WHITE PAPER

APRIL, 2009

The typical hospital's business model and revenue stream are so markedly different from other businesses, its level of financial distress can be difficult to diagnose. The following early warning signs will help hospital leaders as well as bond professionals more clearly identify and proactively react to financial distress. While no single metric can accurately identify early-stage distress in all hospitals, the following financial, operational, and market indicators can offer helpful insight into the outlook of a hospital that might be in trouble.

Early Warning Signs of a Distressed Hospital

What bond professionals, healthcare attorneys, and other stakeholders need to know about early identification of financial distress in hospitals and health systems.

www.intensiveresources.com 888.766.2799
105 Continental Place Brentwood, TN 37207

QHR INTENSIVE RESOURCES

HEALTHCARE CRISIS IN AMERICA

Many American hospitals and health systems are in jeopardy. The cost of providing medical care is rapidly increasing, and resources that have traditionally paid health costs are drying up.

Healthcare spending rose to $2.4 trillion in 2008, representing a 9% increase over 2007, according to Centers for Medicare and Medicaid Services (CMS) projections[1]. By comparison, America's gross domestic product increased by only 3.5%. The same CMS report predicted health spending could reach $4.4 trillion by 2018, and that public payers are expected to cover more than half of that burden. Projections from the report and other sources indicate Medicare insolvency could occur between 2016 and 2018[2,3]. Trends in non-government healthcare reimbursement are problematic as well. Managed care organizations are becomingly increasingly rigid in contract negotiations and payment denials. Employers – long the source of health insurance for most Americans – continue to shift health costs to employees, who are often unprepared for this increased financial burden. In addition, the recent economic downturn has left hundreds of thousands unemployed and, subsequently, without health insurance coverage.

> Hospital administrators across the country are predicting a precipitous decline in operating margins.
>
> *January 2009 HFMA Hospital & Health System Survey*

Hospitals and health systems across the country are experiencing the reality of these factors. According to a survey released by the American Hospital Association (AHA) in January 2009, nine out of 10 hospitals are finding it harder or even impossible to access tax-exempt bonds, a critical source of hospital financing[4]. As a result, about half of all hospitals have delayed a scheduled capital project; 15% have halted an active project.

Healthcare Financial Management Association (HFMA) reports that more than half of America's hospitals experienced a drop in inpatient volumes during the six months leading up to the January 2009 survey, and hospital administrators across the country are predicting a precipitous decline in operating margins[5]. For these reasons, hospitals nationwide are at risk of defaulting on their bond covenants.

Recent actions from Moody's Investors Service demonstrate the real-world implications of these survey findings. Moody's downgraded the creditworthiness of 53 hospitals in 2008, more than it downgraded in any of the previous six years.

> "Moody's downgraded the creditworthiness of 53 hospitals in 2008, more than it downgraded in any of the previous six years."

From hospital administrators to bond professionals to payers, the industry at large is acknowledging that, contrary to conventional wisdom, hospitals are not – perhaps never were – recession proof. However, because the typical hospital's business model and revenue stream are so markedly different from other businesses, its level of financial distress can be difficult to diagnose. Consequently, bond holders and bond insurers are hard-pressed to know when to intervene in a potential bond covenant default. The following early warning signs will help hospital leaders as well as bond professionals more clearly identify and proactively react to financial distress.

> "Contrary to conventional industry wisdom, hospitals are not – perhaps never were – recession proof."

EARLY WARNING SIGNS

Distress identified early can be resolved more quickly and for less money than late-stage distress. Therefore, bond holders and insurers are best-served by tracking the earliest signs of hospital financial distress rather than waiting until a crisis occurs. In today's uncertain economy, no warning sign can be disregarded, and industry-standard metrics must be watched more closely than ever. While no single metric can accurately identify early-stage distress in all hospitals, the following financial, operational, and market indicators can offer helpful insight into the outlook of a hospital that might be in trouble.

