Distressed Healthcare Facilities: Restructuring and Insolvency Options
Planning Strategies for Providers Evaluating Bankruptcy and Alternatives

A Live 90-Minute Audio Conference with Interactive Q&A

Today's panel features:
Hector G. Calzada, Jr., Director, Deloitte Financial Advisory Services, Atlanta
Richard J. Zall, Partner, Proskauer Rose, New York
Samuel R. Maizel, Pachulski Stang Ziehl & Jones, Los Angeles

Wednesday, April 8, 2009
The conference begins at:
1 pm Eastern
12 pm Central
11 am Mountain
10 am Pacific

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Distressed Healthcare Facilities: Restructuring and Insolvency Options
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Along for the ride: implications for healthcare in the current economy

Deloitte Financial Advisory Services LLP
Hector G. Calzada, Jr.

April 8, 2009
Discussion Outline

• Along for the ride
  
  Current market conditions
  
  the ever expanding “credit crunch”

• Critical considerations

• Strategies for cash acceleration and margin preservation

• Illustrative assessment and implementation

• Restructuring implications
### Major Programmatic Efforts in Obama First Term

#### Cost
**Goal:** reduce avoidable costs while increasing access & leveraging IT to improve safety and efficacy

- Medicare cuts 1-2% in July, 2009 to be implemented Oct, 2009 per CMS
- Implementation of comparative effectiveness platform (borrow from NICE, German, Dutch systems)
- Improve Medicare Modernization Act (12/03) to allow direct purchasing and close donut hole for seniors
- Development of health insurance exchanges for Medicare enrollees and newly insured through new government program
- Implementation of episode-based payment system
- Facilitate insurance market reforms to drive premiums down

#### Access
**Goal:** to increase access to affordable insurance

- Increased enrollment in “FEHP2” (new government program)
- Increased enrollment in SCHIP via expanded eligibility
- Legislation to limit (not restrict) plans from denial due to pre-existing condition
- Implement pay-for-play mandate to employers (likely 6% of payroll requirement for companies above 50 employees)
- Facilitate health insurance market reforms i.e. Insurance Connector (a la Massachusetts)
- Innovate with states in Medicaid waiver programs

#### Safety & Effectiveness
**Goal:** to reduce error, facilitate preventive & chronic management, & reduce inappropriate variation

- Enhanced incentives for EMR adoption and e-prescribing application
- Creation of National Comparative Effectiveness Research Institute (Baucus)
- Expansion of pilot programs in disease management, LTC coordination
- Implementation of Medical Home for Medicare, Medicaid
- Increased funding for FDA to focus on food safety, post market surveillance
- Increase funding to NIH for personalized therapeutics
- Increased funding to FDA, CDC for bio-surveillance, safety & efficacy (drugs, food supply); post market surveillance (drugs)
Dateline: February 26, 2009

FY10 budget proposal includes creation of a $634 billion health reform reserve fund – tax increases for wealthy, lower payments to providers, health plans and prescription drug companies, are keys to funding

Spending for Medicare ($453 billion) and Medicaid—federal proportion—($290 billion) account for 20.7% of the entire federal budget—more than defense

- **$311 million increase** in funding to reduce fraud
- **$1 billion increase** for the FDA for drug importation
- **$400 million increase** to $6 billion for cancer research
- **$211 million** for autism research
- **$1 billion** in the USDA overall budget of $26 billion focused on food and nutrition research
- **11% increase** in the VA program to $56 billion to expand eligibility for health services to middle income non-disabled veterans (including Iraq, Afghanistan), mental health screening and health care IT for the VA.

Each of these is in addition to the stimulus package (ARRA) that included $144.8 billion for health care.
A reserve fund will be used to increase access to insurance for the uninsured and fund infrastructure investments including HCIT.

10 Year build up of the reserve fund sourced by:

- **$318 billion** from increased personal income taxes for families earning above $250,000 per year, reduction of mortgage deductions to no more than 28%, and increased corporate income taxes.

- **$177 billion** from changes to Part C Medicare Advantage plans essentially by reducing premium payments from Medicare (CMS).

- **$139 billion** in reductions of payments to providers and prescription drug companies. Among these, **$17 billion from hospitals** that fail to coordinate care appropriately for post-discharged patients and **$8.4 billion from hospitals** that do not achieve quality thresholds, and increased mandatory rebates by drug companies for Medicaid enrollees (increase from 15.1% to 22.1%) and others.
Healthcare reform 2009

President Obama’s focus on reducing costs as a key to economic recovery is in the spotlight. Emphasis is on the urgency of health cost containment.

- CBO deficit forecast prompts moderates to urge caution: Potential to slow health reforms
- CCHIT to fast track certification requirements to align with stimulus plan for HIT adoption
  - States may provide incentives to acute care and children's hospitals
  - To qualify for incentives, acute care and children's hospitals must adopt EHRs prior to 2017; incentives are limited to six years.
- Only 1.5 percent of hospitals have comprehensive electronic health records in use: study by incoming ONC Executive Director Blumenthal points to challenge in HIT implementation
  - Hospital qualifications for Medicare electronic health record (EHR) incentives in stimulus package: acute and critical access hospitals in; specialty hospitals - out
Capital Market Performance – Healthcare Companies
Hospital Valuations & Financial Performance

Hospitals Include (LPNT, UHS, CYH, HMA, THC)

