

# Capital Markets Update



**hfma**<sup>™</sup>

healthcare financial management association

California Fall Conference / September 13, 2009

Ellen G. Riley, Senior Vice President, Kaufman Hall

Charles G. Plimpton, Citi

Christian E. Stein III, Vice President, U.S. Bank

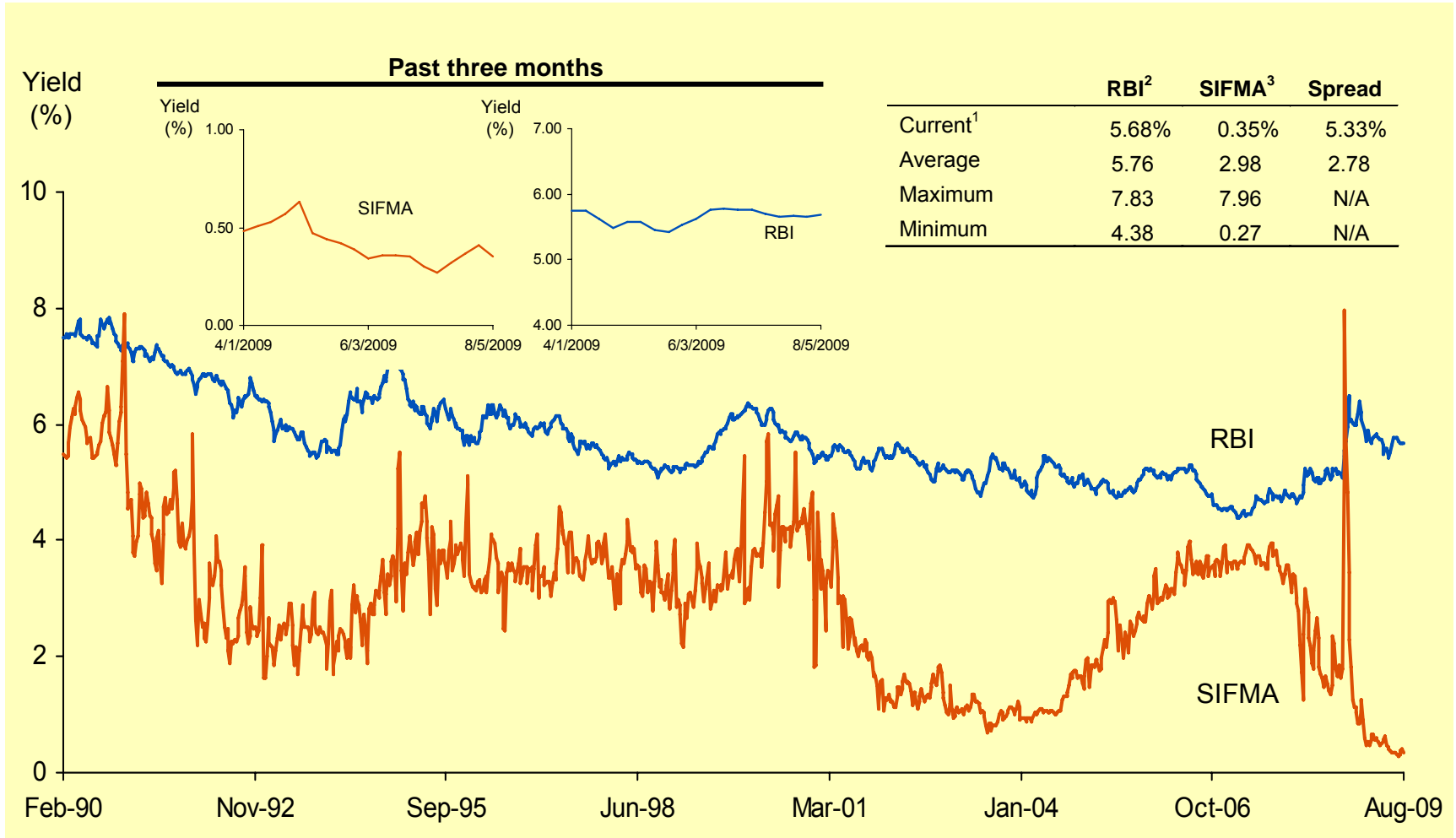


## Today's Agenda

- What Do We know Today: Capital Markets Perspective, Expectations and Implications
- Debt Alternatives – What Choices are Available to Borrowers in the Current Environment
- 2009 Repositioning Actions: Operations, Balance Sheet and Capital Structure
- Longer-term Outlook and Actions to Develop Successful Organizations

