). Interestingly, in the fourth quarter of 2000, the average hospital company generated 33% year-over-year EPS growth, and two companies jumped into positive earnings territory for the first time. Clearly, very strong EPS growth was the result of exceptional performance rather than easy comparisons. Further…growth was generated across the board, with every publicly traded hospital company achieving a gain of at least 25%."

**Figure 21: Hospital Companies: Fourth Quarter 2001 Earnings Performance**

**According to Merrill Lynch, year-over-year EPS growth in the fourth quarter averaged an exceptionally strong 50%.**

| Company | 4Q2001 Consensus EPS | 4Q2001 Actual EPS | 4Q2001 Difference | 4Q2001 % Difference | 4Q2001 EPS Y/Y Growth |
|---|---|---|---|---|---|
| Community Health Systems | $ 0.16 | $ 0.18 | $ 0.02 | 12.5 % | 100.0 % |
| HCA | 0.42 | 0.44 | 0.02 | 4.8 % | 26.0 % |
| Health Management Associates | 0.19 | 0.20 | 0.01 | 5.3 % | 25.0 % |
| LifePoint Hospitals | 0.23 | 0.27 | 0.04 | 17.4 % | 69.0 % |
| Province Healthcare | 0.30 | 0.30 | 0.00 | 0.0 % | 30.0 % |
| Tenet Healthcare | 0.69 | 0.77 | 0.08 | 11.6 % | 43.0 % |
| Triad Hospitals | 0.17 | 0.20 | 0.03 | 17.6 % | 82.0 % |
| Universal Health Services | 0.48 | 0.50 | 0.02 | 4.2 % | 28.0 % |
| Mean | | | | | 50.0 % |

Source: Company Reports, First Call, and Merrill Lynch
Note: Consensus EPS is the average of each Wall Street firm's EPS estimates

Lehman Brothers' Adam Feinstein believes that:

> "Hospitals continue to generate attractive same-facility revenue growth on the back of the strong pricing environment….Hospitals clearly benefited from the favorable commercial pricing cycle, as well as Medicare (with hospitals getting a 2.75% increase versus 2.20% a year earlier). [Growth of] inpatient revenue per admission averaged 9.0% versus the 8.1% in the September quarter. However, this is even more impressive considering that the September quarter benefited from BIPA (with a 4.5% Medicare increase). **We expect this trend to continue throughout 2002, reflecting the attractive rates hospitals negotiated with payers last year."**

Lehman Brothers' Adam Feinstein also states that:

> **"With robust demand and a reduction in the cost of capital (with lower interest rates), hospital companies believe that investments could generate high returns on capital.** The most common investment highlighted was emergency room expansions, as well as capacity additions (more beds). Companies also highlighted increased investments to expand surgical capacity, expansion of higher acuity programs (cardiology and orthopedics), and increased radiology equipment (both CT and MRI technology). We estimate that capital spending for the publicly traded hospital sector will increase 40% in 2002 (with

**Lehman Brothers believes that increased spending could signal that the industry environment is "too good."**

LifePoint, Triad, UHS, and HMA forecasting some of the biggest increases). **This increased spending has some significance and could signal that the industry environment is 'too good.' However, it is difficult to add capacity overnight in the hospital business, and nonprofits (representing 85% of the industry) are not making the same level of investment, due to limited access to capital."**

A.J. Rice of Merrill Lynch believes that:

> "For the first quarter of 2002, we continue to see positive trends and strong results principally benefiting from strong commercial pricing and stable Medicare policy. All of the hospital companies met or exceeded expectations. We continue to see more of the same positive trend that what we saw in the fourth quarter of 2001."