Financial Indicators

1. *Days Cash on Hand: Trend Analysis*

The number of days of cash a hospital has on hand is a classic solvency metric. Astute analysts will track long-term trends as well as review individual instances. Analyzing multiple-year and/or monthly trend lines can add clarity to assessing hospital performance. Further investigation can help determine if large movements resulted from a favorable change, such as an increase in net patient revenue; a neutral change, such as an influx in cash from a real estate divestiture; or an unfavorable change, such as an investment loss.

Financial Indicators:

1. Days Cash on Hand
2. Current Ratio
3. AR Days
4. Capital Expenditures vs. Annual Depreciation
5. Internally Prepared Financial Statements

Benchmark: Simply stated, decreasing cash from year-to-year or month-to-month is a sign of financial distress. In addition, an interim snapshot that reveals the number of Days Cash on Hand at a point materially lower than historical patterns or bond covenant requirements, may well be cause for immediate review, concern, and follow-up.

2. *Current Ratio: Trend Analysis*

Just like Days Cash on Hand, reviewing a hospital's current assets compared to its current liabilities can be more instructive as a trend than as a single snapshot, especially for early detection of financial distress. Developing a Current Ratio trend line for multiple years supplemented by a cycling of the most recent 12 months will likely provide compelling predictive value.

Benchmark: In general, a trending decline that has reached 1.5 is an early sign of financial distress. Any single instance that is 1.0 or less warrants timely investigation.

3. *Accounts Receivable (AR) Days: Trend Analysis*

An increase in AR Days is often indicative of a hospital with poorly negotiated managed care contracts, unfavorable market changes, or ineffective collection practices. The challenge of reducing AR Days is both critically important and exceptionally challenging in the healthcare industry due to highly complex and unorganized payment systems. Reviewing a 12 to 18 month trend of AR Days can indicate a hospital's ability to meet these challenges. Poor revenue cycle management will quickly exacerbate hospital financial distress.

"If AR aging categories by payer are worsening over time, the probability that liquidity will suffer is high – an obvious indicator of distress."

Benchmark: Any trend of increasing AR Days is a sign of trouble; however, an average of 55 days paired with a trending increase is especially concerning. This is even more concerning when coupled with growing bad debt, a relevant consideration as increasing numbers of American workers find themselves unemployed and uninsured. The quality of the AR aging file is another relevant factor when evaluating the revenue cycle management process. That is, if AR aging categories by payer are worsening over time, the probability that liquidity will suffer is high – an obvious indicator of distress.

4. *Capital Expenditures vs. Annual Depreciation*

Capital improvements are critical for hospitals to recruit physicians, attract patients, and deliver quality care. A hospital that does not upgrade its facility and equipment to offset the depreciation of its capital assets, especially in revenue-generating areas of the hospital, is headed for trouble over the longer term. The effect of delayed expenditures is compounding, and the cost to "catch up" on postponed improvements can be far greater than an initial investment. A hospital's capital expenditures and annual depreciation should be calculated for each of the past 10 years to determine if it is keeping pace.

Benchmark: If depreciation has outpaced capital improvements in more than three of the past 10 years – or if this is the case for the most recent two years – the hospital is likely experiencing distress. In addition, if the facility's next scheduled capital project relies on funds exposed to market performance (investment income, grants from foundations or charitable donations), more serious financial issues may exist. This is especially true for hospitals nationwide that are not able to access debt financing due to today's tight credit markets.

5. *Internally Prepared Financial Statements*

Clear financial statements are critical for sound decision making. A hospital that prepares a confusing, inadequate, or poorly organized set of financial statements may be unable to analyze data, look beyond the numbers, or make informed decisions. Reviewing several hospital monthly financial statements can show data being used to make routine and strategic decisions. A fundamental benefit of financial statements is predictive value.

Benchmark: General purpose financial statements that do not contain some narrative, lack compelling financial information (e.g., key statistics and cash flow data), and generally lack substance may be indicative of a hospital that is making decisions based on incomplete or erroneous information. Left unchecked, this can lead to unfavorable financial outcomes and ultimately financial distress.

