Criteria | Governments | U.S. Public Finance:
U.S. Not-For-Profit Acute-Care Stand-Alone Hospitals -- Methodology And Assumptions

Primary Credit Analysts:
Martin D Arrick, New York (1) 212-438-7963; martin.arrick@standardandpoors.com
Cynthia S Keller, New York (1) 212-438-2035; cynthia.keller@standardandpoors.com
Liz E Sweeney, New York (1) 212-438-2102; liz.sweeney@standardandpoors.com

Secondary Credit Analyst:
Kenneth T Gacka, San Francisco (1) 415-371-5036; kenneth.gacka@standardandpoors.com

Chief Credit Officer, Corporate & Government Ratings:
Lucy A Collett, New York (1) 212-438-6627; lucy.collett@standardandpoors.com

Table Of Contents
I. SCOPE OF THE CRITERIA
II. SUMMARY OF CRITERIA UPDATE
III. IMPACT ON OUTSTANDING RATINGS
IV. EFFECTIVE DATE AND TRANSITION
V. METHODOLOGY
A. Health Care Provider Rating Calibrations
B. Framework For Determining A Health Care Provider Rating
C. The Enterprise Profile Assessment
D. The Financial Profile Assessment
Table Of Contents (cont.)

VI. APPENDIX 1: GLOSSARY OF RATIOS

VII. APPENDIX 2: DEFINITION OF MULTIHOSPITAL HEALTH SYSTEM

VIII. APPENDIX 3: MEASURES FOR CLINICAL QUALITY AND INFORMATION TECHNOLOGY

IX. RELATED CRITERIA AND RESEARCH
1. Standard & Poor's Ratings Services is updating its methodology for assigning stand-alone credit profiles (SACPs),
group credit profiles (GCPs), issue credit ratings, and issuer credit ratings (ICRs) to U.S. not-for-profit acute-care stand-alone hospitals (hospitals). These updated criteria will be implemented under the rating framework established in Chart 1 where the final outcome can be a SACP, GCP, issue credit rating, or ICR. These criteria supersede only in part “Public Finance Criteria: Not-For-Profit Health Care” (June 14, 2007) because health care systems will continue to be rated under the existing criteria.

2. This update provides additional transparency and comparability to help market participants better understand our approach in assigning ratings to acute-care stand-alone health care providers, to enhance the forward-looking nature of these ratings, and to enable better comparisons between the sector's ratings and all other ratings. This article is related to our criteria article “Principles Of Credit Ratings”, published on Feb. 16, 2011.

3. All terms followed by an asterisk (*) are defined in the glossary in Appendix 1.

I. SCOPE OF THE CRITERIA

4. These criteria apply to all SACPs, GCPs, issue ratings, and ICRs assigned to U. S. not-for-profit acute-care stand-alone hospitals. Included in this sector are general acute-care facilities as well as hospitals devoted to acute-care niches such as pediatrics, oncology, rehabilitation, orthopedics, and psychiatry.

5. These criteria also apply to hospitals with debt portfolios that include both tax-secured and revenue bonds. Ratings on the tax-secured bonds are governed by our criteria "Tax-Secured Hospital Debt", published May 3, 2007, while the revenue bond rating is governed by these criteria.

6. Multihospital health systems are not rated under these criteria. Any hospital or group of hospitals not meeting the definition of a multihospital health system in Appendix 2 will be rated by these criteria.

II. SUMMARY OF CRITERIA UPDATE

7. These criteria use the same major elements as our criteria for other municipal enterprise sectors. Specifically, these criteria assign ratings using a framework that considers enterprise risk (enterprise profile) and financial risk (financial profile) factors. Chart 1 depicts how enterprise and financial profile characteristics combine to reach an initial indicative rating. The indicative rating is established after applying any appropriate positive or negative overriding factors. The final outcome – which could be a SACP, GCP, issue credit rating, or ICR - is reached after making any appropriate peer adjustments. If a hospital meets the guidelines outlined in "Criteria For Assigning 'CCC+', 'CCC', 'CCC-', And 'CC' Ratings" the hospital will be rated under that criteria published Oct. 1, 2012.
8. We consider four factors each in analyzing the enterprise and financial profiles.

9. Industry risk, economic fundamentals, market position, and management and governance combine to determine the enterprise profile assessment. Within market position, we analyze four sub-factors: 1) market share, competition and demand; 2) medical staff; 3) payer mix; and 4) clinical quality and information technology.