**Figure 22: Hospital Companies: First Quarter 2002 Earnings Performance**

| Company | 1Q2002 Consensus EPS | 1Q2002 Actual EPS | 1Q2002 Difference | 1Q2002 % Difference | 1Q2002 EPS Y/Y Growth |
|---|---|---|---|---|---|
| Community Health Systems | $ 0.24 | $ 0.27 | $ 0.03 | 12.5 % | 42.0 % |
| HCA | 0.72 | 0.76 | 0.04 | 5.6 % | 26.0 % |
| Health Management Associates | 0.27 | 0.27 | 0.00 | 0.0 % | 17.0 % |
| LifePoint Hospitals | 0.31 | 0.38 | 0.07 | 22.6 % | 58.6 % |
| Province Healthcare | 0.35 | 0.35 | 0.00 | 0.0 % | 35.0 % |
| Tenet Healthcare | 0.80 | 0.86 | 0.06 | 7.5 % | 43.0 % |
| Triad Hospitals | 0.39 | 0.55 | 0.16 | 41.0 % | 139.1 % |
| Universal Health Services | 0.70 | 0.71 | 0.01 | 1.4 % | 25.0 % |
| Mean | | | | | 48.2 % |

Source: Company Reports and Wall Street research
Note: Consensus EPS is the average of each Wall Street firm's EPS estimates

Credit Suisse First Boston agrees, saying that for the first quarter of 2002, "Enthusiasm for the group has been reinforced by strong earnings reports from the entire sector."

**Hospitals are experiencing healthy margin expansion, due to some moderation of costs**.

Adam Feinstein of Lehman Brothers notes that in the fourth quarter of 2001:

**Hospital companies have reported significant margin growth.**

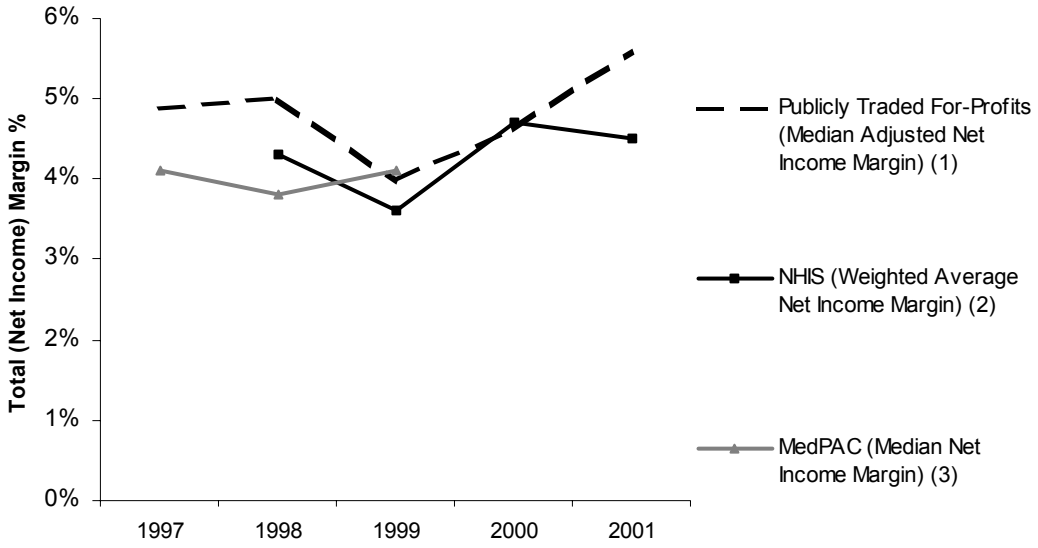
> "Hospital companies reported 40 basis points of margin improvement in the December quarter, representing the eighth straight quarter of significant margin growth. Tenet was the standout in this category with a 155-basis-point increase, followed by Province with margins up 123 basis points. Other operating expenses, bad debt expense, and supply expense declined 80, 23, and 2 basis points, respectively. However, labor costs increased 80 basis points, which was more than anticipated."

## For-Profit Hospital Net Income Margin

Several studies of net income margins for for-profit hospitals are shown in the graph below (Figure 23). This graph illustrates that for the last two years, public for-profit companies have increased their profitability and are experiencing healthy margin expansion. These results, coupled with the EBITDA margins below, indicate that margins have improved since 1999.