Source: CapitallQ.
Diagnostic Imaging Trends

Diagnostic Imaging Valuations & Financial Performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Median EV/EBITDA</th>
<th>Median EBITDA / Net Revenue Margins</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>6.96</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>5.74</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>5.66</td>
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<tr>
<td>2005</td>
<td>6.27</td>
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</tr>
<tr>
<td>2006</td>
<td>6.31</td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>5.73</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>7.47</td>
<td>37.0%</td>
</tr>
<tr>
<td>3/31/2009</td>
<td>6.15</td>
<td>32.0%</td>
</tr>
</tbody>
</table>

Source: CapitallQ.
Assisted Living Trends

Assisted Living Valuations & Financial Performance

Median EV/EBITDA

2002: 10.12
2003: 13.48
2004: 20.71
2005: 21.13
2006: 18.77
2007: 17.67
2008: 11.74
3/31/2009: 8.01

Median EBITDA/Net Revenue Margins

Source: CapitalIQ
Crisis in the Credit Markets

- Yields on 20-Year treasuries have declined by 13% since January 2008.
- At March 2009 it stands at 3.8%.
- The credit default spread was at a historic high, 6% and has narrowed marginally.
The Perfect Storm......

What is keeping hospital executives up at night now?

- Cost of capital increases and limited access to capital
- Managed care contracting challenges
- Reductions in charitable giving
- Reductions in Medicaid funding
- Softening patient volumes, especially with elective services, and declines in funded patients (as unemployment increases)
- Rising uncompensated care and increases in bad debt
- Declining margins of compliance with lending covenants
- Declining investment portfolios impacting liquidity, capitalization and debt capacity
- Increased pension and malpractice trust funding requirements
- Increasing costs of labor, supplies, and technology
Navigating the “Storm”

Critical Considerations

- Are your strategic and capital plans consistent with the new marketplace realities?

- Do you understand your “strategic levers,” and the degree of risk associated with each?

- Is your financial position capable of weathering the credit market realities or do you need to pursue other alternatives?

- Have you waited too long to act? Are you in essence “insolvent”?
- Can you be financially rehabilitated?
Navigating the “Storm”

The Imperative

- Challenge who you are and what you do
  - Evaluate your options

- Refresh your strategic financial plan
  - Sources of capital
  - Capital priorities – strategic, regulatory, replacement

- Scenario planning
  - Economic recovery timetable
  - Capital versus operating “levers”
  - Risk testing via sensitivity analysis
Navigating the “Storm”

Key Options

- Reduction in major / elective capital expenditures
  - Trickle-down effect
- Physician alignment strategies
  - Joint ventures
  - Syndications
  - Regional focus / affiliations
  - Employment / directorships
  - Physician practice acquisitions
- Specialty focus
- Regional focus
- Innovation rewards
- Capital partners – affiliations, joint ventures, go private
- Asset monetization
- Cash acceleration and margin preservation
Cash Acceleration and Margin Preservation Strategies

- Revenue stabilization/growth
- Organizational effectiveness and operating cost
- Asset efficiency
- Capital structure
CAMP Evaluation and Strategy Implementation

Improvement Agenda (CAMP)

Revenue Stabilization/Growth
- Denial Management
- Insurance Eligibility
- Charge Capture
- Programmatic Growth

Operating Margin
- Strategic Pricing
- Contracted Rates and Optimization
- Patient Volume & Access
- Physician / Ambulatory Strategy

- Labor, Compensation & Benefits
- Supply Chain
- Service Line Margins
- Medical Management

- Patient Safety & Quality
- Outsourcing Strategy
- Technology Optimization
- Fixed Cost

Asset Efficiency
- Cash Management/Preservation
- Capital Planning & Management
- AR/Cash Acceleration
- Inventory Reduction

- Pension Funding Strategy
- Real Estate Strategy
- Debt Restructuring
- Asset Monetization

Organizational Effectiveness
- Leadership Management
- Governance
- Change Management
- Risk Management

- Management Information
- Charitable Status
- Regulatory Compliance
- Financial Planning & Oversight

Enablers
- Information Technology
- Sell Side Services
- Capital & Operating Financial Analysis
- Joint Ventures & Affiliations
- Accounting & Financial Investigations
- Human Resources & Talent Management
- Bankruptcy Administration

Recommended immediate focus areas
# Cash Acceleration and Margin Preservation Timetable

<table>
<thead>
<tr>
<th>30-Day Plan</th>
<th>60-Day Plan</th>
<th>90-Day Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appoint cash czar</td>
<td>• Reduce fixed and overhead costs</td>
<td>• Tighten charge capture and coding processes</td>
</tr>
<tr>
<td>• Restrict all expenditures</td>
<td>• Zero-based budgeting</td>
<td>• Out-counsel under-performing staff</td>
</tr>
<tr>
<td>• Freeze hiring for non-revenue generating staff</td>
<td>• Strategic pricing</td>
<td>• Renegotiate physician contracts</td>
</tr>
<tr>
<td>• Begin cash acceleration program</td>
<td>• Address charge capture issues</td>
<td>• Begin consolidation efforts</td>
</tr>
<tr>
<td>• Renegotiate vendor payment terms - consolidate</td>
<td>• Drive GPO compliance - consolidate</td>
<td>• Monetize assets</td>
</tr>
<tr>
<td>• Manage current inventories</td>
<td>• Realign investments</td>
<td>• Consider acquisition</td>
</tr>
<tr>
<td>• Restrict overtime and contract labor</td>
<td>• Diversify financing alternatives</td>
<td>• Consider balance sheet flexibility</td>
</tr>
<tr>
<td>• Lean out operations</td>
<td>• Modify debt; e.g., buy back auction or variable rate debt</td>
<td>• Optimize working capital</td>
</tr>
<tr>
<td>• “Emergency return to the bedside”</td>
<td></td>
<td>• Discontinue unprofitable service lines</td>
</tr>
<tr>
<td>• Expand span of control</td>
<td></td>
<td>• Consider affiliations</td>
</tr>
</tbody>
</table>
Cash Acceleration and Margin Preservation
Execution