# What Do We Know Today: Capital Markets Perspective, Expectations and Implications

# RBI vs. SIFMA Rates

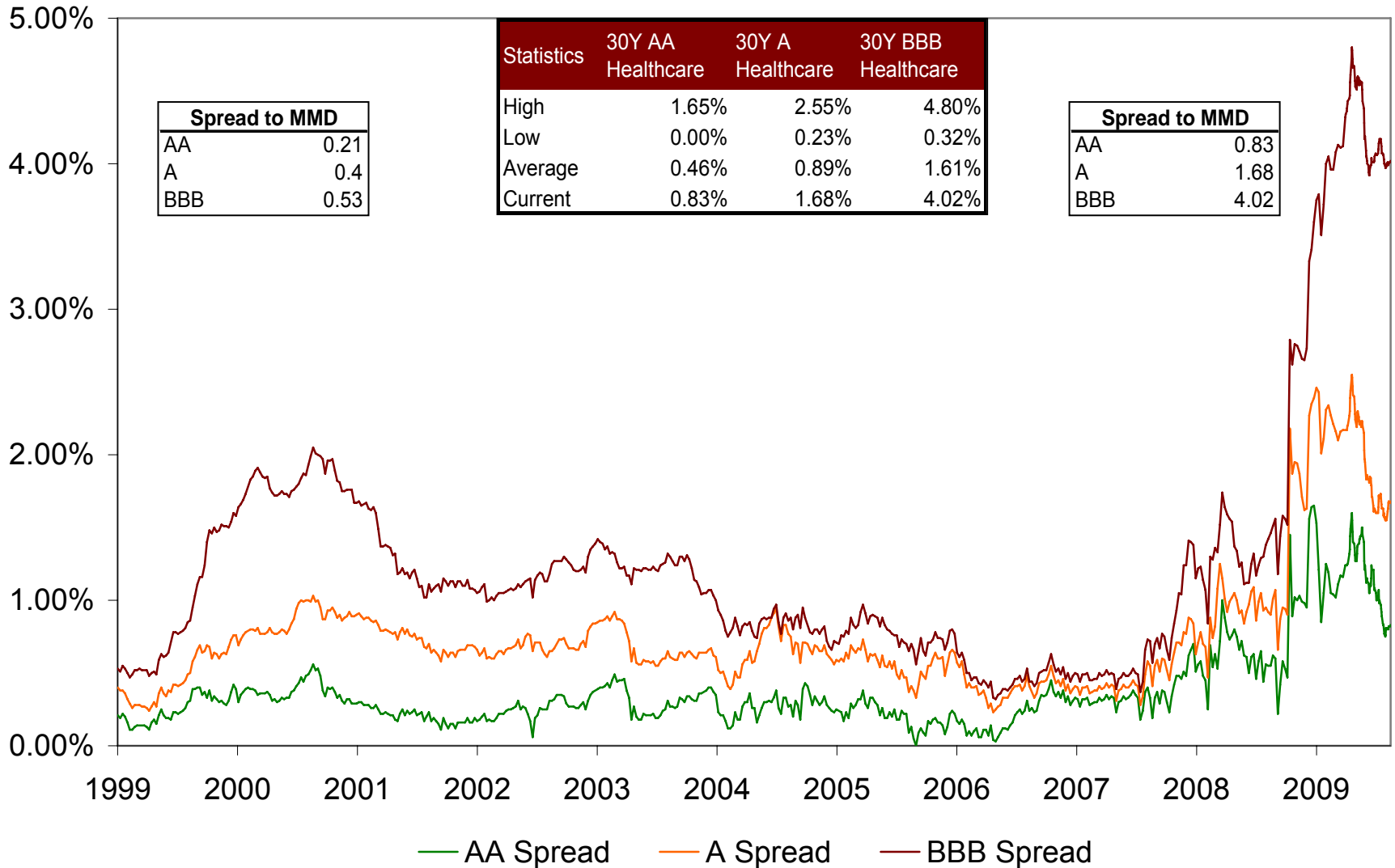


<sup>1</sup> Reflects market conditions as of August 12, 2009

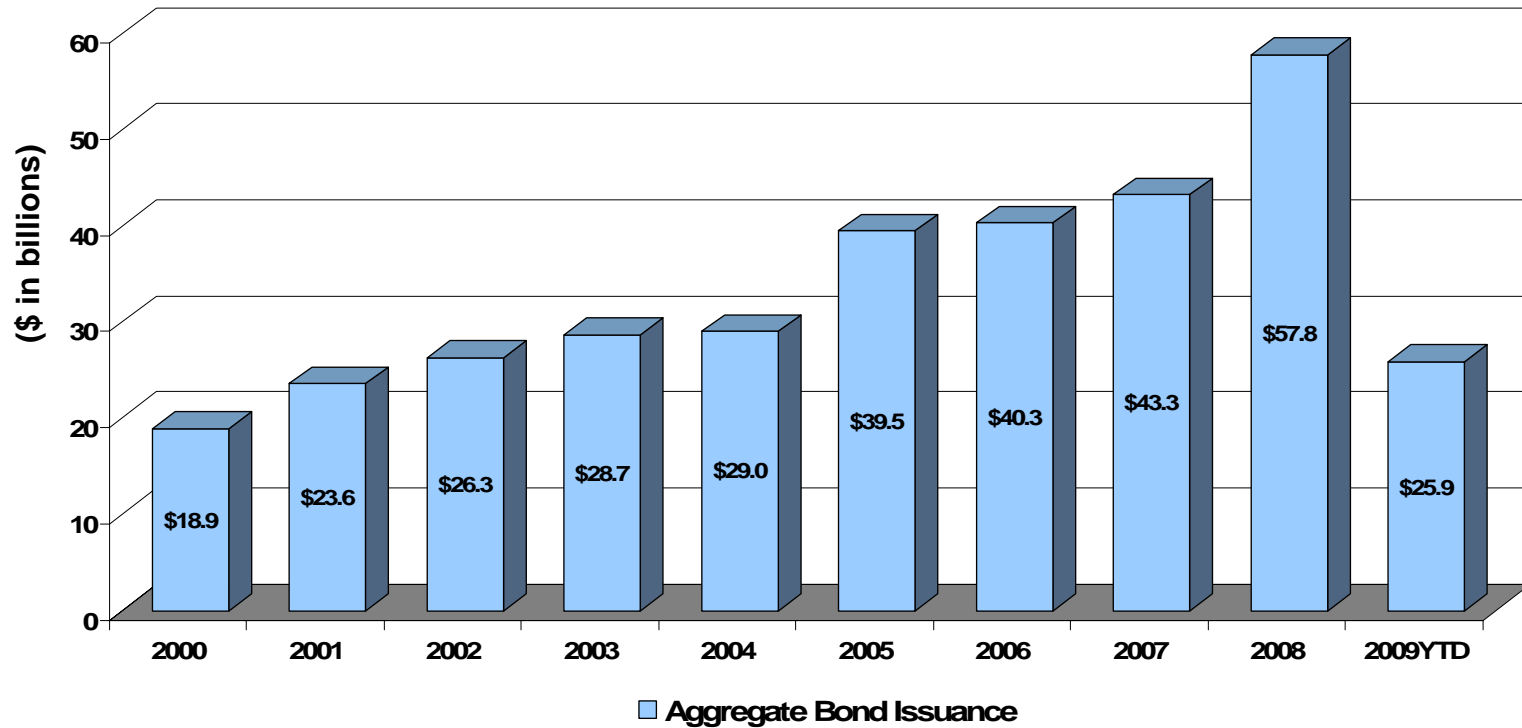
<sup>2</sup> The Revenue Bond Index (RBI) is based on 30-year bonds issued by 25 different revenue bond issuers for a variety of purposes including housing, transportation, hospitals and pollution control. The RBI is widely used as a benchmark for long-term revenue bonds

<sup>3</sup> The Securities Industry and Financial Markets Association (SIFMA) Index is calculated by taking the weighted-average of the clearing rates for 250 of high-grade tax-exempt short-term issues with weekly resets. The SIFMA Index is a widely used proxy for high-grade weekly bonds

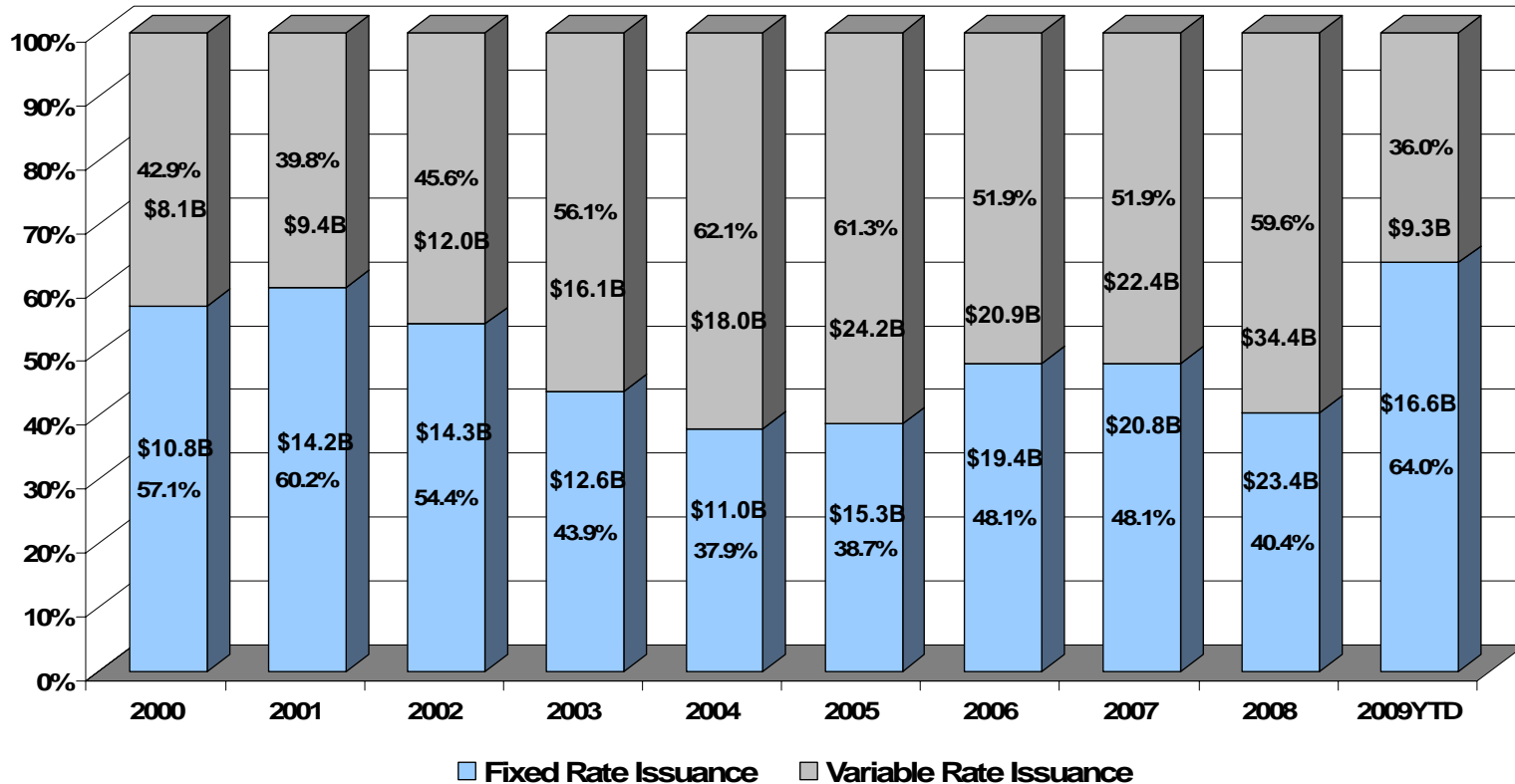
### 'AA', 'A', and 'BBB' Healthcare Credit Spreads over MMD 'AAA' Index



## Aggregate Health Care Bond Issuance



## Fixed versus Variable Health Care Bond Issuance



Source: Securities Data Corporation (as of 8/25/2009)

## Ongoing Adverse Macro Trends: Things You Already Know

- Aging population, but demand for inpatient services has been moderate
- Healthcare costs rising to unsustainable levels of our GNP
- Economic recession further limiting ability of the system to fund cost increases
- Uninsured patients continue to rise
- The rise of “super insurers” with 50%+ market share
- Fixed and variable cost pressures
- Physician shortages, competition and other factors leading hospitals to more physician employment strategies
- Demand for capital continues to be insatiable
- Uncertain impact of healthcare reform
- Economic jolts: pension funding, investment income losses, rising cost of capital, etc.