**Figure 23: Hospital Net Income Margins, For-Profit Only**

**For-profit companies are experiencing healthy margin expansion.**




Sources:
(1) SEC filings, Bloomberg, Wall Street Research. Adjusted net income margin reflects a company's net income adjusted for any extraordinary items (such as gains on sales of facilities, asset impairment charges, settlements with the Government, restructuring and investigation charges and charges from the extinguishment of debt)
(2) National Hospital Indicator Survey, commissioned by CMS and MedPAC and conducted by the American Hospital Association and the Lewin Group, current methodology began in 1998. NHIS surveys nearly 1,900 community (for-profit and nonprofit) hospitals throughout the US
(3) MedPAC analysis of CMS cost reports through 1999

Note: These indicators of hospital margins are calculated differently, and definitions of net income margin vary. Despite these differences, the data are a good indicator on a directional basis.

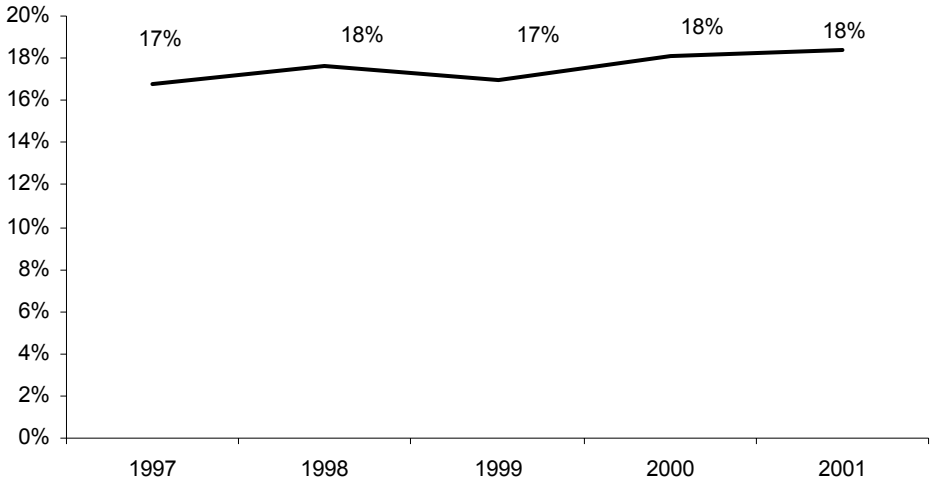
**For-profit hospital operating income margins indicate that profitability has increased and stabilized.**

**For-profit hospitals have had increased profitability.**

Lehman Brothers' Adam Feinstein believes that, "…hospitals are generating significant amounts of cash flow." The median operating income margin[7] for the group expanded from 17% in 1997 to 18% in 2001, indicating that many hospital companies have been able to increase their revenues and control their expenses, and thus generate more cash flow. (Figure 24)

**Figure 24: For-Profit Publicly Traded Hospital Companies Median EBITDA Margin**

**For-profit hospitals are generating significant cash flow margins.**




Source: Bloomberg, Company Reports, and Wall Street Research
Index consists of: Community Health Systems, HCA, Health Management Associates, LifePoint Hospitals, Province Healthcare Company, Tenet Healthcare Corporation, Triad and Universal Health Services.
EBITDA is earnings before interest, taxes, depreciation, amortization and any unusual or extraordinary items.

[7] For a more thorough discussion on margins, refer to page 9.

## Wall Street's Outlook

**Investors believe that the outlook for the sector is bright.**
Investors point to hospital admissions growth, which is fueled by an aging population, to help drive predictable earnings growth. In addition, investors believe that the relatively stronger profitability of the for-profit hospitals will allow them to continue to gain market share from and acquire weaker hospitals. Further, for-profits are enjoying a continuing strong position in pricing negotiations with managed care providers. Finally, analysts are forecasting a modest increase in Medicare inpatient rates in 2003–anticipating a continuation of the positive trend seen in 2001 and 2002. Medicare inpatient rates increased in fiscal year 2001 by 3.40% and by 2.75% in fiscal year 2002.