Phase I: Rapid Assessment
- Cash Review
- Balance Sheet Review
- Benchmarking
- Market and Competitive Position
- Interviews and Validation
- Business Case Development
- Improvement Plan

Typically 4 week - Phase I process to finalize opportunities and implementation plans

Phase II: Implementation

- Install institutional structure and implement “quick-wins”
  - AR cash acceleration initiatives
  - Balance sheet mining
  - Focus on discretionary spend
  - Net revenue realization improvement
  - Asset management controls
  - Liability management
  - Active cash planning

- Implement Sustainable Improvement Strategies
  - Optimize care management and clinical processes
  - Enhance revenue cycle performance and effectiveness to achieve sustainable improvement
  - Enhance supply chain process to reduce purchased services and non labor spend
  - Institutionalize appropriate productivity and staffing models
  - Optimize Shared Services

- Enhance Effectiveness of Transformational Strategies
  - Implementation of CIS, ERP and other supporting technology initiatives
  - Institutionalize strategic planning capabilities and performance
  - Transform financial management to support strategic, clinical and operating performance and expectations
  - Physician and Ambulatory strategic initiatives

Client Executive Leadership — Client Lead Initiatives
Sustainability: Change Management/Leadership Development — Program Management — Measurement Tools
Technology Enabled Solutions  30-60-90 days to 1-2 years
Illustrative Cash Acceleration and Margin Preservation Plan

Revenue stabilization/growth
- Strategic pricing $12.7M
- Medicaid conversion $10.9M
- Third party contracting $10M
- Claims processing $7.5M

Operating cost
- Labor management/OT/span of control $5M
- P4P $10M
- Volume growth $15M
- Supply chain $17M
- Labor process improvement $12.4M
- Care management/LOS cost reduction $9.1M
- Fixed costs $5M

Asset efficiency
- AR reduction $33M
- Throughput $4M
- Capital avoidance $50M
- Pension funding $10M
- Inventory mgmt. $1M

Operational effectiveness
- Managed care contracting $7M
- Ambulatory redesign $6M
- GPO $5M
- Care coordination $2M
- Medical malpractice $10M
- Talent plan
- Quality/risk analysis & plan
- Compliance cost
- Quality events
Capital Structure – Tax Exempt Financing Options

- Debt modifications
  - Investor concerns over losses
  - Modifications
    - Interest features and rates
    - Maturity date extensions

- Considerations
  - Financial relief v. flexibility
  - Tax regulations – rebate periods, yield calculations

- FHA Section 242
- Temporary repurchases
- Increase direct contact with institutional investors
- Review long-term financial plan
Capital Structure – Other Financing Options

- Single leases versus master leasing
- Enhanced collateralized lending
  - Accounts receivable, fixed assets and inventory
- Public/private partnerships
- Tax Increment Financing ("TIF")
  - Community improvement and redevelopment
- Increased third party developer use
- Sale/leaseback transactions
- Enhance transparency of financial reporting
Concluding Thoughts

• Financial performance and a strong credit rating is a lifeline to long-term success

• “Rehabilitation” of financial position is a journey

• Long-term financial plan needed
  – Critically challenge all aspects of your business model
  – Reengineer your balance sheet
  – Manage your cash more judiciously than ever
  – Accountability all around: board, management
  – Stay focused on the end in mind
Profile
Hector G. Calzada, Jr., a Director in the Deloitte Financial Advisory Services LLP’s corporate finance and valuation practice and is a member of the firm’s Health Sciences & Government industry group.

Mr. Calzada has extensive experience advising clients in valuation and financial advisory matters. He has advised clients on matters addressing fairness opinions, corporate planning and strategic alternatives, capital structure, tax and financial reporting, regulatory compliance, estate matters, and shareholder disputes. Mr. Calzada has conducted and supervised assignments for mergers, acquisitions, buy-side advisory, corporate divestitures, joint ventures, equity syndications, restructurings, refinancings, and tax planning. He also advised Boards of Directors in matters involving fairness opinions and strategic alternatives.

Professional Affiliations
FINRA Series 7 & 63 Licenses
Member – Georgia Bio Transaction of the Year Selection Committee (2008-2009)
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Distressed Healthcare Facilities:
Restructuring and Insolvency Options

Presented by:
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Weighing the Options

A. Confronting Financial Distress
B. Consideration of Restructuring Options
C. Key Legal Issues
D. Success Factors
Confronting Financial Distress

- Governance Challenges – Starting at the Top
  - Problem Recognition
  - Active Board Engagement

- Management Focus
  - Challenges for CEO, CFO, General Counsel and Others
  - Evaluating Need for Chief Restructuring Officer (CRO) Function

- Understanding & Isolating the Problem
  - Analyzing the Causes of Financial Distress
  - Relationships with Affiliated Entities
Confronting Financial Distress

- Communication with the Key Stakeholders
  - Board
  - Community
  - Elected Officials
  - Regulators
  - Employees/Labor Unions
  - Medical Staff/Physicians
  - Lenders
Consideration of Restructuring Options