## Consequently, the Industry Has Experienced ...

### ***Significantly Strained Operating Performance***

1. Decreased volume – especially outpatient services and surgery
2. Bad debt/ charity care increases
3. Increased interest expense
4. Threatened state and federal cost containment efforts

### ***Considerable Pressure on Liquidity***

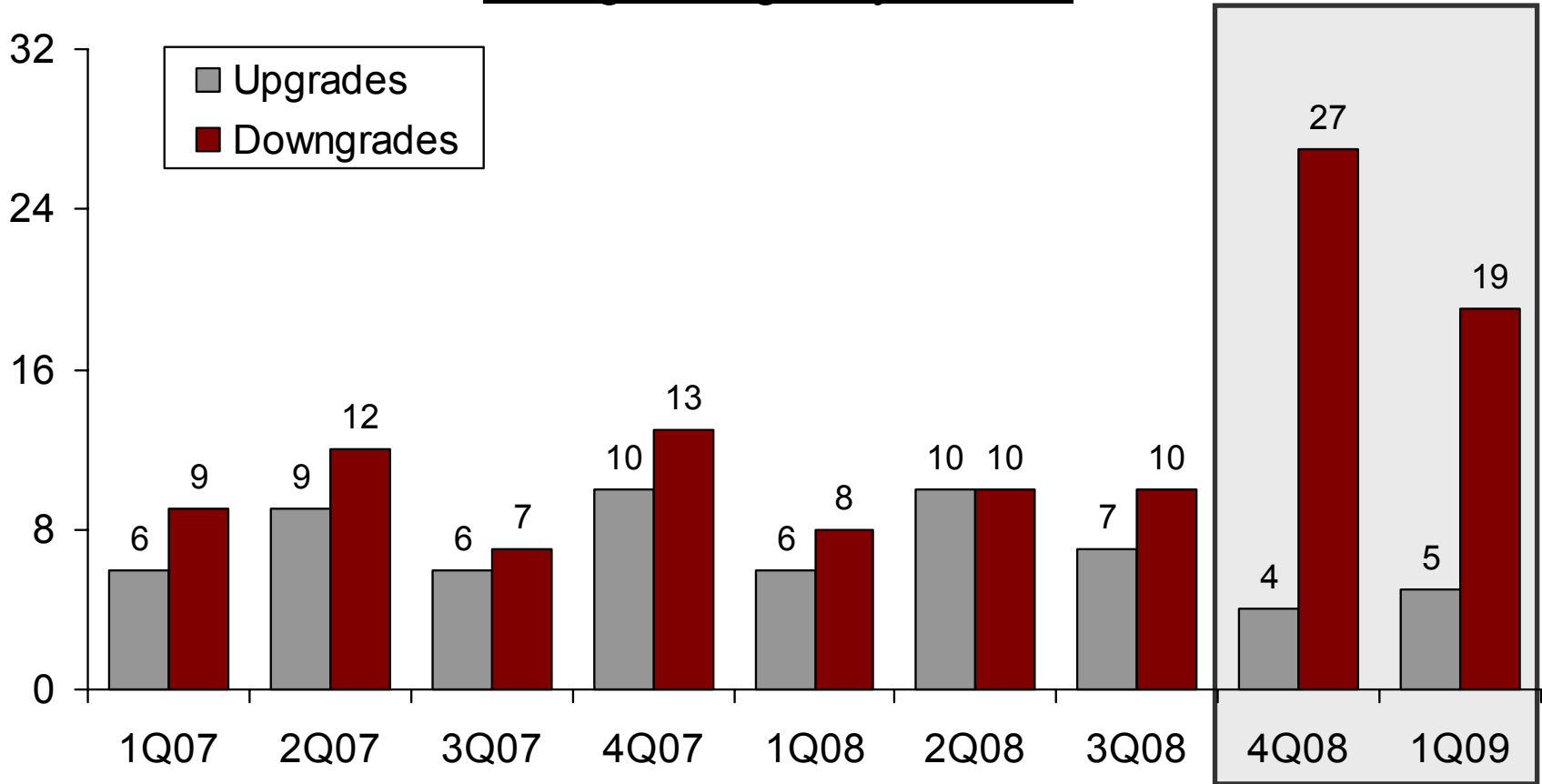
1. Cash and investments losses
2. Pension funding
3. Swap mark-to-market and collateral posting
4. Reduced operating performance

### ***Competitive Capital Needs Continuing to Outweigh Available Resources***

1. Physician alignment strategies: employment, joint ventures, etc.
2. Aging facilities and increasingly costly technology
3. IT requirements
4. Market consolidation

## First Quarter of 2009 Continues Downgrade Trend Experienced in the Last Quarter of 2008

Rating Changes by Quarter



Source: "Moody's Not-for-Profit Healthcare 2009 Quarterly Ratings Monitor",  
Moody's Investors Service, April 2009.

## Key Themes from Recent Negative Industry Outlooks

1. Access to capital is materially impaired and more costly
2. Variable rate debt structures and swaps add considerable risk
3. Investment portfolio losses are adversely impacting cash flow and cash, resulting in weakened balance sheets and less financial flexibility
4. Pension funding is a major financial concern for those with defined benefit programs (i.e., current market value ↓, discount rate ↓, earnings rate ↓)
5. Physician employment strategies are increasingly more important and prevalent, but are creating more demands on finite liquidity
6. Economic recession is reducing utilization and adversely impacting payor mix and bad debt
7. Expect more industry consolidation as the credit gap widens
8. More capital plans will need to go back to the drawing board given all of the above
9. Good management and governance now even more important

## Analytical Red Flags for All Not-for-Profit Hospitals

1. Decline in total operating revenue (same-store basis)
2. 30% decline in operating cash flow
3. Greater notional amount of swaps than debt
4. Days in account receivables rise to 100 and sustained at this level for two consecutive years
5. Failure to deliver audit six months after the fiscal year end; tardy interim statements
6. Qualified audit opinion
7. Technical default under bond covenants; covenant breach in bank documents
8. Unexpected change in CFO
9. Unexpected increase in debt (20% or more)
10. Investment allocation with more than 10% in one fund
11. More than 70% of debt is variable rate (before swaps)
12. Unusually high investment returns
13. Pension liability funded at less than 80%
14. Bank bonds with short payout or auction rate debt with high rates

## Rating Agency Industry Perspective Implications

- Negative rating agency outlook and increasing downgrade-to-upgrade ratio a continued concern to potential investors and credit enhancers
  - Further impact on market access, costs, covenants, and security provisions
- New emphasis on capital structure and investment portfolio event risk
  - Debt: variable interest rate volatility and put risk
  - Enhancers: rating, terms, LOC renewability, bank ability to fund a put, etc.
  - Investment portfolio: risk, returns, hedge fund investment liquidity, etc.
  - Documents: “springing” and default covenant trigger levels, etc.
- Heightened review of audit footnotes: off balance sheet structures, guarantees, operating leases, derivatives, etc.
  - “Off balance sheet” ≠ “off credit”
- Consistency, predictability, market position, management team accountability/ effectiveness, and balance sheet management continue to be key to credit
  - “Remember last meeting when you said . . .”
  - “Show me five years of operating budgets versus audited actual”
- Improved communication and forthright accurate disclosure are essential

## Moody's Minimum Performance Benchmarks: New Ratios and Near-term Expectation Levels

	<b>AA/Aa</b>	<b>A</b>	<b>BBB/Baa</b>
<b>Patient Volume</b>	Growing or flat	Declines up to 2%	Declines up to 4%
<b>Net Patient Revenue Growth</b>	> 4%	> 2%	Flat
<b>Operating Cash Flow Margin</b>	> 9%	> 7.5%	> 6%
<b>Days Cash on Hand</b>	> 190 days	> 115 days	> 90 days
<b>Cash to Debt</b>	> 140%	> 80%	> 55%
<b>Variable Rate Debt Level</b>	< 50%	< 35%	< 20%
<b>Cash to Puttable Debt</b>	> 150%	> 90%	> 70%
<b>Covenant Level Clearance</b>	> 55%	> 40%	> 25%

Source: Moody's U.S. Public Finance – Not-for-Profit Healthcare Rating Roadmap:  
Hospitals Under Stress, but Strong Management and Federal Stimulus May Mitigate Risks.