Lehman Brothers' Adam Feinstein writes that, "…we believe that this group will outperform in the spring, as it did last year, with increased clarity around pricing and continued solid fundamentals. Nothing from the most recent quarter suggests a noticeable change in trend….Thus, we continue to advocate ownership of the sector.…"

**Goldman Sachs believes that the positive investment case for the sector is characterized by predictable projected earnings growth and attractive valuations.**

Goldman Sachs' Andrew Bhak believes that, "…the positive investment case for this [the hospital management] group is characterized by four principal elements: predictable and visible earnings, attractive projected EPS (earnings per share) growth of 15-20% on a sustainable basis, the potential for continued EPS outperformance and upward revisions to estimates and attractive valuations on a risk/return basis."

There are several key factors driving this healthy renaissance in the for-profit hospital business. Predictable earnings and earnings growth are driven by the key metrics, which investors use to evaluate hospital stocks. (Figure 25)

**Figure 25: Key Metrics Investors Use to Evaluate Hospital Potential for Predictable and Growing Earnings**

| Key Metric | Driver |
|---|---|
| **Hospital Admissions/Volume Growth** | • Aging population<br>• Market Share Gains – for-profits gaining market share from not for-profits |
| **Managed Care / Medicare Pricing Stability / Growth** | • Managed care negotiations<br>• CMS policy |
| **Balance Sheet Strength / Access to Capital** | • Ability to generate cash flow |
| **Operating Profitability** | • Labor costs<br>• Increased scale – centralization of billing offices, operating efficiencies<br>• Management incentives |

Source: Wall Street research reports

**Investors are looking for growth in admissions to come from an aging population. The fastest growing segment of the population during the next five to ten years will be the group aged 55-64.**

This segment of the population is particularly lucrative for hospitals for two reasons. First, this group is likely to be insured through a private health plan, which is more profitable for a hospital than Medicare. Second, hospital admissions begin to accelerate for this segment of the population as their age makes them more likely to be in need of health care services. Longer term, however, as the baby boomer population reaches Medicare age, some believe that profitability for hospitals may decline somewhat. This is because as the population ages, the average length of a patient's stay tends to increase.

**Profitability is causing for-profit hospitals to gain market share from nonprofit hospitals.**

**For-profit hospitals are gaining market share from neighboring nonprofits.**

Wall Street analysts believe that a major factor in gaining market share has been the ability of for-profit hospitals to make significant capital investments to improve facilities, purchase needed medical technology, and recruit physicians. As such, for-profit hospitals are focused on measures that improve profitability to generate the capital required to make these investments. Once a for-profit hospital has purchased advanced medical technology, improved its facilities, and recruited physicians, it can draw patients away from its competitors because patients prefer to be treated in the best facility available.

**For-profit hospitals currently have a strong position with respect to pricing negotiations with managed care providers.**

According to Goldman Sachs, "This [positive change in pricing] at the margin has been important because commercial payers account for approximately 50% of the revenue base of the hospital management group. We expect pricing trends to persist.…" According to Charles Boorady of Goldman Sachs, health insurance premiums are expected to rise 13% in 2002.

**For-profit hospitals with strong positions will be able to demand price increases.**

Credit Suisse First Boston believes that, "…only hospitals with strong positions in their local markets will be able to demand price increases that are sufficient to expand margins. Generally, the [for-profit, publicly traded] companies we cover, have clout in their local markets and thus we believe they will be able to raise prices."

## Access to Capital

**For-profit hospital companies have access to both the debt and equity markets, a key advantage.**

While for-profit hospital companies do not have the tax advantages and philanthropic income of their nonprofit peers, they do have access to both the debt and equity markets, a key advantage to accessing capital. These companies can make capital decisions based on optimizing their cost of accessing funds. Importantly, and perhaps ironically, the for-profit hospital companies do not need to raise capital as desperately as their nonprofit counterparts because they are generating healthy cash flow from their operations.