- First Stage: Developing a Turnaround Plan
  - Short Term (Next 3-6 months)
  - Intermediate Term (6-18 months)
  - Beyond

- Components of the Turnaround
  - Operational Improvement
  - Debt & Other Contract Restructuring
  - Government Assistance
  - Strategic Affiliations and/or Sale/Merger

- Second Stage: Other Restructuring Options
  - Chapter 11 Reorganization
  - Closure (in or out of Chapter 11)
  - Chapter 7
Consideration of Restructuring Options
First Stage

- **The Turnaround Plan**
  - **Short Term**
    - Revenue Cycle Improvement
    - Staff Reductions – Union/Non-Union
    - Government Assistance Programs
  - **Intermediate Term**
    - Third Party Reimbursement Appeals
    - Renegotiation of Managed Care Contracts
    - Sale of Non-Core Assets
    - Debt Restructuring
    - Restructuring labor arrangements
    - Government Assistance Programs
    - Affiliation or Strategic Alliance
    - Sale or Merger of Part or All of Operation
Consideration of Restructuring Options
Second Stage

- Other Restructuring Options
  - Chapter 11 Reorganization
    - Weighing Costs & Benefits
      - Benefits (contract rejection, recasting liabilities)
      - Costs ($$, stigma, loss of control)
    - Variations on the Theme
      - Prepackaged Bankruptcy
      - Controlled Bankruptcy
      - Liquidating Bankruptcy
  - Closure (in or out of Chapter 11)
    - State Closure Plan requirements
    - Patient transfers/safety
    - Sale of assets
  - Chapter 7
Key Legal Issues

- Board of Director Responsibilities
- Contracting with Restructuring Consultants
- Debt and Vendor Contract Restructuring
- Labor Relations/Arrangements
- Physician Arrangements
- Preference Transactions
Key Legal Issues

- Board of Director Responsibilities
  - Fiduciary Duties
    - Duty of Care, Loyalty, Mission
    - Business Judgment Rule
    - Conflicts of Interest Generally; Affiliated Entity Issues
  - Patient Safety
  - Payment of Taxes
  - Zone of Insolvency Issues
    - Gheewalla (Del. Supreme Court, 2007)
    - Acting in “Best Interests of Entire Corporate Enterprise”
    - “Deepening Insolvency” Doctrine
  - Directors and Officers Insurance
    - Direct, Indemnification, Entity Coverage
  - Indemnification Rights
Key Legal Issues

- Contracting with Restructuring Consultants
  - Scope of Work
  - Performance Standards
  - Officer Designation/Roles and Responsibilities
  - Payment Terms
  - Term and Termination
Key Legal Issues

- Debt and Vendor Restructuring
  - Lenders
    - Evaluating Current Agreements
      - Default Provisions
      - Reps/Warranties & Covenants
      - Security/Collateral
      - Required Consents
    - Forbearance Agreement
    - Additional capital
  - Critical Vendors
    - Information Technology
    - Food Service & Maintenance
    - Utility
    - Other
Key Legal Issues

- **Labor Relations/Arrangements**
  - Contract renegotiation
    - Reduction in Force process
    - Work rules
    - Outsourcing
  - WARN & Severance Issues
    - State
    - Federal
Key Legal Issues

- Physician Arrangements
  - Flexibility to renegotiate Employment & Independent Contractor Agreements
  - Medical Malpractice Insurance
  - Teaching Programs (residents, medical students)
Key Legal Issues

- Preference Transactions
  - Maintaining neutrality within classes of creditors
  - Avoiding preferential treatment to “insiders”
  - Preference liability
    - Transfers outside of ordinary course of business, made:
      - Within one year of bankruptcy filing (for insiders)
      - Within 90 days (for others)
    - Examples: deferred comp; severance; note repayment
Success Factors

- Problem Recognition & Culture of Urgency
- Effective Board Oversight
- Effective Turnaround Team
- Realistic Turnaround Strategy & Action Plans
- Strong Support of Key Constituents
  - Unions
  - Medical Staff
  - Regulators
  - Elected Officials
  - Community
- Effective Communication
Distressed Healthcare Facilities: Restructuring and Insolvency Options

Thank You
Capital for maintenance, technology and growth is a requirement to maintain market share in the competitive hospital industry. The hospital industry is particularly dependent on capital access because its ability to provide quality service (and produce operating revenue) is heavily dependent on monetizing tangible assets such as land, facilities, medical equipment and information technology. Hospitals finance themselves through a variety of capital sources including operating cash flow, existing liquid investments and cash, bond debt (both tax-exempt and taxable), commercial banks, specialty finance companies (such as equipment leases, lines of credit, real estate), philanthropy, investor equity and various government subsidies. Hospital lending and borrowing entails many unique issues. Hospitals typically have slow collection cycles, an average of 75 to 120 days, compared to 30 to 60 days for most industries. For asset-based lenders, this factor is important because it effectively lengthens the duration of an exit during a forced liquidation scenario. For bonds and other types of financing, increased liquidity (versus most industries) and a strong balance sheet tend to be requirements from bond investors. For all hospital lenders, the enforceability of liens is an important issue. Given the importance of government payors, a lender’s inability to obtain a fully-perfected lien on government accounts receivable typically reduces the amount that can be borrowed. The widely accepted right of Medicare and Medicaid to recoup past overpayments or other liabilities from ongoing payments, even if the hospital is in bankruptcy, also creates significant issues for lenders. Examples of situations in which future payments may be offset include Medicare Cost Report liabilities, lien- or appeal-based payments such as personal injury or worker’s compensation claims, or risk pools that have unpredictable costs such as capitated payments from health plans.