10. Within the enterprise profile assessment, the factors are weighted as follows: (see chart 2)
    - Industry risk 20%
    - Economic fundamentals 20%
    - Market position 50%
    - Management and governance 10%

11. Within market position, the sub-factors are weighted as follows: (see chart 3)
    - Market share, competition and demand 50%
    - Medical staff 20%
    - Payer mix 15%
    - Clinical quality and information technology 15%

12. Financial policies, financial performance, liquidity and financial flexibility, and debt and contingent liabilities* combine to determine the financial profile.

13. Within the financial profile assessment, the factors are weighted as follows: (see chart 4)
    - Financial performance 40%
    - Liquidity and financial flexibility 30%
    - Debt and contingent liabilities 30%

14. Financial policies are assessed but only have a neutral or negative impact on the financial profile assessment.
Chart 1: Analytical Framework For Stand-Alone Hospital Ratings

Enterprise Profile

- Industry Risk
- Economic Fundamentals
- Management & Governance

Financial Profile

- Financial Policies
- Financial Performance
- Liquidity & Financial Flexibility
- Debt & Contingent Liabilities

Initial Indicative Rating

Positive Overriding Factors
- Extraordinarily high reserves (one-notch adjustment)
- Academic medical center with closely related higher-rated university (one-notch adjustment)
- Tax-supported hospital (up to two-notch adjustment)

Negative Overriding Factors
- Lack of willingness or potential bankruptcy (caps rating)
- Credit emerging from financial crisis (caps rating)
- Weak management (up to three-notch adjustment)
- Extraordinarily low reserves (caps rating)
- Limited revenue base (one-notch adjustment)
- Specialty hospital (one-notch adjustment)

Indicative Rating

Peer Comparisons (one-notch adjustment)

Final Rating

The final rating can be an SACP, GCP, ICR, or issue credit rating. The final criteria are also governed by related criteria, including “Ratings Above The Sovereign — Corporate & Government Ratings: Methodology And Assumptions” and “Rating Government-Related Entities: Methodology And Assumptions”, both of which could result in a different final rating than indicated in Table 1. The final rating could also be affected by structural enhancements or other security features.

© Standard & Poor’s 2014.
Table 1 depicts the overall rating framework and shows how the initial indicative rating results from the application of the enterprise profile and financial profile assessments in Table 1 within the grid.

A final rating could be different from the initial indicative rating due to comparisons with similarly rated peers or overriding factors. Peer adjustments can be used to move the indicative rating up or down by one notch to arrive at a final rating which captures a more holistic view of creditworthiness and recognizes sustained, predictable operating and financial underperformance or outperformance, as informed by competitive analysis. The holistic analysis includes rare or strongly positive or negative characteristics which the criteria do not separately identify.

These criteria define peers as other stand-alone not-for-profit hospitals. Peers may include other organizations with similar ratings, size, market position, scope of services, geographic location, or financial profile characteristics. Based on our assessment, location may be defined as geographically contiguous or an area in another part of the country with similar economic and market fundamentals. Peer adjustments could also be made based on comparisons with sector-wide data, including ratio analyses. Peer groups may change through time as operating conditions or organization-specific features evolve.

Table 2 depicts overriding factors which can adjust the initial indicative rating suggested by Table 1 to arrive at the indicative rating. The final rating may be adjusted by one notch for peer comparisons.

The final rating may be constrained by the sovereign rating on the U.S., in accordance with "Ratings Above The Sovereign -- Corporate And Government Ratings: Methodology And Assumptions", published Nov. 19, 2013.

The final rating may also be affected by the likelihood of extraordinary government intervention, in accordance with "Rating Government-Related Entities: Methodology And Assumptions", published Dec. 9, 2010. In the case of hospitals affected by the government-related entities criteria, the final rating could be above the rating otherwise constrained by a cap in Chart 1.

Finally, the final rating could be affected by structural enhancements or other security features such as ring fencing, subordination, or additional collateral.

III. IMPACT ON OUTSTANDING RATINGs

Standard & Poor's maintains issue and issuer ratings on the debt of approximately 400 U.S. not-for-profit acute-care health care providers included in the scope of these criteria. Assuming that health care providers maintain their current credit characteristics, testing suggests that at least 75% of the ratings would remain unchanged under these criteria, while up to 15% of the remaining ratings could be lowered and up to 10% could be raised, generally by one notch.