**For-profit hospitals have enjoyed relatively good access to the debt and equity markets.** Lehman Brothers' Adam Feinstein believes that:

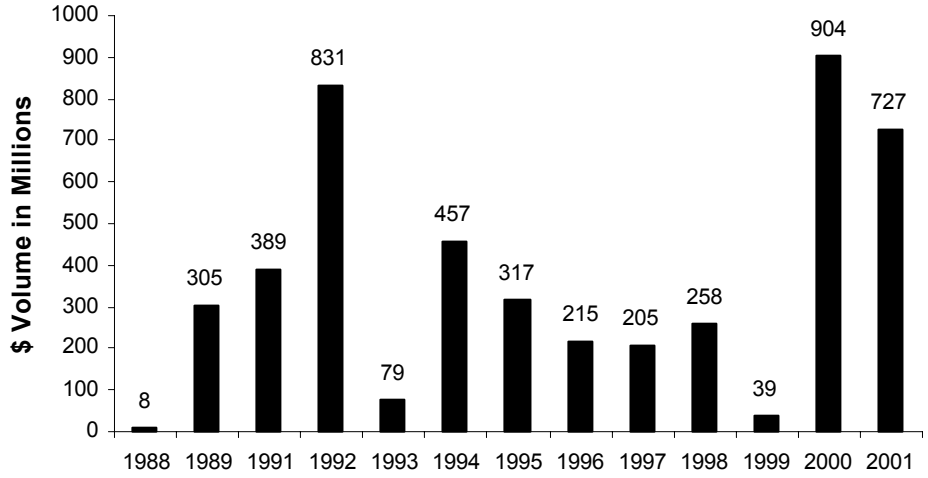
**Hospital companies continue to benefit from improved borrowing costs.**

> "Hospital companies continue to benefit from improved borrowing costs. Hospitals have experienced a sizable reduction in credit spreads, reflecting the improved industry environment and lower interest rates (down almost [4%] over the past year). Thus, most companies benefited from refinancing activities, as well as debt reduction initiatives during the [fourth quarter of 2001]. The group average debt/total capitalization declined to 45.2% at the end of December from 49.2% a year earlier. At the same time, interest expense declined to 2.6% of revenues from 4.0% in the December 2000 quarter."

The figures below further illustrate that the for-profit hospital companies are clearly able to access the capital markets. Figure 26 shows that this group has seen a significant increase in equity issuance in 2000 and 2001 relative to 1999. Figure 27 demonstrates that the sector has also seen a tremendous surge in corporate debt issuance in 2001.

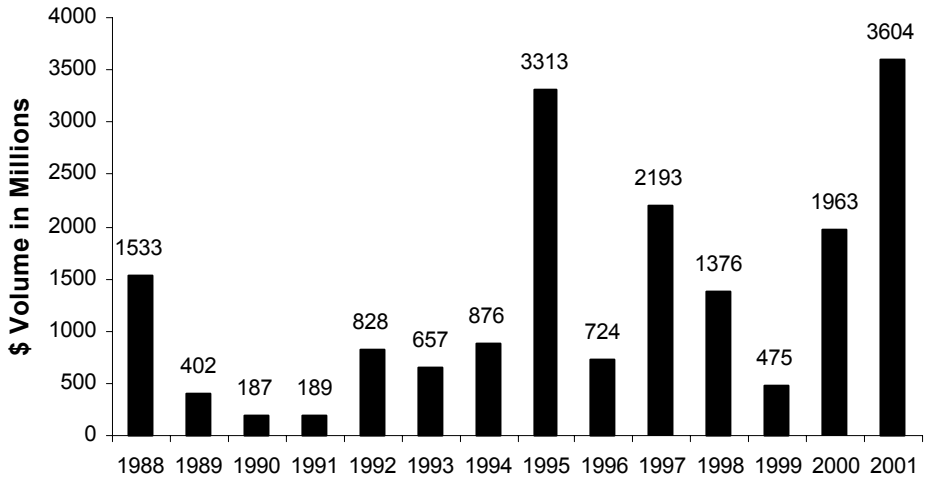
**Figure 26: Annual Hospital Equity Issuance**

**Hospital equity issuance remains robust.**




Source: Goldman Sachs and Securities Data Corp.