The increasing emphasis on finding and punishing health care fraud by the federal government, which can result in the imposition of treble damages and dismissal from the Medicare Program, also adds uncertainty to the hospital’s ability to borrow in the capital markets and increases costs for those that do. Bankruptcy workout costs tend to be significantly higher in health care cases due to the potential numerous stakeholders and constituents involved, with examples including Medicare, Medicaid, health plans, regulatory agencies, accreditation entities, shareholders, community members, secured creditors, financial guarantors, vendors, patient care ombudsmen and unsecured creditors. In the end, lenders often cannot lend as aggressively to hospitals compared to most industries due to quality-of-earnings issues and higher bankruptcy workout costs, otherwise they face the risk that they may not recover their original investment. As Ben S. Bernanke, the Federal Reserve Chairman, told the U.S. House of Representatives a year ago:

[A]s the rising rate of delinquencies of subprime mortgages threatened to impose losses on holders of even highly rated securities, investors were led to question the reliability of the credit ratings for a range of financial products, including
structured credit products and various special-purpose vehicles. As investors lost confidence in their ability to value complex financial products, they became increasingly unwilling to hold such instruments. As a result, flows of credit through these vehicles have contracted significantly.1

To say that credit in America has “contracted significantly” is an understatement. Many believe that America may be on the verge of suffering through its worst financial crisis since the Great Depression. During the current credit crisis, capital—even from the most reliable of sources—has evaporated. An unprecedented era of credit stability has been replaced by a frightening deterioration of credit quality among commercial banks and debt investors. Through December 2008, 25 banks and thrifts have failed (including Washington Mutual, the largest bank failure in history) compared with three in 2007 and zero for 2006 and 2005.3 Major money center banks such as Citibank have survived by diluting shareholders with massive capital raises and government-funded bailouts.4 Bear Stearns needed a bailout sale to avoid bankruptcy,5 and Lehman Brothers, one of the most prestigious institutions on Wall Street, declared bankruptcy.6 The government seized control of mortgage finance companies Fannie Mae and Freddie Mac, which own or guarantee approximately half of the nation’s $12 trillion in outstanding home mortgage debt.7 Freddie Mac, which own or guarantee

health care facilities traditionally operated at low or near-zero default rates and were regarded by investors as a noncyclical safe haven. As attractive risks, they were easily insured by financial guarantors such as MBIA or Ambac. Since most health care facilities were viewed as essential community assets and as one of the largest employers in town, lenders and debt guarantors slept well with these risks in their portfolios. But times have changed. Perhaps this really is the beginning of the end for many hospitals that loaded up on debt when money was cheap and easily available. In recent years, there has been an increasing level of health care defaults and, as previously mentioned, facilities continue to be shuttered on a regular basis. “Standard & Poor’s has taken a meat-ax to the credit ratings of not-for-profit hospitals of late. During the first six months of 2008, credit downgrades for nonprofit hospitals and health systems rated by S&P almost doubled, while upgrades fell, compared with the same period during the previous year. The agency downgraded 31 for-profits during that six-month period and upgraded only 11.”9 This trend continued into the fourth quarter of 2008 as credit availability continued to tighten. Moody’s downgraded 18 hospital bond ratings in October and November 2008 while upgrading only one.10

Further complicating matters is the lack of financial covenants (commonly referred to as “covenant-lite”) in many transactions completed in the past several years. While many lenders were chasing deals and competing with each other, credit standards became relaxed and many lenders were willing to waive the inclusion of financial and other kinds of covenants. Without the early warning system of covenant breaches, however, lenders and other players that rely on the hospital to provide financial information end up facing the immediate risk of insolvency or a defensive bankruptcy filing without prior notice. Lenders are now realizing that they do not have as much protection in their existing lending agreements as they would like and are frequently trying to establish more restrictive covenants, in exchange for allowing “workouts” of existing troubled loans or bonds.

Few hospitals that historically obtained financing through the taxable and tax-exempt bond markets used fixed-rate debt.11 Similar to an adjustable-rate vs. a fixed-rate home mortgage, many hospitals took on interest-rate exposure with variable-rate securities. Similar to adjustable-rate home mortgages, in the short-term, there were potential interest-rate cost savings using variable-rate securities. However, as the taxable and tax-exempt bond market became less reliable, borrowing costs soared. Few hospitals had hedges in place against interest-rate risk.12 As a result, many hospitals saw their borrowing costs jump significantly. As is the case with a homeowner, if one were to take a risk of a potential increase in interest rates, one should have adequate cash flow and/or liquidity reserves to absorb potentially higher borrowing costs. Unfortunately for many hospitals that used variable-rate debt, they did not reserve adequate liquidity to absorb increased borrowing costs.13

Compounding the problem for hospitals is an exotic class of securities known as Auction Rate Notes (ARNs). Many hospitals borrowed through the use of such notes without fully understanding the risks involved in these transactions. The market for ARNs effectively disappeared in the weeks following the subprime mortgage meltdown. ARNs work much like the commercial paper market in that borrowers enter the market.

5 BusinessWeek, “Bear Stearns’ Big Bailout,” available at www.businessweek.com/bw/daily/dailyflash/content/mar2008/db20080314_k993311.htm (March 14, 2008).
10 www.fiercehealthfinance.com/story/moodys-downgrades-18-
for short-term variable-rate debt and must continue to borrow new funds every few weeks to pay off the old funds. In stable markets, variable-rate securities are an inexpensive form of financing, but this was not the case in volatile markets where investors were running scared. In the absence of willing purchasers, hospital and health systems quickly saw their borrowing costs jump from approximately 5 percent to 15 percent, choking off the supply of capital. Suddenly, the taxable and tax-exempt bond markets were no longer stable and consistent sources of capital for investment-grade hospitals.

