CAIN BROTHERS

Capital Markets Perspectives on Funding Seismic Compliance

Overview

Just as the phrase "new normal" is applied to the restructuring taking place as a result the U.S. and global financial crises and related economic downturns, California hospitals and health systems are entering a "new normal" period where their traditional internal sources of funding: 1) income from operations; 2) income from investments; and 3) philanthropy; are expected to be more constrained and uncertain than in the past. What the "new normal" will mean for hospitals and health systems in California is becoming clearer: reduced operating cash flows over time, more limited investment returns, and less philanthropy to support their businesses. In this environment, ensuring access to the capital markets has become more urgent than ever. However, capital access for tax-exempt hospitals, like for nearly all other issuers of securities, has become more difficult, more costly and more uncertain. Capital is allocated across a fluid international capital market based primarily on two key metrics: risk and expected return. California hospitals face a near term future which is unfavorable on both of these measures and which will challenge all but the most financially strong hospitals ability to consistently maintain access to capital in the future.

In response to the greater uncertainty facing all health system borrowers, the rating agencies and investors have placed increasing reliance on the cash and investment balances of health care systems to determine the perceived credit or investment risk of those systems. This amount of balance sheet liquidity for health care system borrowers is measured by "days cash on hand" which is essentially the number of days of operating expenses that are held in cash and investment balances. In 2008, the most recent period for which these ratios are available, Moody's Investor Service calculates the median "Days Cash of Hand" ratios for Aa, A, and Baa rated hospitals and health systems to be 208, 157 and 100 days respectively. The level of these ratios in 2008 were sharply lower than in previous years due to the decline in investment balances during 2008 and hospitals will likely be under pressure to increase in the near term. In the next few years, as bond investors and rating agencies will be expecting hospitals to increase cash and investment balances, hospitals will also be expected to make the necessary investments in their core operations to ensure they remain competitive and able to meet the health care needs of the communities they serve. Absent significant increases in reimbursement rates, which seems quite unlikely in the current environment, hospitals must evaluate a number of operational strategies, including:

- Eliminating, slowing down and reducing capital expenditures on existing projects;
- Evaluating capital projects for ways to increase the financial return those projects generate;
- Forcing expense reductions through staff layoffs, attrition, and reduced hours, and strict limitations on purchasing;
- Raising payment rates in limited situation where that has been possible;
- Reducing spending on non-essential operations;
- Pursuing programs to increase operational efficiencies; and
- Selling and joint venturing non-core assets and operations.

Even with these strategies, more than half of the state's 430 hospitals are currently operating in the red, i.e., doing business while losing money, and a number of hospitals are on the brink of financial distress or in bankruptcy. As a result, it is estimated that a significant proportion of California hospitals will not be able to access the financial capital necessary to comply with the SB1953 2013/2015 deadlines.

Capital Formation

In the hospital industry it generally requires $1 of capital investment for every $1 of revenue generated. With California hospitals' net margins averaging approximately 5% over the past 5 years, substantial new investment is necessary to generate significant improvement to cash flows. Thus, for all but the very strongest California hospitals and health systems, generating sufficient cash flow from operations to increase days cash on hand, make new investments in operations, fund charity care and bad debt, and service debt is a daunting challenge. Imposing the further burden of funding seismic retrofit projects, which are generally viewed by the investors as providing little or no return on capital, compound an already difficult capital environment. In this "new normal" environment, it is clear that for all but the most highly rated hospitals with ready access to capital, funding seismic retrofit projects will adversely impact their ability to deliver services. Balance sheet constraints will necessarily divert funding away from new equipment and technology, improvements to patient care, support for indigent services, recruiting physicians and addressing other community health care needs.

Capital Market Perspectives

Capital market conditions and uncertainty around seismic regulations has made access to tax-exempt debt capital for most California hospitals difficult and costly and has added risk for those hospitals with existing bonds outstanding. These conditions are compounded by the fiscal challenges being faced by the State of California, which increases the perception of risk for California borrowers whether they are public entities, not-for-profit corporations or investor owned companies.