**Figure 27: Annual Hospital Corporate Bond Issuance**




Source: Goldman Sachs and Securities Data Corp.

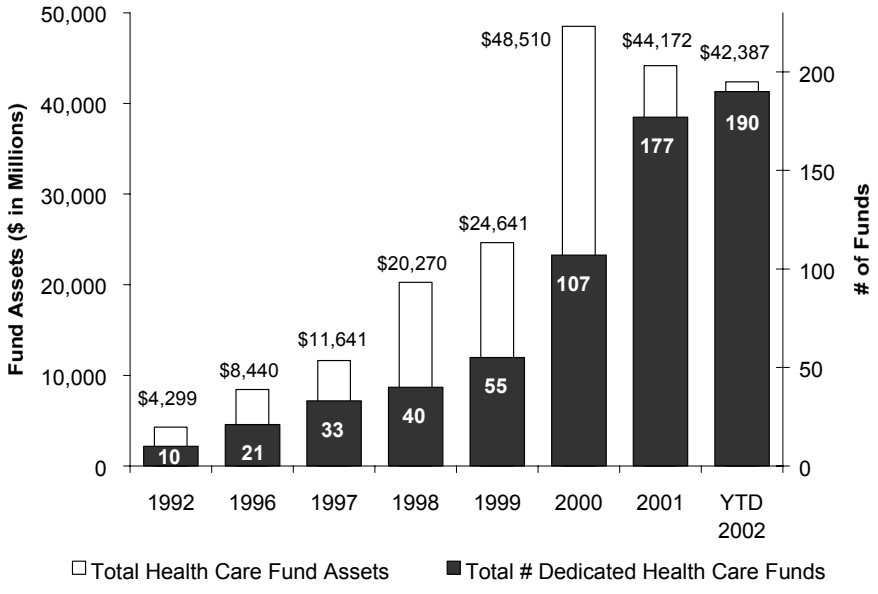
**Hospital corporate bond issuance is on the rise.**

**Health care mutual funds continue to invest in the equity markets.**
Equity investors, having lived through the Internet bubble and the Enron debacle, have continued to invest in the health care industry because the demand for health care services and products is generally inelastic—and hence—less sensitive to changes in the economy.

**Salomon Smith Barney believes that hospitals, the centerpiece of the health care delivery system, are a core holding in any portfolio.**

The chart below (Figure 28) indicates that despite a slight decline, investors have continued to invest in health care equities, and that assets of U.S. health care equity funds total $42 billion. Research analysts covering hospital stocks, such as Salomon's Deborah Lawson believe that, "Hospitals, as the centerpiece of the health care delivery system, are, in our view, a core holding in any portfolio…." This opinion suggests that hospital equity will remain in demand as health care portfolio managers allocate their assets.