IV. EFFECTIVE DATE AND TRANSITION

The criteria described in this article are effective immediately and apply to all new and outstanding ratings within scope. We intend to complete our review of issuers affected within the next 12 months.
V. METHODOLOGY

A. Health Care Provider Rating Calibrations

24. We calibrate our hospital rating criteria based on our analysis of the history of defaults, the impact of changes in medical care delivery patterns over time, our view of the industry's essentiality, the industry's sensitivity to economic cycles, and the credit strength of the not-for-profit health care sector compared with that of other sectors. We outline our framework in three articles: "Understanding Standard & Poor's Rating Definitions", June 3, 2009; "Credit Stability Criteria", May 3, 2010; and "The Time Dimension of Standard & Poor's Credit Ratings", Sept. 22, 2010.

25. While overall hospital-sector default rates are relatively low in absolute terms, hospitals account for a disproportionately high share of U.S. public finance defaults. Of the 73 nonhousing defaults from 1986 through 2012, 26 (36%) were hospitals, although hospitals comprised only 3% of U.S. public finance ratings. Furthermore, hospital ratings are more volatile than any other U.S. public finance sector, with 13% of hospital ratings raised or lowered in 2013, compared with an average of 10% for all of (nonhousing) U.S. public finance. (For more information, see "U.S. Public Finance Defaults And Rating Transition Data: 2013 Update", published March 31, 2014).

26. We believe that the historic number of health care defaults, while much higher than other sectors in U.S. public finance, still understates the level of credit risk in the sector. We have observed that when hospitals experience deteriorating performance, and may be bordering on or heading toward default, they often merge into or are acquired by a larger, more financially secure system, thereby avoiding a default. While the current environment, with its high level of mergers and acquisitions, has precluded many distressed hospitals from defaulting, our ratings do not rely on a favorable merger and acquisition environment as potential credit support for distressed hospitals.

27. The hospital industry is highly regulated. Hospitals are required to comply with numerous regulatory standards at federal, state, and local levels. The high level of regulation is, in our view, an indication of the public perception that hospitals have an essential purpose. On the other hand, regulation and public policies generally do not guarantee the survival of any particular hospital, although there have at times been government interventions to prevent hospital closures. The regulatory framework can reduce risk in certain states by limiting competition (see paragraph 83 on certificates of need). However, failure to meet regulatory guidelines can also have catastrophic consequences and substantially impair credit quality. Our ratings are calibrated to seek a balance between our view that the sector is essential and the fact that each individual hospital is not guaranteed survival.

28. The health care sector in general, including hospitals, tends to be only moderately sensitive to economic cycles. However, hospitals are not businesses that are easily portable, and changes in local demographics, medical care delivery patterns like the decades-long shift to more outpatient procedures, or shorter hospital stays, can affect demand for hospital services over time. Some markets that used to have sufficient demand to support several hospitals now only support one or two, while other markets have experienced increased demand for medical services with aging, growing, or disease-prevalent populations.

29. Our criteria are informed by several periods of heightened stress that resulted in an increased number of significant
hospital failures and/or dramatically reduced credit quality. These periods of stress were more industry-specific than macroeconomic and include 1989 through 1992, 1999 through 2003, and 2008 through 2013.

30. From 1989 through 1992, 11 rated hospitals defaulted. The defaults were concentrated among hospitals with high debt levels and only modest business positions in markets that were urban, highly competitive, or overbedded. Industry forces driving credit stress during this period included reimbursement pressure stemming from Medicare's prospective payment system, the rapid growth of membership in health maintenance organizations, and decreased demand stemming from rapidly declining average length of stay and lower inpatient admissions.

31. From 1999 through 2003, five rated hospitals defaulted. Downgrades also exceeded upgrades by approximately 4.3:1. This period followed rate cuts by Medicare and included a national recession, a significant decline in investment markets, and a period of high risk-taking by hospitals purchasing physician practices and assuming insurance risk.

32. From 2008 through 2013, seven rated hospitals defaulted. This period was characterized by constrained revenue due to fiscal stress at governmental payers and reduced demand brought on by several factors, including a sharp economic recession, payor scrutiny of hospital coding practices, advances in medical technology, and increased patient financial responsibility. The beginning of this period also included a severe decline in investment markets which damaged hospital balance sheets.

33. These criteria address the issues that caused these failures by more transparently articulating the importance of an assessment methodology for market position, management, and payer mix. Furthermore, these criteria use outlier adjustments and rating overrides for hospitals with certain financial characteristics that are inconsistent with its other credit factors and that could potentially cause credit stress.

34. The acute-care stand-alone hospital rating distribution is heavily concentrated, with the 'A' and 'BBB' rating categories totaling about 80% of ratings. Of the approximately 400 stand-alone hospitals rated by Standard & Poor's, 47% are in the 'A' category and 34% are in the 'BBB' category. The remaining organizations are split evenly between the 'AA' (10%) and speculative-grade categories (10% spread throughout the 'BB', 'B', 'CCC', 'CC', 'C', and 'D' categories). Currently there are no 'AAA' rated acute-care stand-alone providers.