# Moody's Investors Service Recently Released Rating Roadmap

- Moody's released a new report in April 2009 to specifically address their rating methodology during market turmoil
- The four key factors identified by Moody's are: (1) weaker market demand and declining cash flow margins; (2) investment losses and weaker balance sheets; (3) debt structure and liquidity stress; and (4) market access problems
- These risk factors are offset by two risk mitigants: (1) management and governance actions; and (2) Federal government stimulus

Recession and Credit Market Risks: Health Care Rating Guidance										
Rating Category	Weaker Market Demand and Declining Cash Flow Margins		Investment Losses and Weaker Balance Sheet	Debt Structure and Liquidity Stress		Market Access Problems		Management and Governance Actions	Federal Government Actions	
Aa	Patient volume still growing or flat; net patient revenue growth at least 4%; bad debt expense growth no more than 30%	Operating Cash Flow Margin at least 9.0%	Days Cash at least 190 days; Cash-to-Debt at least 140%	Significant head-room under bank and swap covenants (at least 55% clearance); strong diversification of investment managers and funds, banks and counterparties		Unrestricted Cash-to-Putable-Debt at least 150%	Viable market access still assured although at elevated spreads	No more than 50% variable rate debt	<p>(1) NEAR-TERM ACTIONS: Evidence of operational, capital and liquidity decisions to mitigate effects of downturn even if impairment of cash flow or liquidity has not fully materialized yet, including establishing operating lines of credit with banks, restructuring debt structures, reducing or abating large capital projects to conserve cash.</p> <p>(2) LONG-TERM ACTIONS AND BOARD SUPPORT: Evidence that management and board agree to take defensive actions if needed; including changes in strategic plans for possible M&amp;A, capital program, compensation, staffing and clinical services; also including revisiting of investment allocation; consideration to change benefit pension plan</p>	<p>(1) STIMULUS PROGRAM: Stimulus Act is expected to help most hospitals in short-term to some degree through grants for information technology and expansion of COBRA insurance for unemployed; urban safety-net hospitals, children's hospitals, academic medical center likely to see greatest benefit given higher Medicaid and charity care</p> <p>(2) HEALTH CARE REFORM: Likely will provide broader healthcare coverage for previously uninsured although may come at the expense of more stringent Medicare reimbursement compliance and possibly lower profitability for each procedure as costs rise</p>
A	Patient volume declines limited to no more than 2%; net patient revenue growth at least 2%; bad debt expense growth no more than 15%	Operating Cash Flow Margin at least 7.5%	Days Cash at least 115 days; Cash-to-Debt at least 80%	Significant headroom under bank and swap covenants (at least 40% clearance); strong diversification of investment managers and funds, banks and counterparties		Unrestricted Cash-to-Putable-Debt at least 90%	Strained but still viable market access at much higher spreads	No more than 35% variable rate debt		

Source: Citi

# Overview of Key Risks

## Interest Rate Risk

- Risk that short-term rates will rise, resulting in an increased cost of funds on variable rate debt and variable rate components of outstanding interest rate swaps. Tax risk is subsumed in interest rate risk.

## Credit Enhancement Risk

- The possibility of bond insurer or letter of credit banks' credit deterioration resulting in investors either putting the securities or, if a put option is not available, requiring a significantly higher yield.

## Credit Risk

- Risk that adverse events in the hospital's financial performance would cause a deterioration in its credit profile and subsequently contribute to investors' unwillingness to buy or hold bonds or demands for yield premiums. Significant rating downgrades can also cause certain events in the hospital's swap portfolio and letter of credit arrangements

## Overview of Key Risks (continued)

### Put/ Acceleration Risk

- Risk that the put option on variable rate bonds will be exercised by the investor. In addition to the holder's ability to optionally put the bonds on irrevocable notice, a mandatory put would occur upon certain events such as a bank facility being replaced, terminated or maturing. The hospital may subsequently need to find an alternative source of financing or be forced to pay off the bonds on an accelerated basis.

### Liquidity Provider Risk

- The possibility of liquidity banks' credit deterioration resulting in investors either putting the securities or, if a put option is not available, requiring a significantly higher yield.

### Tax Risk

- The risk that tax reform or other market events cause tax-exempt variable interest rates to approach, equal, or exceeded the taxable variable interest rates.

### Product Risk

- Risk that events within a particular segment of the market would contribute to illiquidity or higher yields in the hospital's debt profile (e.g., auction rate securities).

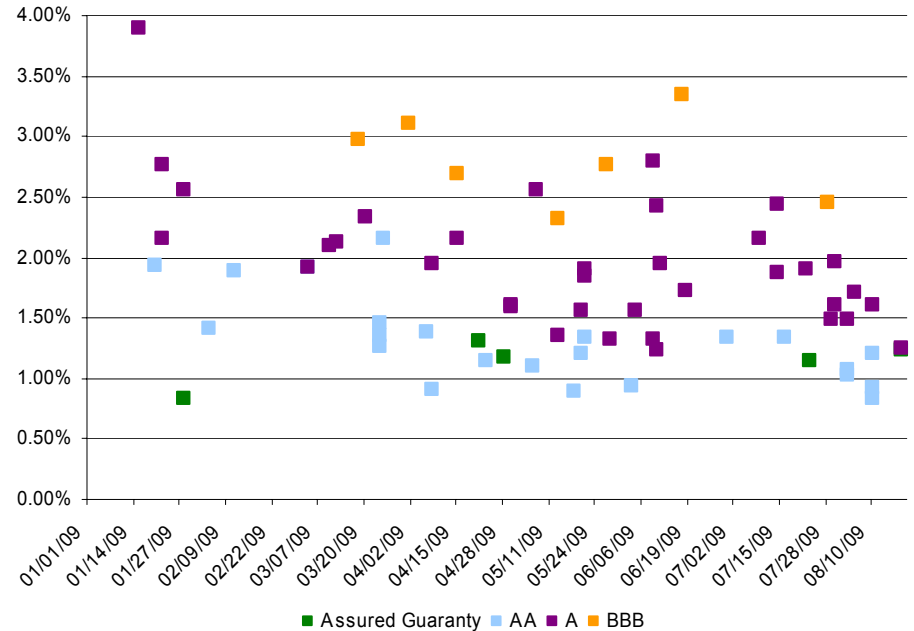
# An Updated Discussion of Debt Alternatives and Considerations