While the seismic retrofit and replacement projects may address valuable public policy and safety concerns, from a financial perspective, most of these projects create little or no increase in earnings or cash flow. Therefore, for many hospitals, investments in seismic projects reduce future access to capital on nearly a dollar for dollar basis. Whether hospitals fund major capital projects using new borrowing or the expenditure of balance sheet cash and investments, their future access to capital will be dependent on those expenditures generating a positive financial return. For some hospitals that are on the threshold of investment grade status, expenditures to fund seismic upgrades may limit or close completely their access to the capital markets until they can re-establish borrowing capacity through increases in operating cash flow or the repayment of debt. The difficulties of meeting the SB 1953 requirements are all the more daunting given the generally challenging backdrop facing California health care borrowers. These challenges include:

- Weaker balance sheets from investment losses and higher borrowing costs have changed the fundamentals of health care financing;
- Capital markets have "tightened" significantly, with lenders less willing to place extraordinary amounts of leverage on hospitals and have returned to more conservative lending practices;
- Although appetite for attractive investment opportunities in the hospital sector have seen increased interest in recent months, bond investors remain very cautious and risk averse;
- Investors are focused on the risk that non-SB 1953 compliant hospitals are at risk to be shut down;
- Given this risk, bondholders will demand a substantial risk premium to invest in non-compliant hospitals; and
- Given California's well publicized budget problems, the perception of financial risk to California hospitals is elevated.

The implications of a more difficult bond market and concern about "California Seismic Risk" are that fewer funds will be available to provide financing for California hospitals and their core clinical operations. Furthermore, to the extent funds are diverted to meet SB1953 seismic compliance requirements, debt capacity for core uses will be decreased dollar for dollar.

Hospital Operations

Current conditions are all too familiar to California hospital operators. Operating and non-operating earnings necessary to generate liquidity and support existing and new borrowings are under pressure. Nationally, the Healthcare Financial Management Association (HFMA) reported recently that hospitals are experiencing negative margins, declines in non-operating income (with the largest hospitals suffering the most), decreases in days cash on hand, and reductions in patient revenue.[1] In its report, HFMA's findings indicated that 54% of the hospitals surveyed had negative total margins, and 80% of the hospitals with more than 500 beds had negative total margins. Non-operating revenue declined at 78% of the hospitals, and 64% of the hospitals reported declines in non-operating income of more than 20%. In terms of liquidity, HFMA reported that 73% of responding hospitals had decreases in days cash on hand, a key measure of financial strength; and 96% of the hospitals with more than 500 beds suffered decreases in days cash of more than 20%. Finally, net patient revenue was down at 43% of the hospitals.

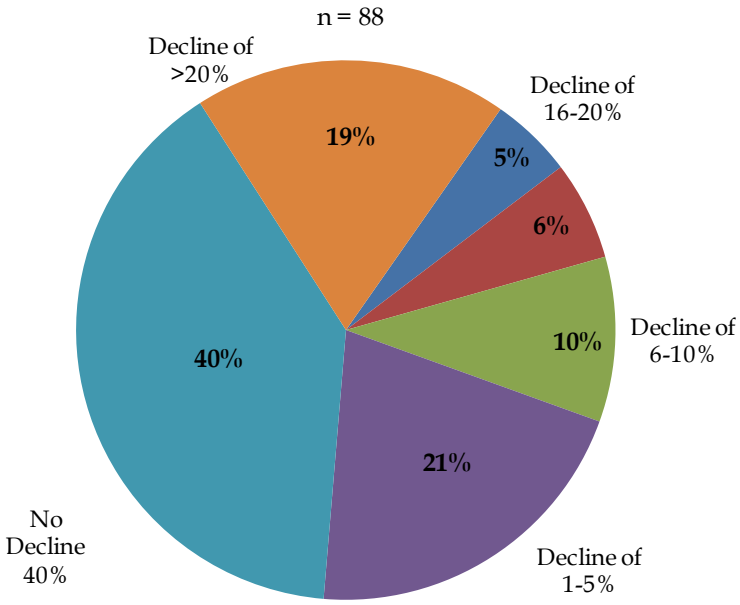
The major reasons for these negative results are widely known. Primary among these is the general financial maelstrom that commenced in 2007[2] and accelerated in 2008 and the resulting tight conditions in the debt markets and realized and unrealized investment portfolio losses. As the value of donors' portfolios declined, philanthropy has also declined and contributed to lower non-operating income. Indirect causes include widespread job losses and layoffs and increases in the number of uninsured, which have led to reductions in patient-elective volume and increasing charity care and bad debts.