The news is much more severe for sub-investment-grade and distressed hospitals. There is a limited appetite for noninvestment-grade credits from retail and institutional bond buyers. Today, there is a relatively small universe of active institutional buyers. In the authors’ estimation, there are perhaps 50-75 total accounts nationally with only 30-35 active, and even fewer that are willing to buy bonds at the range of BBB or below. The active “market place” for hospital bonds has severely reduced its size.

In addition to a smaller group of potential purchasers, the credit crisis has made the bond purchasers more careful. Bond purchasers are (1) imposing tighter covenants, (2) asking for more security (debt-service reserve-funding, lockboxes, etc.), (3) expanded reporting and disclosure requirements, and (4) increased transparency through more frequent and direct institutional-investor interactions. All of these hurdles make issuing bonds all the more difficult.

Bond insurers, suffering massive losses from the subprime mortgage exposure, are pulling back from or moving out of the market. MBIA and Ambac, two of the largest insurers of municipal debt, have themselves been downgraded and the largest insurers of municipal debt, the market. MBIA and Ambac, two of these lines of credit, operating and capital leases, companies and REITs were providing for many of the noninvestment grade and distressed hospitals have become limited, more expensive and more restrictive than in the past. While there were many specialty health care finance companies and REITs competing for business before the credit crisis, now only a handful are left standing with an active interest in the health care industry. These specialty finance companies and REITs were providing lines of credit, operating and capital leases, sale leasebacks and mortgages to fund vital working capital, capital expenditures and plant expansion and improvements for many of the noninvestment grade and distressed hospitals before the credit crisis. Credit standards have tightened and interest rate spreads have widened 100-500 basis points during this financial crisis. Fewer entities are willing to lend in risky situations. For example, many lenders historically perceived debtor-in-possession (DIP) financing to be a lucrative line of business because of its low risk and high return value proportion. DIP loans tended to be structured as last-in and first-out vehicles because they have a super-priority, fully-perfected lien from the bankruptcy court and tend to be over-collateralized by all the assets of the borrower. In addition, despite a lower risk profile, lenders are typically able to charge borrowers higher interest rates and fees on short-term loans. According to the Wall Street Journal, credit has now become so scarce that many companies filing bankruptcy are unable to obtain DIP financing.

It may well be that credit is running out for hospitals. The credit crisis has resulted in intense pressure on hospitals nationwide. Access to capital is critical in financing hospitals because they are capital-intensive businesses with thin profit margins and slow collection cycles. There will be few safe havens in the sector... In a system in which the flow of funds is controlled by a handful of insurance companies and the federal government, it is difficult to see how many of today’s hospitals will make it out to the other side of the current credit crisis.

With regard to bank letters and lines of credit (LOC), most commercial banks, especially foreign banks, have retreated from this market. Bank letters are much more difficult than LOCs due to credit default exposure. LOCs are no longer considered a profitable business line by many banks. Borrowers should expect (1) a much-higher degree of selectivity, (2) shorter LOC renewal terms (one, three or five years), (3) more restrictive and highly-negotiated covenants and security provisions (similar to bond insurer requirements, but sometimes more or different requirements), and (4) explicit


15 A monoline guarantees the timely payment of bond principal and interest when an issuer defaults. For further reference, see en.wikipedia.org/wiki/Monoline_insurance (last visited on Oct. 31, 2008).

tie-ins with other banking services, such as investment management. Hospital borrowers are seeing much less use of LOC-backed variable-rate demand note structures.

Many of the failed or failing hospitals are municipally owned in places like Texas and California, or are health care districts (quasi-governmental entities). These entities have been hurt disproportionately by the credit crisis due to their reliance on government funding. “Hospitals supported by state and local governments have become a significant drain on state and county tax dollars. In some cases, budget shortfalls at small, county-supported community hospitals could threaten the financial viability of the entire county,” according to the A&M study. As tax revenues decrease, one would expect to see an increase in the financial failures of these hospitals.

Conclusion

A former chairman of the Federal Reserve said about the Great Depression: “As in a poker game where the chips were concentrated in fewer and fewer hands, the other fellows could stay in the game only by borrowing. When their credit ran out, the game stopped.” It may well be that credit is running out for hospitals. The credit crisis has resulted in intense pressure on hospitals nationwide. Access to capital is critical in financing hospitals because they are capital-intensive businesses with thin profit margins and slow collection cycles. There will be few safe havens in the sector. Today, many highly-rated hospitals with significant cash on hand still hit the panic button and freeze capital spending or institute a hold on new hires when there is a 400-point drop in the Dow Jones Index.

Is this unnecessary anxiety or a real fear of losing the access to capital necessary to execute on a mission? Perhaps it is a bit of both. In a system in which the flow of funds is controlled by a handful of insurance companies and the federal government, it is difficult to see how many of today’s hospitals will make it out to the other side of the current credit crisis.


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The Financial Crisis Facing America’s Hospital Industry: Part I

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Intensive Care

Throughout most of 2008, news of the presidential election and America’s two pending wars have taken second billing to the world’s potentially greatest financial crisis since the Great Depression. America’s hospitals, which for many years have operated under significant financial stress and survived on razor-thin profit margins,1 have felt the impact of the financial crisis in a significant and damaging way. This article will explore the micro- and macroeconomic factors that create financial difficulties for hospitals generally, as well as the impact of the current financial crisis on the capital markets for hospitals nationwide. Finally, the authors offer their prognosis of what to expect from the health care industry in the coming year.