# Selected Recent Tax-Exempt Health Care Offerings

System	State	Par (\$MM)	Pricing Date	Final Maturity	Final Yield	Spread to MMD
<b>Assured Guaranty</b>						
WakeMed	NC	169.75	1/28/2009	2038	5.88%	0.84%
AnMed Health	SC	112.00	4/21/2009	2038	5.75%	1.31%
Virtua Health	NJ	379.65	4/28/2009	2038	5.63%	1.17%
Iowa Health System	IA	351.27	7/23/2009	2037	5.77%	1.15%
Jackson Health System	FL	83.32	8/18/2009	2039	5.80%	1.23%
<b>AA / Aa2 / AA</b>						
Baylor Health	TX	213.81	1/20/2009	2029	6.38%	1.94%
Northwestern Memorial Hospital	IL	371.84	3/24/2009	2039	6.20%	1.35%
Northwestern Memorial Hospital	IL	103.16	3/24/2009	2039	6.30%	1.45%
Inova Health System	VA	354.64	4/8/2009	2035	5.65%	0.91%
Central DuPage Hospital	IL	90.00	4/23/2009	2039	5.50%	1.15%
Partners HealthCare System	MA	125.00	5/6/2009	2022	4.56%	1.10%
Geisinger Health System	PA	157.00	5/18/2009	2039	5.30%	0.89%
Texas Children's Hospital Project	TX	200.00	6/3/2009	2039	5.58%	0.93%
Cleveland Clinic Health System	OH	804.95	8/10/2009	2039	5.58%	0.92%
<b>AA- / Aa3 / AA-</b>						
Baptist	KY	216.03	2/4/2009	2027	5.80%	1.42%
Miami Valley Hospital	OH	115.00	2/11/2009	2039	6.56%	1.89%
The Carle Foundation	IL	79.42	3/4/2009	2020	5.45%	1.92%
FirstHealth of the Carolinas	NC	45.51	3/24/2009	2039	6.13%	1.27%
Reid Hospital	IN	99.85	3/25/2009	2039	7.00%	2.15%
Luther Hospital (Mayo Clinic)	WI	90.00	4/6/2009	2030	5.96%	1.38%
Hoag Memorial Hospital Presbyterian	CA	66.84	5/20/2009	2024	4.70%	1.21%
University of Pittsburgh Medical Center	PA	400.00	5/21/2009	2039	5.69%	1.34%
Children's Medical Center of Dallas	TX	200.00	6/18/2009	2039	6.00%	1.34%
University of Pennsylvania Health	PA	89.06	7/16/2009	2023	4.91%	1.34%
University of Chicago	IL	85.00	8/3/2009	2039	5.70%	1.02%
Seattle Children's Hospital	WA	115.17	8/3/2009	2038	5.73%	1.07%
St. Joseph Health System	CA	254.41	8/10/2009	2039	5.87%	1.21%
Carolinas HealthCare System	NC	222.65	8/10/2009	2039	5.49%	0.83%
<b>A+ / A1 / A+</b>						
Swedish Health Services	WA	100.00	3/4/2009	2033	6.73%	1.92%
Deaconess Hospital	IN	57.34	3/10/2009	2039	6.95%	2.10%
All Children's Hospital	FL	64.38	4/8/2009	2039	6.72%	1.95%
ProHealth Care, Inc.	WI	139.06	4/15/2009	2039	6.87%	2.16%
Presbyterian Intercommunity Hospital	CA	58.00	5/7/2009	2017	5.10%	2.56%
Kaiser Permanente	CA	750.00	5/21/2009	2019	4.68%	1.90%
Theda Care	WI	126.59	5/28/2009	2038	5.81%	1.33%
MidMichigan Health	MI	80.22	6/4/2009	2039	6.20%	1.56%
Adventist Health System	KS	330.39	6/10/2009	2038	5.95%	1.24%
Meriter Hospital	WI	50.00	7/29/2009	2038	6.15%	1.48%
CHRISTUS Health	LA	156.01	7/30/2009	2029	6.13%	1.97%
Dartmouth-Hitchcock	NH	134.92	8/3/2009	2038	6.15%	1.49%
Parkview Health System	IN	265.53	8/10/2009	2031	5.98%	1.61%
Sarasota Memorial Health System	FL	103.89	8/18/2009	2039	5.82%	1.25%
<b>A / A2 / A</b>						
William Beaumont Hospital	MI	393.00	1/15/2009	2039	8.65%	3.90%
Fred Hutchinson Cancer Center	WA	90.00	1/22/2009	2038	7.63%	2.76%
University Hospitals Health System	OH	175.00	3/12/2009	2039	7.00%	2.12%
OSF Healthcare System	IL	124.99	3/20/2009	2037	7.25%	2.33%
Catholic Healthcare West	CA	339.12	4/30/2009	2039	6.15%	1.61%
Catholic Healthcare West	AZ	50.91	4/30/2009	2039	6.13%	1.59%
Legacy Health System	OR	113.86	5/13/2009	2035	5.75%	1.36%
Oregon Health and Science University	OR	158.51	5/20/2009	2039	5.96%	1.56%
Baystate Medical Center	MA	63.38	6/9/2009	2036	6.00%	1.32%
Children's Hospital of Orange County	CA	139.57	6/11/2009	2038	6.70%	1.95%
Pinnacle Health System	PA	193.88	6/18/2009	2036	6.39%	1.72%
Franciscan Missionaries of Our Lady	LA	125.00	7/14/2009	2039	7.00%	2.44%
University of Colorado Hospital Authority	CO	51.80	7/15/2009	2029	6.07%	1.51%
University Hospitals Health System	OH	60.04	7/30/2009	2039	6.30%	1.61%
Riverside Health System	IL	66.50	8/5/2009	2035	6.32%	1.71%

System	State	Par (\$MM)	Pricing Date	Final Maturity	Final Yield	Spread to MMD
<b>A- / A3 / A-</b>						
Anne Arundel Health System	MD	120.00	1/22/2009	2039	7.15%	2.15%
Rush University Medical Center	IL	176.27	1/28/2009	2038	7.60%	2.56%
Evangelical Lutheran Good Samaritan Society	CO	80.98	5/21/2009	2038	6.20%	1.85%
Albert Einstein Healthcare Network	PA	148.02	6/9/2009	2023	6.50%	2.79%
Health First, Inc.	FL	85.85	6/10/2009	2039	7.10%	2.42%
Rush University Medical Center	IL	200.00	7/9/2009	2039	6.72%	2.16%
Sharp Healthcare	CA	140.00	7/14/2009	2039	6.43%	1.87%
Memorial Healthcare (CO Springs)	CO	101.95	7/22/2009	2033	6.40%	1.90%
North Shore Long Island Jewish Obligated Group 2009A	NY	235.62	8/26/2009	2037	5.75%	1.23%
North Shore Long Island Jewish Obligated Group 2009E	NY	60.89	8/26/2009	2033	5.70%	1.28%
<b>BBB+ / Baa1 / BBB+</b>						
Mountain States Health	TN	115.96	3/18/2009	2038	7.95%	2.97%
Butler Health System	PA	75.99	4/15/2009	2039	7.40%	2.69%
University Medical Center Corporation	AZ	61.80	5/13/2009	2039	6.75%	2.32%
Provena Health	IL	200.00	6/17/2009	2034	8.00%	3.35%
<b>BBB / Baa2 / BBB</b>						
University of Medicine & Dentistry	NJ	258.08	4/1/2009	2032	7.80%	3.11%
Silver Cross Hospital and Medical Center	IL	260.00	5/27/2009	2044	7.25%	2.76%
Central Washington Health Services	WA	116.54	7/28/2009	2039	7.17%	2.45%

Recent Spreads to MMD:



## So How Is Access to Capital Different in Today's Environment ?



### *Lending*

- Not as much credit to lend since lenders' liquidity, credit rating and capital access is down
- Tighter restrictions on who can borrow, how much and under what terms
- Lenders' balance sheets are pressured, so their own capital costs have increased, requiring their returns on capital from loans to be higher

---



### *Borrowing*

- Harder to find dollars to borrow; fewer institutions with dollars to lend
- Higher costs and tighter terms
- Try to borrow now, or just wait?
- True across all sectors: municipal and corporate markets
- Off balance sheet  $\neq$  off credit; looking at all types of obligations

## Now What... Unclear What Happens from Here

- Are we at the “bottom” of bank credit deterioration or is there more dislocation to come? Who will be the long-term survivors?
- Which investment banks will survive? What will it now cost borrowers to do business with less bank competition in a more difficult market?
- Will investors and borrowers support a bond insurer recovery?
- Is the recent improvement in the variable rate debt market sustainable?
- When will investors reliably return to buying fixed rate bonds? At what cost and under what terms? Who will have access?
- What should we do about existing swaps? What future opportunities will be available?
- How will healthcare borrowers perform going forward?
- How will contemplated strategic and facility plans change prospectively?
- How will the rating agencies react to all of the above?