Operational Indicators

1. *Full-Time Equivalents (FTEs) per Adjusted Patient Days*

Maintaining appropriate staffing is critical for both hospital quality and financial viability. It is often a delicate balance among hospital needs, regulatory requirements and the availability of qualified caregivers. FTEs per Adjusted Patient Days should be compared to regional averages for the healthcare industry and government regulations. Because of the high cost of temporary and agency staffing, analysts should also review the percentage of a hospital's staffing expenditure allotted for temporary help.

Benchmark: If FTEs per Adjusted Patient Days exceed competitor or regional averages or routinely dip below regulatory requirements, the hospital may have workforce-related issues. If the hospital must consistently rely on very expensive temporary or agency personnel, further investigation is warranted.

2. *Outpatient Volumes and Market Share: Trend Analysis*

Outpatient procedures are responsible for almost 45% of the average hospital's net patient revenue and they contribute significantly to operating margins[6]. In addition, outpatient volumes are a strong indicator of a hospital's community reputation when patients have a choice of providers. A three year analysis of a hospital's outpatient volumes can help determine if negative trends exist. When measured against the hospital's market share, analysts can draw conclusions about the hospital's reputation in the community and the likelihood it will perform well over the long term or experience distress.

Benchmark: Any trending decrease in outpatient volumes is a cause for concern. Declining volumes paired with decreasing market share for outpatient procedures can spiral quickly and should be addressed immediately. Medical staff input will be essential if this situation is to be remedied.

Note: Delayed capital improvements paired with decreasing patient volumes can be an important distress indicator. Patients and clinicians can recognize a neglected facility and will modify their behaviors accordingly. A hospital with three or more years of insufficient capital expenditures and declining market share may already be in deep financial distress. An unintended consequence of this scenario could be an unfavorable market perception of clinical quality.

Operational Indicators:

1. FTEs per Adjusted Patient Days
2. Outpatient Volumes and Market Share: Trend Analysis
3. Physician Relations
4. Employee Issues
5. Quality and Accreditation

3. Physician Relations

Physicians govern both inpatient and outpatient treatment decisions. Hospitals that interface poorly with physicians suffer the consequences. For example, disenfranchised physicians may seize an opportunity to launch an outpatient surgery or imaging center and direct lucrative business away from the hospital. On the other hand, hospitals that align themselves with physicians (e.g., joint ventures) may prevent or at least mitigate such drastic outcomes.

Benchmark: Hospitals that face a great deal of marketplace competition from outpatient facilities, as well as sole community providers whose patient volumes are decreasing, may be suffering from poor physician relations. Left unchecked, these issues can advance rapidly, and the long-term competitive consequences can be insurmountable.

4. Employee Issues

Hospitals with low employee morale and high employee turnover for long periods of time are at risk for many unfavorable events. In addition to high recruitment costs and poor customer service that can lead to decreasing patient volumes and market share, these hospitals may face increased exposure to lawsuits, disputes with organized labor, etc. Unions are showing heightened interest in the healthcare industry, and pending federal legislation could increase the ease with which bargaining units can organize. Reviewing employee turnover patterns and simply talking to informal employee leaders can help determine if the hospital is experiencing employee-related issues.

> "Hospitals with low employee morale and high employee turnover for long periods of time are at risk for many unfavorable events."

Benchmark: Hospitals with low employee satisfaction and a long-term trend of high turnover are at risk for many issues that can exacerbate other financial challenges.

5. Quality and Accreditation

Accreditation by a CMS-deeming organization such as The Joint Commission is a requirement for hospitals to receive reimbursement from government programs like Medicare and Medicaid. In addition, real or perceived quality issues in a hospital can affect its bottom line in a variety of ways, including litigation, physician/clinician recruitment issues, decreasing patient volumes, decreased reimbursement and unfavorable payer contracts.

Benchmark: Hospitals that face repeated censure by the regulators, or are routinely cited for deficiencies in state or federal quality compliance, are very likely to face financial risk.