[1] How Hospitals Are Combating the Financial Downturn, HFMA's Healthcare Financial Pulse, April 2009.
[2] Municipal bond insurance company credit rating downgrades, for example.

In short, for most hospitals, operations are producing lower earnings, less cash flow, and reduced liquidity to support borrowings for new capital projects.

Philanthropy

Given the tremendous loss of wealth in the equity markets in 2008 and even despite equities' good performance in the second half of 2009, philanthropy and hospital development offices cannot be expected to supplement revenues to the degree they might have in the past. Key findings by the Foundation Center in a recent study suggests that foundation giving will decrease in the range of the high single digits to low double digits. Although foundations slightly increased giving in 2008, with asset declines of nearly 22% in 2008, the Foundation Center found that more than two-thirds of foundations will decrease funding in 2009; and the outlook is for further decreases in funding in 2010:



Source: Health Care Advisory Board, "Leadership Through the Downturn,"2009, p. 40.

Philanthropy and development, therefore, in the short-term cannot be counted on to provide capital expenditure support to the degree it has in the past.

Debt Markets

The harsh lesson of 2008 and 2009 in the debt markets for tax-exempt health care borrowers is that easy access to the tax-exempt debt market has ended and can no longer be taken for granted. The days of

multiple borrowing options and flexibility are now greatly curtailed, especially for lower rated and non-rated credits.

Tax-Exempt Fixed Rate Debt Markets

General financial markets turmoil accelerated during 2008, and the fixed income markets essentially seized up in the immediate aftermath of Lehman Brothers' September 2008 bankruptcy. This was especially true in the tax-exempt fixed income health care market that saw no new long-term tax-exempt health care hospital bonds issued for a five-week period in September and October 2008.

An important factor in the dislocation of the tax-exempt market was that non-traditional investors, such as hedge funds, deserted the municipal market, because leveraged municipal bond arbitrage strategies failed. These kinds of investors had been major drivers of the market from 1998 to 2008.

Starting in the spring of 2009, liquidity returned to most markets including the tax-exempt health care market, although the pace has been slow. The participation of traditional institutional bond funds and individual retail investors has been primarily responsible for the improvement. By the end of the second quarter of 2009, new tax-exempt health care bond issuance had returned to near normal levels, at least for single-A and double-A quality credits, although credit spreads to comparable maturity U.S. Treasurys remain wide by historical measures. Issuance of triple-B quality hospital bonds has been sporadic, and rates for these kinds of hospitals have been very expensive. New bond issuance of non-rated tax-exempt health care credits has remained very difficult or impossible.

The result is that many hospitals are no longer be able to generate enough internal cash flow or borrowed money to pay for all of their capital programs.

CONCLUSION

Hospitals and health systems are entering a "new normal" period where the basic sources of liquidity and cash flow generation are constrained and the environment for funding capital expenditures is much more difficult for all but an exceptional few. Adding the additional burden of meeting seismic retrofit requirements will be difficult for all hospitals and may not be possible for some of the most financially vulnerable hospitals and health systems. For those that have the ability to raise the capital to meet the requirements of SB1953, diverting this capital away from core operations and their balance sheets will mean compromising these hospitals' ability to provide capital to their core operations and will significantly limit financial flexibility in the future.