B. Framework For Determining A Health Care Provider Rating

35. These criteria assess four enterprise profile factors and four financial profile factors (see chart 1).

36. Assessments for each factor range from '1' (the strongest) to '6' (the weakest). The market position, financial performance, liquidity and financial flexibility, and debt and contingent liabilities assessments receive the highest weights and in total account for three-quarters of the weighting. We believe that a hospital's location, size, medical staff, and relative strength in the market establish the conditions for the level of operating and financial success achieved. In addition, we also believe that hospitals with strong balance sheets -- evidenced by ample reserves and limited debt -- have a financial cushion to support the organization during less-favorable operating periods.

37. Table 1 shows the initial indicative rating that results from the combination of the enterprise and financial profile assessments. To reach the indicative rating, the initial indicative rating can be adjusted up or down due to overriding
factors listed in table 2.

38. In certain cases, the initial indicative rating in table 1 contains two options for a given combination of enterprise profile and financial profile assessments. In those cases, we use our expected view of the obligor's future performance to determine the initial indicative ratings.

Table 1

Determining The Initial Indicative Rating

<table>
<thead>
<tr>
<th>Enterprise Profile</th>
<th>Financial Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely strong</td>
<td>aaaa</td>
</tr>
<tr>
<td>Very strong</td>
<td>aa+</td>
</tr>
<tr>
<td>Strong</td>
<td>a-</td>
</tr>
<tr>
<td>Adequate</td>
<td>bbb/bbb-</td>
</tr>
<tr>
<td>Vulnerable</td>
<td>bb/bb-</td>
</tr>
<tr>
<td>Highly vulnerable</td>
<td>bb-</td>
</tr>
</tbody>
</table>

The initial indicative rating results from the interaction between the enterprise and financial profile assessments. Potential adjustments to the initial indicative rating are noted in table 2. The final rating will be within one notch of the indicative rating with the one-notch difference attributable to peer comparisons. For ratings below 'B-' see “Criteria For Assigning 'CCC+', 'CCC', 'CCC-', And 'CC' Ratings”, published Oct. 1, 2012.

Table 2

Summary Of Overriding Factors To The Initial Indicative Rating

<table>
<thead>
<tr>
<th>Overriding Factor</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Financial Distress</td>
<td>Final rating is capped at 'B'</td>
</tr>
<tr>
<td>Credit recovering from a financial crisis, emerging out of recent bankruptcy, receivership, or with significant consultant oversight following an event of default including a covenant violation. This also applies to a hospital with a going concern audit (see paragraph 42)</td>
<td>Final rating is capped at 'BB+' until the organization achieves resolution of its covenant defaults and establishes a one- to three-year record of sustainable financial performance</td>
</tr>
<tr>
<td>Operational Risk</td>
<td>Indicative rating may be up to three notches lower than suggested by table 1</td>
</tr>
<tr>
<td>Extraordinary Financial Characteristics</td>
<td>Indicative rating may be one notch higher than suggested by table 1</td>
</tr>
<tr>
<td>Unrestricted reserves exceed 365 days’ cash or are greater than 3x existing or pro forma debt including contingent liabilities (see paragraph 46)</td>
<td>Final rating is capped at 'BB+' for hospitals with less than 50 days’ cash except where unrestricted reserves exceed outstanding debt despite being under the days’ cash threshold. The ‘BB+’ cap also applies in cases where unrestricted reserves are less than 25% of debt. Final rating is capped at ‘BBB+’ for hospitals with less than 75 days’ cash. The caps do not apply to hospitals with tax-secured debt.</td>
</tr>
<tr>
<td>Net patient service revenue below $125 million (see paragraph 48)</td>
<td>Indicative rating may be one notch lower than suggested by table 1</td>
</tr>
</tbody>
</table>
### Table 2

**Summary Of Overriding Factors To The Initial Indicative Rating (cont.)**

<table>
<thead>
<tr>
<th>Distinct Organization Structure or Service Specialty</th>
<th>Indicative rating adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic medical centers that have a close relationship with a university (see paragraph 49)</td>
<td>Indicative rating may be one notch higher than suggested by table 1 if the university is rated higher than the hospital. If the university is not rated or rated lower than or equal to the hospital, no positive adjustment is made.</td>
</tr>
<tr>
<td>Specialty hospitals (see paragraph 50)</td>
<td>Indicative rating may be one notch lower than suggested by table 1 for hospitals serving one specialty or otherwise serving a unique niche.</td>
</tr>
<tr>
<td>Tax-supported hospitals (see paragraph 51)</td>
<td>Indicative rating may be up to two notches higher than suggested by table 1 given the support provided by local taxing districts. The final rating for tax-supported districts' general obligation bonds will be governed by the tax-secured hospital debt criteria.</td>
</tr>
</tbody>
</table>