Market Indicators

1. Employment and Health Benefit Trends

Employers are increasingly seeking ways to pass on more health costs to employees. In addition, unemployment has skyrocketed nationwide. Medical care is expensive. Individuals who are accustomed to employer-sponsored health insurance are often unprepared to cover their own medical expenses. Reviewing the past 12 monthly state labor market reports can help analysts determine labor trends in a hospital's community. In addition, a clear understanding of a community's employer base can reveal the potential for layoffs or dramatic shifts in healthcare coverage.

Benchmark: Hospital distress may emerge if a hospital is located in a community with an unemployment rate that has increased by more than one or two percentage points during the last 12 months, or if the unemployment rate has topped the national average (8.1% as of February 2009). In addition, a community that is highly dependent on one or two large employers, or a single industry, is at risk for a dramatic increase in unemployment. An investigation of the employment environment in which a hospital operates can determine whether this is likely to be a problem.

2. *Declining Population*

Hospitals experiencing a decline in the population of their service area face the risk of patient volume decreases, caregiver recruitment issues, and other major challenges. Reviewing 10 years of population numbers for the hospital's service area as well as population projections from the U.S. Census Bureau can help determine how a hospital may need to adjust its services to align with community needs.

Benchmark: A hospital located in a region with a steadily decreasing population is likely to suffer. However, a hospital in a growing area may not necessarily see increased profitability. The specific reasons for an increase or decrease in population are often more important than the actual shift in numbers. Strategic planners should investigate the root causes of population changes before determining their likely effect on the hospital.

CONCLUSION

The challenges are great for our nation's hospitals and health systems. Many need immediate intervention to prevent crisis situations. Early detection and swift intervention can help ensure that: (a) communities maintain access to the healthcare services they need, and (b) risk is mitigated for financial stakeholders in the hospital.

Effectively addressing these issues requires specialized resources. QHR Intensive Resources provides short-term, high-intensity support to hospitals and health systems facing immediate challenges such as bond covenant default, loss of accreditation, sale/merger issues and bankruptcy.

Intensive Resources is a wholly owned subsidiary of Quorum Health Resources (QHR), the market leader in hospital management serving approximately 150 multi-year clients across the U.S. Through QHR's nationwide network, Intensive Resources has access to 300 top tier hospital administrators and 150 management consultants.

Bond holders and insurers, healthcare attorneys and other stakeholders who wish to discuss a specific hospital's situation can turn to IRG for expert insight, strategic planning, and timely, effective action.

INTENSIVE RESOURCE CONTACT INFORMATION

Bob Vento
Senior Vice President

105 Continental Place
Brentwood, TN 37027
888.766.2799
www.intensiveresources.com

REFERENCES

1. Centers for Medicare and Medicaid Services. *National health expenditure projections 2008-2018.* February 2009. < http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf> (accessed March, 6 2009)

2. "Medicare: Economic Downturn Could Hasten Medicare Part A Insolvency, Actuary Says." *Kaiser Daily Health Policy Report.* December 2008. <http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=55834> (accessed March, 11 2009).

3. Sisko A, Truffer C, Smith S, Keehan S, Cylus J, Poisal J, et al. "Health Spending Projections Through 2018: Recession Effect Adds Uncertainty to Outlook," *Health Affairs,* 24 February 2009. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.2.w346> (accessed March, 6 2009)

4. American Hospital Association. *Report on the capital crisis: Impact on hospitals.* January 2009. <http://www.aha.org/aha/trendwatch/2009/twjan2009econimpact.pdf> (accessed March 11, 2009)

5. Healthcare Financial Management Association. *The financial health of U.S. hospitals and health systems.* January 2009. < http://www.hfma.org/NR/rdonlyres/E59B2DD1-C1DF-4D71-B9E1-1D273A55CF80/0/FinancialPulse_Highlights.pdf> (accessed March 11, 2009)

6. Healthcare Financial Management Association. *Outpatient revenue percentage of net patient revenue depends on hospital size.* November 2008. <http://provider.thomsonhealthcare.com/uploadedFiles/docs/1108DT.pdf> (accessed March 11, 2009)