In the past six months, as the “credit crunch” in America worsened, it has aptly adopted a new name: the “credit crisis.” While some think that the hospital industry is insulated from the effects of a weak economy be-cause “people need health care even during tough times,” in fact hospitals are now especially vulnerable. The obvious challenge is that it is more difficult to obtain credit, and that situation will worsen in the near future. The credit crisis continues to disrupt capital markets, increasing borrowing costs and decreasing the credit availability for all health care borrowers. Nonprofit hospitals, nursing homes and other health care providers that frequently raise capital by employing variable-rate interest bonds have felt the impact.

Unlike an airline or other capital-intensive service business, hosp-ital is cannot pass on the rising cost of borrowing to their customers in the form of higher prices: Third-party re-imbursement rates are set and remain fixed for long periods of time. Moreover, hospitals cannot easily make draconian cuts to reduce costs, such as reducing staffing, because staffing levels are frequently set by statute and wage levels lower income and increasing financial stress.

The financial prognosis for the hospital industry has been bleak for a while. As the state with the most hospitals, California is often the “early warning system” for the nation’s hospitals. Last year, even before the bottom dropped out of the financial markets, newspapers were already writing about the tough financial situation facing California’s hospitals. Nearly two dozen private hospitals in Los Angeles and Orange counties, accounting for up to 15 percent of beds in the region, were reported to be about the tough financial situation facing California’s hospitals. Nearly two dozen private hospitals in Los Angeles and Orange counties, accounting for up to 15 percent of beds in the region, were reported to be


Microeconomic Drivers of Financial Distress

In good times and bad, there are three primary microeconomic drivers of financial distress for hospitals: (1) capital structure, (2) organization and governance and (3) revenue-cycle mismanagement. Many hospitals suffer from an inappropriate capital structure, with capital spending as the most telling metric. A decreasing amount or complete cessation of capital spending can lead to a “death spiral” for a hospital and is a “genetic marker” for lenders and board members that the institution is in distress. Given the lack of free cash flow from operations, investing too much or too little can jeopardize a hospital’s long-term survival. In a well-managed hospital, the goal is patient, employee and physician satisfaction, and the avoidance of unnecessary capital spending that leads to a technology arms race with local competitors. Nonetheless, hospital managers frequently will delay capital expenditures first when cash is tight, because they are focusing on surviving today. Because the hospital industry operates with EBITDA margins of 10-12 percent (low compared with other industries) and a necessary minimum capital expenditure of 4-6 percent of net revenues every year (high compared with other industries), balance sheet strength is a key determinant in measuring a hospital’s ability to withstand a financial crisis.

Therefore, hospital management must be disciplined in its capital planning and budgeting process, ensuring the proper level of capital expenditures, balanced against the need for liquidity (cash on hand, lines of credit, sustained credit ratings) in the context of the hospital’s operating performance.

Hospitals with poor organization and governance tend to be questionable credit risks for lenders. In these situations, management is frequently unmotivated as a result of a lack of clear financial incentives and a clear “chain of command” with regard to long-term strategic planning accountability. As a result, management teams frequently focus on uncoordinated incremental change without any strategic planning or overall context, versus coordinated changes as part of a comprehensive strategic plan. Executives often find themselves more worried about preserving their jobs than investing in long-term planning or long-term solutions. Additionally, nonshareholder boards are often appointed without financial incentives, further exacerbating the issue of short-term vs. long-term goals, and further misaligning the interests of the stakeholders and the hospital.

Century City Doctors Hospital is a noteworthy case because it demonstrates the range and complexity of strategic issues that hospital operators face in today’s marketplace. Nearly $100 million in capital was reported to have been invested in the 142-bed hospital from debt and equity sources. The hospital invested significant capital in property improvements, providing patients with private rooms, Wolfgang Puck cuisine and flat-screen TVs with on-demand pay television services.

However, in this case, the hospital primarily failed due to, despite it having a “spa-like” environment, it was unable to pull patients from nearby well-established hospitals. In the end, the hospital discovered that whether one serves Wolfgang Puck or fast food, reimbursement from payors is the same and is dependent on patient volume.

The health care industry is unique because of its complicated billing and collection practices, usually referred to as “revenue-cycle management.” For example, unlike most industries, the customer receiving the services is typically not paying for those services. Rather, a third-party payor, such as an insurance company, Medicare or Medicaid, is typically paying the bills. Thus, making sure that the patient is entitled to the service per its third-party payor and that the hospital will be compensated for the services is essential. Additionally, the rate of reimbursement for a health care service will differ depending on the payor. In other words, while the hospital may have a set rate for a procedure, each payor contract may set a different rate for the same procedure. Other examples include physicians that are not properly credentialled with payors, failure to collect insurance information on the front end and writing off a patient claim as uninsured, or improper coding that understates revenue. Unfortunately, there is no easy fix; generally throughout the health care industry, the claims adjudication and payment collection process is complex and often time-consuming. Some health care providers have manually intensive, paper-driven systems that tend to compound already existing inefficiencies. Others invest millions in information technology and implementation, embarking upon system conversions in which it is difficult to measure returns. Often one hears in the health care industry that systems conversions “never go well, just hope it’s not a disaster.” The net result is that while revenue cycle management is an essential element of the financial success of a hospital, the reality of the situation—that many hospitals do this poorly—has led to financial distress in the past for hospitals.