**Figure 28: Dedicated Health Care Funds and Asset Fund Flows**




Source: J.P. Morgan and AMG Data

**The number of dedicated health care funds has grown from 177 in 2001 to 190 today.**

**Figure 29: For-Profit Company Snapshots**

| | |
|---|---|
| HCA (HCA)<br><br>Firm Value:<br>$32 Billion | The largest for-profit hospital company, with 176 hospitals located in suburban and urban markets within the United States. HCA strives to obtain significant market share in a geographic region by owning multiple hospitals in a region. This allows the company to have pricing power over managed care companies. HCA has about half of its hospitals in Florida, Texas, and Georgia. HCA's size allows it to have economies of scale. HCA's strategy is to invest its free cash flow into its existing operations. |
| Tenet Healthcare Corporation (THC)<br><br>Firm Value:<br>$29 Billion | Tenet has 114 hospitals located in suburban and urban markets in the United States. Tenet strives to obtain significant market share in a geographic region by owning multiple hospitals in a region. A majority of Tenet's hospitals are located in California, Florida, and Texas. Tenet's strategy is to develop and expand high-acuity services such as oncology and cardiology. An advantage Tenet has because of its large size is general economies of scale as well as pricing power with managed care providers. |
| Health Management Assoc. (HMA)<br><br>Firm Value:<br>$6 Billion | HMA has 40 acute care hospitals and two psychiatric facilities located primarily in rural communities that are often the sole hospital in the market. Approximately half of HMA's hospitals are located in Florida and Mississippi. HMA is the leading provider of rural health care, with a strategy to improve the operations of its hospitals in underserved markets. HMA's hospitals are the most profitable in the industry, indicating that HMA's operating efficiency is consistent. |
| Triad Hospitals, Inc. (TRI)<br><br>Firm Value:<br>$5 Billion | Triad, which was formed from HCA's smaller-city and poorer-performing hospitals, owns 46 acute care hospitals in suburban and small urban markets in Texas, Alabama and Indiana. Triad's hospitals are often one of two hospitals in a market; in most cases, the direct competitor is a nonprofit hospital. |
| Community Health Systems (CYH)<br><br>Firm Value:<br>$4 Billion | Community Health Systems owns 58 hospitals in rural and non-urban markets, 15 of which are the sole hospital in the community. A large number of Community Health Systems' hospitals are located in Texas, Alabama, Pennsylvania, Tennessee, South Carolina, and New Mexico. Community Health's strategy is to acquire rural and non-urban hospitals and improve their operations so that the hospital is either the sole provider or has dominant market share in a market. |
| Universal Health Services (UHS)<br><br>Firm Value:<br>$3 Billion | Universal has 33 acute care hospitals and 37 behavioral health centers. Universal provides services in general surgery, internal medicine, obstetrics, radiology, pediatric services, and behavioral health services. The company is closely held, and not covered as thoroughly by Wall Street, so the dynamics of its operations are more difficult to track. |
| LifePoint Hospitals, Inc. (LPNT)<br><br>Firm Value:<br>$1 Billion | LifePoint owns and operates 23 hospitals in non-urban areas, where its hospital is the only one in the community. LifePoint's hospitals are located in Alabama, Florida, Georgia, Kansas, Tennessee, Kentucky, Louisiana, Utah, and Wyoming. |
| Province Healthcare Company (PRHC)<br><br>Firm Value:<br>$1 Billion | Province has 16 acute care hospitals in non-urban markets in the United States. Province was formed in 1996 through the leveraged recapitalization and simultaneous merger of Brim Inc. and Principal Hospital Company. |

## SUMMARY

- Nonprofit hospitals are recovering at differing rates. Current hospital profit margins are near the historical average.

- Strong nonprofits have stabilized but face increasing scrutiny from investors on performance and disclosure. Weaker nonprofits are in a "vicious cycle" of underinvestment in capital and dwindling market share.

- For-profit hospitals have exhibited solid growth and exceeded Wall Street's expectations. Clearly, they have more than recovered from the payment squeeze of the 1990's.

- Both bond and equity investors are looking for predictability and a stable long-term payment policy. As Lori Price of J.P. Morgan said, "Wall Street's biggest concern is uncertainty. Lack of stable government payment rates means that companies aren't able to plan and are forced to manage through volatile rate changes."

- The inpatient market basket update drives nearly $100 billion per year in hospital payments, making it the single most important payment variable for the hospital sector. If Congress decides to keep payments stable at a status quo level, it will have to define what status quo is. Three options are: (i) the historical median (Market Basket minus 1.9%); (ii) a continuation of current law (Market Basket minus .55%), or, (iii) the full Market Basket Update.

- And finally, in determining the status quo, Deborah Lawson of Salomon Smith Barney reminds investors, "In fact, this year, fiscal 2002, hospital Medicare payment rates have been updated by 'market basket minus 0.55%.' This, in our opinion, is 'status quo' on hospital payments….And, again, we never expected that hospitals would receive full market basket in the out years."



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