### 1. Overriding factors

39. These criteria use overriding factors that can result in the indicative rating being different from the initial indicative rating outcome suggested by table 1. Table 2 summarizes these overriding factors. Certain conditions result in the indicative rating moving a specified number of notches above or below the initial indicative rating. Other conditions place a specific cap on the final rating. Rating caps are absolute, meaning that the positive relative adjustments described below do not allow ratings to exceed the cap.

   **a) Significant financial distress; lack of willingness to pay or bankruptcy filing may be imminent**

40. A management team or board may formally discuss whether or not to make debt service payments or may decide not to make timely payments to preserve resources for operations during financially challenging times. In those cases, and once we have learned of this intent through conversations with management or governance, reports in the press, public disclosure, or other informational sources we judge to be relevant, the final rating will be capped at ‘B’.

41. The final rating will be capped at ‘B’ for a hospital that we believe may file for bankruptcy or receivership, based on conversations with management or governance, reports in the press, public disclosure, or other informational sources we judge to be relevant.

   **b) Significant financial distress; recovering credit**

42. A hospital that has just emerged from bankruptcy or receivership or a period of consultant or governmental oversight by definition has just been in a period where the financial profile, and potentially the enterprise profile, are both extremely weak. Although a credit may emerge from bankruptcy, receivership, or oversight with an improved financial profile after debt forgiveness or other negotiated settlements, or under a new management team, we will cap the final rating at ‘BB+’ until all covenant violations have been cured and the organization has established a one- to three-year record of sustainable financial performance.

   **c) Operational risk; weak management**

43. A demonstrably weak management team, as measured by a management assessment of ‘5’ or ‘6’, may make financial, strategic, or operating decisions that have or are expected to negatively affect the enterprise profile or financial profile assessments. In those cases, the indicative rating may be up to three notches lower than that suggested in table 1.

44. When a hospital receives a management assessment of ‘6’, a three-notch (one rating category) adjustment is likely. The adjustment would generally be made in cases where the management issues involve fraud, conflict of interest, or evidence of purposeful wrongdoing. A three-notch adjustment would generally also be made in cases where we believe
the existing management team is putting the organization's future at risk, by making decisions involving outsized risk, such as entering a highly competitive market dramatically outside its service area, or by taking a persistently myopic and short-term view to problem solving that results in a recurrence of the same issues year after year.

45. For hospitals receiving a management assessment of '5', a one- or two-notch adjustment is possible. A two-notch adjustment might be appropriate for a hospital that has had chronic management turnover and an inability to accurately project the organization's financial and operational direction. A one-notch adjustment generally would be made for similar reasons, but the smaller adjustment could reflect recent governance action to improve the leadership team's expertise and depth, although there is not yet evidence of the team's success.

d) Extraordinary financial characteristics; unrestricted reserves

46. The level of unrestricted reserves relative to expenses and debt is incorporated into the liquidity and financial flexibility assessment. However, because its importance as a rating factor increases when unrestricted reserves are unusually high or low, the initial indicative rating may be adjusted up or down. In cases where unrestricted reserves exceed 365 days' cash or exceed three times outstanding debt and contingent liabilities – ratios that are above the median for our highest rating category – the indicative rating would generally be one notch higher than suggested by table 1. Where unrestricted reserves exceed 3x debt only because the amount of debt is extraordinarily low, the usefulness of the ratio is limited and the adjustment may not be applied. Low debt for these overrides is defined as a debt burden or debt to capitalization ratios that are about half of the number for assessments of '1' in table 21. This adjustment is less likely to be made at the higher rating levels.