## Long-Term, Fixed-Rate Investor Perspective

- Institutional funds
  - Volatile mutual fund cash in/ outflows and devaluation of existing bond investment portfolios in 2008 and 2009, but seem to be improving
  - Long-term healthcare bonds were illiquid in the secondary market at the end of 2008 – still a concern to any prospective primary bond market investor
  - True equilibrium and price discovery has yet to be established (uncertain MMD rate and credit spreads), but successful bonds placements particularly with stronger credits
- Underlying credit/ market fundamentals will matter most, so expect to speak with buyers more diligently looking for highly rated and clear long-term market winning borrowers
  - Extended pre-marketing period (full one to two weeks)
  - Investor calls and possibly in-person investor meetings/ road shows, depending on credit
  - Heightened review of Appendix A and credit reports
- Significant buying opportunity for retail investors (10% tax adjusted, in some cases)

## Long-Term, Fixed-Rate Investor Perspective (continued)

- Expect a total buyer's market – now is not the time to cut corners and push the edge on security, structure, covenants, and disclosure
  - Security structure expectations
    - ✓ Revenue pledge a given for all credits
    - ✓ Mortgages for most “A” and lower credits (plan ahead, this takes time)
    - ✓ Debt service reserve funding for nearly all “A+” and lower credits
  - Covenants and structuring matter a lot more to fixed rate investors
    - ✓ Emerging use of liquidity and debt-to-capitalization covenants
    - ✓ Tightening thresholds for additional debt, asset disposition, senior liens, etc.
    - ✓ Parity with existing commercial bank LOC and insurer covenants an emerging trend (be prepared to address this head-on during investor calls)
  - Structure
    - ✓ 40-year amortizations not likely to sell; buyers appear to be more retail oriented
  - Disclosure matters
    - ✓ 45 to 60 days quarterly (yes, all 4 quarters) and 120 to 150 days audit
    - ✓ Direct obligation to investors in many cases now
- Insured options may add value: Assured Guaranty/ FSA and FHA/ HUD 242; Cal Mortgage/ OSHPD (but concern resulting from State rating downgrade)

## Short-Term, Variable-Rate Investors Stepping Up, but Selectively

- VRDBs supported by “good banks” are currently very attractive
  - “Good banks” have the highest ratings (perceived staying power) and are not overexposed in the LOC market
  - Recent market rates have been around 125 to 130 bps (for A rated hospitals)
  - Nearly all insured variable rate paper tainted
- Documentation/ structuring details under heightened review
  - What exactly happens if the remarketing agent resigns or goes out of business and a replacement can’t be found?
  - What exactly happens if the bonds are put and the bank can’t cover?
  - How close is the borrower to a downgrade triggering LOC termination?
- Auction market dislocation
  - If you’re sitting on low max rate programs, consider:
    - ✓ Continued insurer downgrades will drive the multiplier factor up considerably
    - ✓ Some documents require remediation after so many periods of a failed auction

## Bank Letters of Credit Are Still Available, but More Challenging

- For borrowers considering letters and lines of credit, expect:
  - Current relationship bank(s), if highly rated, will likely be your best partner (one-off lenders to non-comprehensive clients are very infrequent)
  - Less capacity for any one borrower (generally \$50 to \$85 million for a stand-alone hospital, perhaps more for systems and highly rated stand-alone hospitals)
    - ✓ Bank syndication available on a “best efforts” basis, but more complicated and costly
    - ✓ Higher pricing: liquidity at 40 to 70 bps and LOCs from 90 to 150+ bps annually
  - Shorter renewal cycles (364-day to 3 years versus 5 to 7+ years in 2007)
    - ✓ Annual evergreen renewal provisions very helpful
    - ✓ Insist on “real” term-out provisions in the event of a remarketing failure – 3 to 5 years
  - Restrictive and highly negotiated covenants, security, and termination provisions
    - ✓ Be mindful of insurer (e.g., “AA-”) and borrower rating (e.g., “A-”) downgrade termination triggers
  - Possible subjective consent provisions (e.g., issuing new debt, asset disposition, mergers, joint ventures, sale lease back transactions, etc.)
  - Tie-in with other banking services (e.g., commercial business account management, investment management, and other fee-generating services)

# A Reminder of Primary Variable Rate Demand Note Risks

Risk	Mitigating factors	Options
<b>Interest rate increase</b>	<ul style="list-style-type: none"> <li>Fixed payor swaps, if in place, may act as a hedge against general rate inflation via short-term LIBOR assuming a correlation is maintained</li> <li>Portfolio returns on any short-term/ fixed-income investments</li> </ul>	<ul style="list-style-type: none"> <li>Stay the course</li> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> </ul>
<b>Tax rates decline</b>	<ul style="list-style-type: none"> <li>None, but seems very unlikely in the near term</li> </ul>	<ul style="list-style-type: none"> <li>Stay the course</li> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> </ul>
<b>Healthcare industry risks</b>	<ul style="list-style-type: none"> <li>Bank LOC enhancement will shield most, but not all, of the interest rate risk (however, healthcare industry risks may affect cost or availability of the bank LOC)</li> </ul>	<ul style="list-style-type: none"> <li>Stay the course</li> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> </ul>
<b>Borrower credit downgrade</b>	<ul style="list-style-type: none"> <li>Bank LOC usually okay if Borrower is at least mid “A” category or higher (will affect pricing and availability, though)</li> </ul>	<ul style="list-style-type: none"> <li>Stay the course</li> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> </ul>
<b>Bank downgrade</b>	<ul style="list-style-type: none"> <li>Use highly rated banks</li> <li>Ability to replace LOC provider if alternates exist</li> </ul>	<ul style="list-style-type: none"> <li>Stay the course</li> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> <li>Replace LOC provider</li> </ul>
<b>Bank LOC renewal</b>	<ul style="list-style-type: none"> <li>Maintenance of Borrower’s credit rating in the “A” category or better</li> <li>Use relationship bank</li> <li>Ability to replace LOC provider</li> <li>Add “evergreen” provisions or longer-dated renewal terms (5 years, if available)</li> </ul>	<ul style="list-style-type: none"> <li>Stay the course</li> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> <li>Replace LOC provider</li> </ul>
<b>VRDN market demand/ supply concerns and dislocation</b>	<ul style="list-style-type: none"> <li>Historical stability/ marketability of VRDN market up until now</li> <li>VRDNs have traded very well over the last 17 years at an average of 3.09% with a range of 0.50% to 7.89%</li> </ul>	<ul style="list-style-type: none"> <li>Stay the course</li> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> </ul>
<b>Failed debt remarketing (bank put)</b>	<ul style="list-style-type: none"> <li>Bank term out provides time to fix (depending on the course of the put – bank, market, remarketing agent, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Stay the course</li> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> <li>Replace LOC provider</li> </ul>
<b>Inability of bank to fund a bond put</b>	<ul style="list-style-type: none"> <li>Check documents for provisions and procedures as to whether this is an event of default</li> </ul>	<ul style="list-style-type: none"> <li>Refinance to fixed (more expensive)</li> <li>Cash prepayment</li> <li>Replace LOC provider</li> </ul>