Macroeconomic Drivers of Financial Distress

The macroeconomic challenges facing the
hospital industry seem to be contrary to logic. The demographic and economic trends all seem to be poised to create an industry that is large, healthy and growing. Health care is one of the largest industries in the nation, and its costs—as widely discussed in the past presidential election cycle—are staggering. Total national health expenditures were expected to rise 6.9 percent in 2007—double the rate of inflation.8 Health care expenditures in the United States amounted to approximately $2.3 trillion in 2007, or $7,600 per person (about 16 percent of the gross domestic product), and this trend is not projected to slow down in the near future.9

To the contrary, health care spending is expected to increase at similar levels for the next decade, reaching $4.2 trillion in 2016, or 20 percent of GDP. According to NHEA, total hospital expenditures were approximately $648 million in 2006 (or greater than one-quarter of the total health care expenditure figures). In addition to the immense outlays for hospital care, the aging U.S. population (78.2 million estimated “baby boomers” by the U.S. Census Bureau as of July 1, 2005) is a key demographic trend that is expected to drive overall health care spending nationally.10

Nonetheless, there are many macroeconomic factors that create a bleaker financial picture for the health care industry in general and the hospital segment in particular, which include: (1) increased labor costs due to an acute shortage of registered nurses; (2) the loss of lucrative outpatient procedures to freestanding ambulatory care centers and specialty hospitals; (3) an increase in bad debts, driven by an increase in the number of uninsured patients; (4) an overall decline in hospital utilization because of advances in technology and the use of pharmaceuticals; (5) a decline in employer-based health care spending, as industry tries to control growing health care costs; and (6) the “leverage” of health maintenance organizations (HMO), which can negotiate contracts that are significantly less favorable to hospitals.

The nation is in the midst of a nursing shortage that is expected to intensify as baby boomers age and health care needs grow. Compounding the problem, colleges and universities across the country are struggling to expand enrollment levels to meet the rising demand for nursing care. In some states, insurers are providing scholarships and even funding nursing-education programs. For example, Independence Blue Cross of Pennsylvania has awarded millions of dollars through its Nurse Scholar program.11 According to a report released by the American Hospital Association in July 2007, U.S. hospitals need approximately 116,000 registered nurses to fill vacant nurse positions nationwide, translating into a national registered nurse vacancy rate of 8.1 percent.12 One report found that 44 percent of hospital CEOs had more difficulty recruiting registered nurses in 2006 than in 2005.13 According to a report published by the U.S. Bureau of Labor Statistics, more than one million new and replacement nurses will be needed by 2016. Based on a projection by government analysts, nursing is the nation’s top profession in terms of job growth, citing that more than 587,000 new nursing positions will be created through 2016 (a 23.5 percent increase).14 This shortage of nurses creates pressure on wages, increasing labor costs significantly for hospitals nationwide.

The growth in freestanding ambulatory care centers and specialty hospitals has posed a significant challenge to traditional, general acute-care hospitals. Advancement in anesthesia and surgical equipment and techniques has allowed an ever-increasing range of procedures to be performed in lower cost and more convenient outpatient settings. The reimbursement rates for cardiovascular and orthopedic surgery procedures are competitive for freestanding ambulatory facilities and surgical centers, compared to hospitals. Not surprisingly, there has been a proliferation of Medicare-certified ambulatory surgery centers, and the number of procedures performed out of the conventional inpatient hospital setting.15 As a result, increasing numbers of outpatient surgical procedures are now performed outside of a hospital-owned facility. This trend is significant because hospitals typically report higher operating margins on outpatient and ancillary businesses than they do on inpatient care.

An increasingly uninsured population is pushing bad debt rates higher. According to the U.S. Census Bureau, more than 47 million people lacked medical insurance in 2006 (approximately 16 percent of the population). More than half of those had annual incomes of less than $50,000.16 According to some studies, medical debt is the single largest catalyst for personal bankruptcies in the United States; a recent study found that 50 percent of all personal bankruptcy filings were at least partly the result of medical expenses.17 With unemployment increasing, bad debts are a growing source of concern for hospitals and their lenders.

Despite the demographic trends discussed earlier, hospital inpatient admissions have remained flat at about 34 million per year and the average length of hospital stays has decreased nearly 25 percent since 1980.18 This change in hospital utilization is due to many factors, including technology advances and the use of pharmaceuticals that have reduced the need for and length of inpatient medical care. Breakthroughs in cardiovascular care and cholesterol-management drugs have alleviated the need for many hospital admissions. The result is that while there are an increasing number of older Americans, they use hospitals less than previous generations.

Most hospitals are paid by a limited number of “payors.” The largest of these payors are two government programs: Medicare, which generally covers the elderly, and Medicaid, which generally covers the poor. These two programs pay for nearly half of all hospital services. The other large payors are HMOs, which can include entities such as Kaiser Foundation Health Plan, Blue Cross/Blue Shield and HealthNet. About one-third of all Americans are enrolled in an HMO. In some markets, HMO penetration is more than 70 percent. This results in what economists call a “monopoly,” or a market dominated by a few or single purchaser of services. By aggregating millions of patients, HMOs are able to exert collective buying power in price negotiations with hospitals. This dynamic leads to more downward pressure on hospital revenue.

As a result of all these micro- and macroeconomic issues, the hospital industry has been under unremitting pressure for many years. The current credit crisis, however, adds a whole new dimension to the situation.


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