47. In cases where unrestricted reserves are lower than 50 days' cash or amount to less than 25% of outstanding debt and contingent liabilities – ratios that are below the median for speculative-grade hospitals – the final rating will be capped at 'BB+'. Some hospitals with a weak level of days' cash have unrestricted reserves in excess of debt solely because debt levels are light, and in those rare cases this cap generally would not apply. Where unrestricted reserves are lower than 75 days' cash, the final rating will be capped at 'BBB+' because this level of cash is inconsistent with an 'A' category rating. Hospitals with debt portfolios that include tax-secured debt are excluded from these caps because they have independent sources of revenue to fund certain debt service payments (see paragraph 51).

e) Extraordinary financial characteristics; limited patient revenue

48. Many hospitals with annual net patient service revenue under $125 million face increased volatility related to their small size, including a reliance on a small number of physicians that makes them vulnerable to turnover and recruitment risk, location in rural areas with dependence on a more-limited population, and an economy where jobs, volumes, and revenues may be dictated by a concentrated employment base. A small revenue base may also be an indication of a business concentrated in a single specialty or service niche, which may be vulnerable to changes in clinical developments or reimbursement for that specialty. In our view, this in turn can lead to volume fluctuations and volatility in financial performance and we would generally adjust the initial indicative rating down by one notch below that suggested in table 1.

f) Distinct organizational structure or service specialty; academic medical center

49. By definition, most academic medical centers have a relationship with a university, but the closeness of that relationship can vary significantly. Academic medical centers with an extremely close relationship with a university
can take advantage of synergies not present in a more distant relationship between hospitals and universities. For academic medical centers with this type of relationship, as evidenced by a shared legal structure, overlapping or shared governance, shared name, or joint management oversight, the indicative rating generally would be one notch higher than suggested by table 1 as long as the affiliated university's rating is higher than the academic medical center's initial indicative rating and as long as we believe that the university is a supportive and stabilizing factor for the hospital. If the university's rating is lower, equal to, or not rated, then the academic medical center's initial indicative rating would not be adjusted. The university's rating is not a cap on the hospital's indicative rating if the hospital has a separate corporate identity and we believe the hospital is unlikely to default in the event of the university's bankruptcy. In cases where a hospital has benefitted from an affiliated university's rating, and the university's rating is subsequently lowered below the hospital's rating, a review of the stand-alone hospital would be initiated.

**g) Distinct organizational structure or service specialty; single-specialty hospitals**

Because of the narrow revenue stream, greater exposure to changes in medical practice in a single field, and reimbursement methodologies for narrow niches, the initial indicative rating generally would be adjusted down one notch from that suggested by table 1. For purposes of this adjustment, a single specialty hospital is defined as a rehabilitation, orthopedic, oncology, long-term care, or psychiatric hospital. Pediatric hospitals that have a narrow service range or clinical focus will also be considered specialty hospitals. This adjustment would generally also apply to a full service acute-care hospital with significant revenue or profitability reliance on a single service, if revenue from that single service is greater than 30% of total revenue* or greater than 50% of operating profitability.

**h) Distinct organizational structure or service specialty; tax-supported hospitals**

A hospital with tax-supported debt benefits significantly from being able to levy taxes to support all or a portion of its debt. As a result, the security provided by tax revenues can allow a hospital to take on a greater debt load than if it issued solely revenue bonds, and also allows it to operate with fewer days' cash on hand to the extent that tax receipts cover certain expenditures. In addition, we believe that tax revenues provide added stability and revenue flexibility and diversity. In light of these strengths, we would generally adjust the initial indicative rating upward by up to two notches from that suggested in table 1.

### C. The Enterprise Profile Assessment

The enterprise profile assessment evaluates the operating environment and incorporates broad industry factors as well as organization-specific factors. Four factors are assessed: industry risk, economic fundamentals, market position, and management and governance. Each section is assessed based on measures outlined below (see chart 2).

Industry risk is important as it measures risk in each sector and allows comparisons across sectors. Economic fundamentals remain important as the broad economy correlates with many factors that drive overall business volumes, including the nature, level, and availability of health insurance as well as the number of people with insurance. Market position helps assess a hospital's desirability relative to its competitors, while management and governance helps us assess the strategic direction, depth, and competence of those running the organization.
Assessments for each factor range from '1' (the strongest) to '6' (the weakest). We average each of the assessments according to the weights described in paragraph 10 and chart 2 to determine the initial enterprise profile assessment. After making any necessary adjustments to the initial enterprise profile assessment for those factors outlined in table 3, the final enterprise profile assessment will be applied in table 1 along with the final financial profile assessment to arrive at the initial indicative rating.

When assessing the enterprise profile or any component of the enterprise profile, if the assessment falls at or near a cut-off or midpoint, we generally would assign the lower (stronger) assessment if trends are improving or we believe future performance will improve. The higher (weaker) assessment generally would be assigned if trends are weakening or we believe future performance will be weaker.

Table 3 outlines three situations where we generally would adjust the initial enterprise profile assessment to arrive at the final enterprise profile assessment.