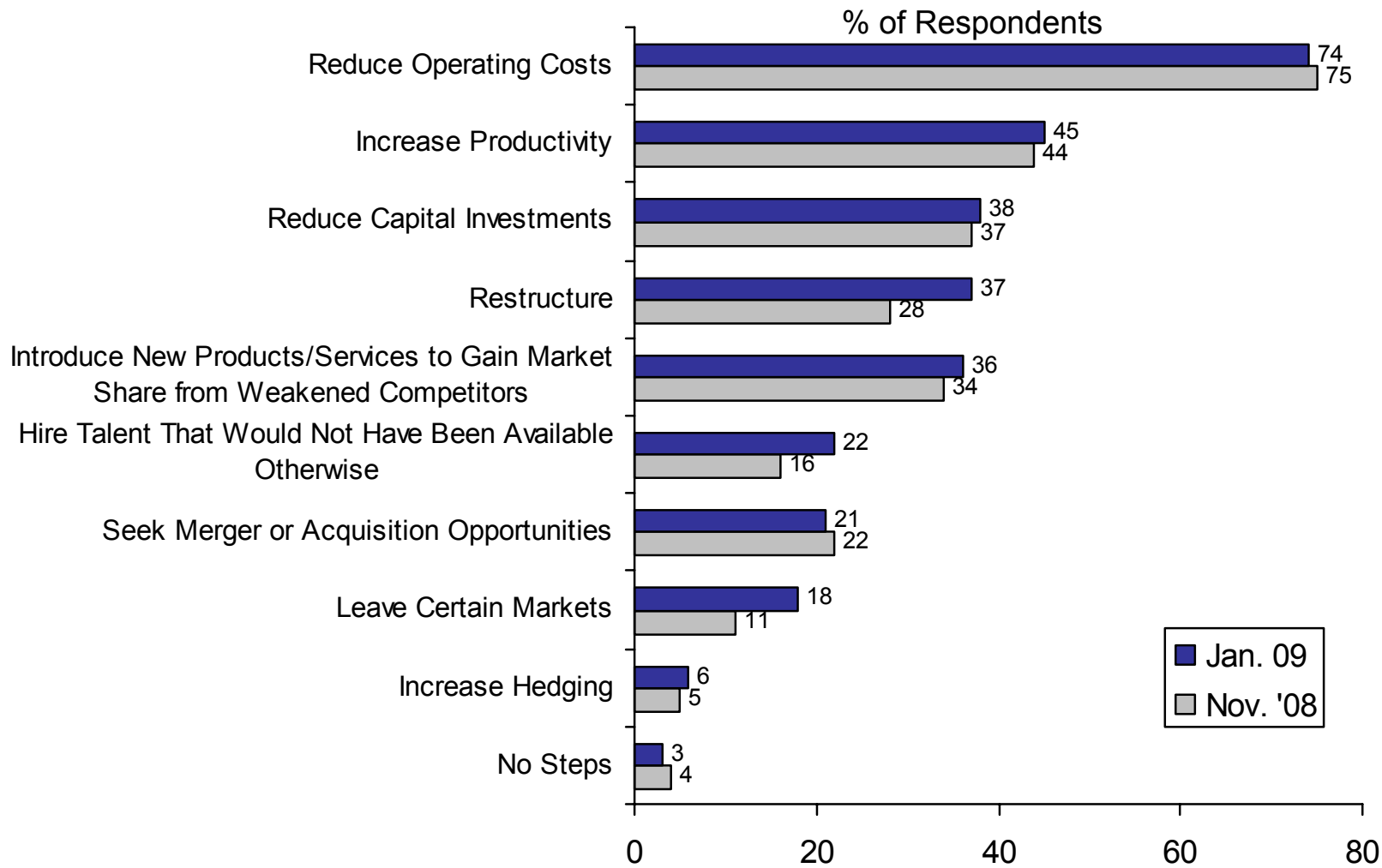
**Additionally, rating agencies have expressed considerable “event risk” concern**

## Increasingly Unpleasant Choices for Healthcare Borrowers

1. Load up on bank risk and VRDB exposure
  - Uncertain if/ when market will return to historical levels
  - Nearly impossible to predict which banks will survive
  - Costs, access, renewal, capacity and terms will be even more difficult
  - In the end, it's totally uncommitted capital
2. Lock-in higher than expected cost of fixed rate funds and increasingly unattractive covenants and security
  - Uncertain what the buyer market will really look like
3. Use higher cost, shorter amortizing bank loans, private placements or leasing vehicles, if capacity even exists
4. Use cash to fund capital spending and/ or pay off variable debt
5. Suspend capital investment
6. A little bit of all of the above

# 2009 Repositioning Actions: Operations, Balance Sheet and Capital Structure

# What Are Organizations Doing to React to the Economic Turmoil?



Note: January 2009 sample size is 1,820; November 2008 sample size is 1,424. The survey was conducted of executives from around the world who represent a full range of industries and functional specialties. Source: "Economic Conditions Snapshot, February 2009: McKinsey Global Survey Results," *The McKinsey Quarterly*, February 2009.

## 2009 Repositioning: Cash Flow Improvement Strategies

- Maximizing revenue from current contracts
  - Sophisticated revenue-cycle management strategies
  - Improved patient registration and payment processing
  - Upfront payment for non-emergent cases that present in the ED
  - Improved qualification of state and federal payment programs
  - Better documentation of charity care to qualify for disproportionate share payments
  - Purchase/ lease software to monitor managed care payments vs. contract terms
- Focus on expense controls
  - Reduction in force
  - Supply chain management
  - Reduced use of agency/ traveler nurses through flexible work hours, part-time arrangements, and in-house nursing pools
  - Convert to a defined contribution plan from a defined benefit plan (long-term impact)
  - Elimination of employer directed defined contribution in 2009
  - Reduction of discretionary expenses
- Elimination of non-core services operating at a loss
  - Long-term care, skilled nursing, behavioral health, etc.

## 2009 Repositioning: Balance Sheet Improvement Strategies

- Capital allocation process redesign
  - Redesign of capital allocation process to a more corporate approach emphasizing analytical rigor, incremental net present value return, and future accountability
  - Deferment, downsizing or elimination of large strategic capital plans that do not provide adequate return on investment
- Monetization of non-core assets/ service lines
  - Real estate: medical office buildings, surplus property, etc.
  - Services: home health, hospice, skilled nursing, nursing homes, behavioral health, rehab, etc.
  - Managed care plans
- Reconsideration of investment strategy
  - Reconsidering risk, liquidity and return in asset portfolio allocation decisions
  - Caution: repositioning investment strategy could trigger realized losses and covenant defaults, thereby tripping lock boxes, springing reserve funding, etc.
- Better Working Capital Management
  - More focused attention to A/R improvement and extended A/P processing cycle
  - Bank working capital lines of credit

## 2009 Repositioning: Capital Structure Strategies

- Protecting credit rating = better capital access, cost and flexibility
  - Balancing act amongst difficult trade-offs to keep the financial house in order: both income statement and balance sheet
  - Enact strategies to avoid or mitigate moody's 14 “red flags”
  - Set and achieve targets to surpass minimally acceptable performance benchmarks
- Revisiting capital structure: mix, risks, costs, products and covenants
  - Rebalance fixed/ variable mix: de-leveraging from uncommitted underlying variable rate capital structures in excess of 50% over time (reduction in risks: own credit, bank renewal, market interest rate, bond remarketing/ put, bank/ swap counterparty, market dislocation, etc.)
  - Plan for higher costs: operating and borrowing plans must account for greater proportions of higher cost committed fixed rate debt (6% to 8%) with fully funded debt service reserve funds and/ or higher cost bank letters of credit on variable rate debt
  - Consider alternate products: FHA/ HUD 242, assured guaranty, bank direct lending, operating leases, build America bonds (non 501(c)(3) issuers, etc.)
  - Carefully monitor covenants: covenant expectations are much higher in today's market and compliance risk is becoming a major concern

## Must-Do Actions for Management

1. Reassess strategic and financial position
2. Re-examine strategic plans
3. Think the big think
4. Consider risk

# 1. Reassess Strategic and Financial Position

Key questions to be addressed:

- How has utilization of inpatient and outpatient care changed? How has our payor mix changed? What do expect utilization to be in 2009 and beyond?
- How have our competitors been impacted? What strategies are they likely to pursue and how will that impact our organization?
- How have our physician's been affected? Do we expect physicians to increasingly seek the security of employment models in uncertain times? Will physician joint venture partners look to unwind their positions and "cash out?"
- How much damage has occurred to our credit profile and balance sheet? What level of performance do we expect for 2009 and beyond?

## 2. Re-examine Strategic Plans

Build an in-depth, impartial understanding of your organization's market position, key market trends, and likely future developments. Develop strategies within market and financial realities, with a clear understanding of the financial impact, including:

- Facility projects
- Business/ program/ service portfolio analysis
- System-wide service line plans
- Physician strategies
- Reset priorities
- Strategic partnerships

**Build upon specific programs, services, markets, and/ or other characteristics that distinguish you from your competitors**

**Do not count on strategic plans that require the complete cooperation of the capital markets. External events can easily disrupt such strategies, leaving no acceptable alternatives. Extremely thoughtful visioning is required now, accompanied by very strategic, very careful capital spending**

### 3. Think the Big Think

#### Key Considerations

- Consolidation strategies
- Multispecialty group formation and management
- Exploring alternative delivery models
- Care and disease management as a core competency
- IT infrastructure development

## Consolidation Strategies



- Many of the weaker providers have been pushed over the edge and now are turning to consolidation as a survival strategy and a means to carry forward the organization's mission
- Strong, small, independent providers are now re-evaluating their ability to stand-alone – particularly those in need of significant capital
- Some larger, stronger systems are looking at the downturn as a time to re-evaluate their portfolio of operations – pursuing opportunities to consolidate the market as well as divesting underperforming businesses

## Wave of Consolidation Is Foreseeable During the Current Economic Downturn

**The trend of large, well-funded health systems acquiring smaller, struggling hospitals continues. Some recent acquisitions by large systems include:**

<b>Arizona</b>	Banner Health purchased Sun Health in September 2008
<b>California</b>	St. Joseph Health System acquired South Coast medical Center in Laguna Beach from Adventist Health (announced Nov. 2008)
<b>Indiana</b>	Clarian Health acquiring Cardinal Health (announced Sept. 2008) and negotiating the addition of Bloomington Hospital to the System
<b>Illinois</b>	Advocate added Condell to its system. In discussion with BroMenn Healthcare System and Rockford Health System (both announced December 2008) Northwestern Memorial to affiliate with Lake Forest Hospital (November 2008)
<b>Louisiana</b>	Opelousas General Health System acquiring Doctors' Hospital of Opelousas by year-end 2008/early 2009 (announced Nov. 2008)
<b>Maryland</b>	John's Hopkins Health System announced acquisition of Suburban Health System (April 2009)
<b>New York</b>	Montefiore Medical Center completed the acquisition of Our Lady of Mercy in July 2008
<b>Oregon</b>	Providence Health & Services to merge with independently owned Willamette Falls Hospital in Oregon City (announced Nov. 2008)
<b>Pennsylvania</b>	Community Health Systems, Inc. acquires Wyoming Valley Health Care Systems (May 2009)
<b>South Dakota</b>	Sanford Health to acquire Canton-Inwood Memorial, an 18-bed critical access hospital (announced Sept. 2008)
<b>Virginia</b>	Novant announced acquisition of Prince William Hospital (March 2009)
<b>Washington</b>	Community Health Systems completed the acquisition of Empire Health in October 2008

# Multispecialty Group Formation and Management

## - Key Issues

**Independent Physicians**

Migrating independent physicians into the employed group

**Recruitment**

Establishing a successful recruitment package and process

**Leadership**

Securing the right leadership – both physician and administrative

**Infrastructure**

Developing effective practice management infrastructure (e.g., billing, IT, care management protocols, etc.)

**Service Distribution**

Balancing access and efficiency considerations in defining both primary care and specialty service distribution

## Care and Disease Management as a Core Competency

- Managing chronic conditions has not typically been a major focus of healthcare providers in the past
- However, given the national health status and the increasing prevalence of chronic disease (specifically Diabetes, Heart Disease, Asthma, and Cancer, among others), it is becoming increasingly important to manage these conditions on an ongoing basis
- Focusing on the broader health of the patient (not only a specific acute episode) will be important for providers' future success

### Disease Management

#### Current Payment System

- Incentives are not to treat patient with multiple office visits, but rather during an acute setting and/or procedure

#### Bundled Payment System

- Requires integration among physicians and other providers
- Incentives are to manage the disease and prevent excess utilization

## Sound Capital Management Embraces Three Sources of Risk



- **Business operations risk**
  - Industry
  - Service area
  - Institution-specific operations
- **Investment risk**
  - Institutional decisions
  - Global capital markets
  - Domestic capital markets
- **Financial/ capital risk**
  - Debt structure decisions
  - Absolute borrowing rates
  - Fixed versus floating rates

**These three risks equal an organization’s affordable “risk budget” and thus need to be balanced and offsetting. The stronger the credit, the larger the affordable “risk budget”, given the implied greater “room for error.”**

# Appendix

## Ellen G. Riley, *Senior Vice President*

Ellen Riley is a Senior Vice President of Kaufman Hall and has worked out of the Los Angeles office since 1988. She has over 25 years of experience in the healthcare industry. Her experience and responsibilities include developing and providing senior level consulting in all aspects of strategic financial and capital planning, development of capital allocation processes and providing financial advisory services in support of debt transactions and business valuations. Ms. Riley has worked with a diverse group of clients including healthcare systems, academic medical centers, specialty hospitals, community hospitals and children's hospitals.

Ms. Riley is a regular speaker on healthcare finance topics at Healthcare Financial Management Association regional and local chapter educational programs, National Association of Children's Hospitals and Related Institutions, National Council of Health Facilities Finance Authorities and Healthcare Transactions. Additionally, Ms. Riley has been a guest lecturer on healthcare finance topics at the University of California, Los Angeles School of Public Health to graduate students in the Masters of Public Health program. Ms. Riley is currently serving as a member of the USC School of Policy, Planning and Development's Health Advisory Board and is an adjunct professor teaching for the USC School of Policy, Planning and Development's Health Administration program.

Prior to joining Kaufman Hall, Ms. Riley was a Manager in the Los Angeles office of Ernst & Young in the firm's Western Region Healthcare Finance and Business Planning Group. During her six years at Ernst & Young, Ms. Riley directed consulting engagements for healthcare organizations in the areas including financial feasibility assessment, business evaluation and planning, capital planning and formation, acquisition valuation and Certificate of Need preparation.

Before joining the consulting practice at Ernst & Young, Ms. Riley was a Project Analyst in the Corporate Acquisitions and Development Department at National Medical Enterprises, Inc. in Santa Monica, California. In that capacity, she was responsible for financial analyses and due diligence related to hospital acquisition and development projects.

Ellen holds a Masters of Business Administration from the University of Southern California, Graduate School of Business Administration in finance and marketing and a Bachelor of Arts from the University of California at San Diego, graduating with high honors, *Magna Cum Laude*.

(310) 426-2801  
eriley@kaufmanhall.com

## Charlie Plimpton, *Director, Healthcare Finance Group*

Charlie has 28 years of experience in providing investment banking services to healthcare organizations. He is serving as lead banker to major provider organizations in the West coast, including: Scripps Health (CA); Hoag Memorial Hospital Presbyterian (CA); MemorialCare (CA); Daughters of Charity Health System (CA); Legacy Health System (OR); Swedish Health Services (WA); University of Colorado Hospital (CO); and Exempla, Inc. (CO).

The types of engagements he has managed include taxable and tax-exempt financings, merger and acquisition transactions and comprehensive asset and liability management advisory services. He is a featured speaker at seminars and Board retreats.

Charlie received his B.A. from the University of Pennsylvania and his M.B.A. from Amos Tuck School of Business at Dartmouth.

(213) 486-8856

## Christian E. Stein, III, *Vice President and Team Leader*

For the past 13-plus years, Mr. Stein has facilitated financings for a variety of healthcare service providers in roles including both investment and corporate banking. Mr. Stein is a Vice President and Team Leader in U.S. Bank's Corporate Healthcare Division, responsible for all Non-Profit Healthcare relationships in the western half of the US. In his role as a Relationship Manager, Mr. Stein directs all aspects of each relationship including credit, depository/ treasury management, corporate payment systems, healthcare payments, trust, etc.

Mr. Stein's portfolio consists primarily of large Non-Profit healthcare systems and as of September 1, 2009, his credit commitments exceeds \$1 billion. Mr. Stein holds a B.S. in Information Management from Washington University and a Master of Finance from St. Louis University. Both degrees were conferred with final honors.

(314) 418-2711