<table>
<thead>
<tr>
<th>Adjustment Factor</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization implements aggressive policies and strategies or is operating in a rapidly changing competitive environment (see paragraph 57)</td>
<td>Final enterprise profile assessment may be one point weaker than the initial enterprise profile assessment</td>
</tr>
<tr>
<td>Change in reimbursement or competitive position that is not already factored into market share or financial metrics (see paragraph 58)</td>
<td>Final enterprise profile assessment may be one point lower or higher than the initial enterprise profile assessment depending on whether the reimbursement or competitive changes are positive (lower) or negative (higher)</td>
</tr>
<tr>
<td>Medical staff assessment is '6' (see paragraph 59)</td>
<td>Final enterprise profile assessment may be capped at '4'</td>
</tr>
<tr>
<td>U.S. country risk assessment of '4', '5', or '6' (see paragraphs 60–61)</td>
<td>Final enterprise profile assessment may be capped at '4', '5', or '6'</td>
</tr>
</tbody>
</table>

In cases where the organization has what we consider aggressive expansion plans, is entering into significant new
payment methodologies, or where the competitive landscape is rapidly changing, and we believe as a result of these changes that the organization's enterprise profile assessment will weaken over time, we generally would negatively adjust the enterprise profile assessment by one point on the table in anticipation of the effect of these changes.

58. In cases where a change could be positive, such as the bankruptcy of a close competitor or a change in reimbursement designation, the enterprise profile assessment would generally be positively adjusted by one point on the table.

59. Because of the fundamental importance of the medical staff and physicians to an organization as the gatekeepers for patient care, a weak medical staff assessment of '6' will cap the enterprise profile at '4'.

60. The relevant credit risks for U.S. not-for-profit stand-alone hospitals are also influenced by country-specific risks (see "Country Risk Assessments Methodology And Assumptions", published Nov. 19, 2013). Country risk is the risk an entity faces by having some of its operations or assets exposed to one or more countries. Country-specific risks consist of economic risks, institutional and governance effectiveness risks, financial system risk, and payment culture/rule of law risk. The country risk assessment is determined on a scale from '1' (very low risk) to '6' (very high risk).

61. The country risk assessment with respect to these criteria derives from the current U.S. country risk assessment as determined under the criteria cited above. If the U.S. country risk assessment is '3' or better, there is generally no positive or negative impact on the final rating. However, if the U.S. country risk assessment were to worsen to '4' or above, this could affect the enterprise risk profile assessment. Specifically, if the U.S. country risk assessment is '4', '5', or '6', the criteria generally assign an enterprise risk profile assessment of no better than '4', '5', or '6', respectively.

1. Industry risk

62. We believe the health care services industry represents intermediate credit risk when compared to other industries and sectors, which equates to a '3' on a six-point scale. The industry risk assessment of '3' is consistent with principles outlined in "Methodology: Industry Risk", published Nov. 19, 2013 and "Standard & Poor's Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries", published Nov. 20, 2013.

63. The following are key characteristics of the hospital industry:

- Limited price flexibility;
- Payment and reimbursement risk;
- Regulation;
- Relatively low sensitivity to macroeconomic conditions;
- Sensitivity to overall payer mix and, in particular, to private insurance coverage;
- Benefits of not-for-profit status;
- Service essentiality and competition;
- Favorable long-term demand growth underpinned by demographic trends;
- Minimal threat of substitutes, obsolescence, or innovation;
- Consolidation among service providers and payers;
- Competition generally is local; and
- Capital intensity.
2. Economic fundamentals

64. The economic fundamentals assessment measures the viability of the service area and the characteristics of the service area population. These factors influence the hospital's payer mix, amount and type of capital spending, available pool of patients, and philanthropic support, all of which in turn directly affect the level of revenue available for debt service payments currently and in the future. In addition, the economic fundamentals of a service area influence management's overall strategy.

65. The population of the hospital's primary service area (PSA), which is generally defined as the region from which the hospital derives at least 75% of its inpatients, forms the initial economic fundamentals assessment because it provides an indication of the pool of patients available to the hospital. Table 4 details the assessment for this measure.

66. The final economic fundamentals assessment equals the initial economic fundamentals assessment adjusted up or down for qualitative factors as shown in Table 4. For any qualitative factor met, the economic assessment would generally be adjusted up or down by one point.

67. However, after assessing the applicability of all qualitative adjustments, and because many of these factors are interrelated, the final assessment generally would be only one point in total away from the initial assessment unless all positive or all negative qualitative measures are met, in which case the final assessment generally would be two points away from the initial assessment.

68. Hospitals with a PSA population of less than 100,000 are not eligible for any positive qualitative adjustments because of the risks inherent of operating in a small service area.

Table 4

<table>
<thead>
<tr>
<th>Assessment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Service Area Population</td>
<td>&gt;1.5 million</td>
<td>500,000–1.5 million</td>
<td>350,000–500,000</td>
<td>150,000–350,000</td>
<td>100,000–150,000</td>
<td>&lt;100,000</td>
</tr>
</tbody>
</table>

Qualitative factors with a positive impact on the initial assessment (see paragraph 69)

- Population growth in the primary service area is projected to grow at 2x or greater than the projected U.S. growth rate over the next five years
- Employment growth in the primary service area is projected to be 150% or higher than the projected U.S. growth rate over the next five years
- Per capita personal income in the primary service area is projected to be greater than 125% of the projected U.S. per capita personal income in five years
- An ongoing, stabilizing institutional influence such as the presence of a major state university, state capital, military base, or large and stable corporate presence

Qualitative factors with a negative impact on the initial assessment (see paragraph 70)

- Population in the primary service area is projected to decline over the next five years
- Employment growth in the primary service area is projected to be half or less than the projected U.S. growth rate over the next five years
- Per capita personal income in the primary service area is projected to be less than 75% of the projected U.S. per capita personal income in five years
- Primary service area employment concentration where an individual sector or one employer represents a significant part of the employment base, but is not considered a stabilizing institution (as defined by the corresponding positive qualitative factor)

Each qualitative factor would change the initial assessment by one point, but would be capped at a one-point change unless all four positive or negative qualitative factors are met, in which case a two-point change is possible. For the purpose of assessing quantitative factors, a county or combination of counties most closely associated with the primary service area will be used. Sub-county data may be used in some cases where appropriate.
69. Economic characteristics of a PSA can be a key health care demand determinant. The size of the PSA, while an important starting point, can have very different characteristics from market to market. A stronger current and future patient base is more likely in a region with population growth, rising employment, and higher income indicators. Furthermore, an area with access to a diverse metropolitan area is more likely to attract future growth and will also have more and varied employment opportunities which in turn can lead to more commercially insured residents. For purposes of qualitative adjustment factors in table 4, the county or combination of counties most closely associated with the PSA will be used. In some cases when appropriate, sub-county data may be used.

70. In contrast, a smaller region with slower employment growth, employment concentration, or low income levels may deteriorate more rapidly in times of economic stress and produce a less favorable operating environment. If a significant portion of the local population lacks health insurance or if the hospital has growing self-pay and Medicaid business, local health care providers may be challenged to produce positive operating margins*.

3. Market position

71. Market position has the highest weight in the enterprise profile assessment because a leading or dominant market share in a large and diverse region positions a hospital to be able to successfully operate through economic cycles, assuming other factors such as cost and quality are in line with competitors. Conversely, multiple competitors in a retrenching market could result in the emergence of a true regional leader, generally average performance for all providers, or multiple poorly performing hospitals.

72. The market position assessment is derived from a weighted average of the four components outlined below and in chart 3:

- Market share, competition, and demand 50%
- Medical staff 20%
- Payer mix 15%
- Clinical quality and information technology 15%
a) Market share, competition, and demand

73. Market share is defined as the percentage of primary service area admissions that are admitted to a specific hospital. Higher market share has historically been an indicator of a hospital’s essentiality and contracting leverage. However, health care reform pressures are prompting the industry to focus on cost and quality measures and move toward a value-based model where higher admissions may not necessarily be financially beneficial. Certain management teams, medical staff, and local insurers may be more forward-looking than others. Because of the uncertainties and the high degree of change in the industry, it is difficult to project at what point additional volume is beneficial or harmful. However, we believe that market share still remains a relevant measure for traditional inpatient providers.

74. Single-specialty providers often need to serve a much larger and more regional population base than general acute-care providers as their pool of potential patients is limited to a single specialty or narrow niche. For that reason, we expect that the defined service area for a single-specialty provider will be geographically expansive. For single-specialty hospitals within a metropolitan area where there is a large enough population base, the service area could be more localized, however it is also more likely that the competition with acute-care providers, especially tertiary providers, will be more intense.

75. For single-specialty providers, market share considers the hospital’s share of the single specialty or narrow niche only. For example, a rehabilitation hospital will be measured based on its share of rehabilitation admissions originating in its primary service area. While most specialty hospitals define service area and market share in a similar way as acute-care providers, for those that do not provide data in the format outlined in table 5, we expect that management will be able to provide comparable information enabling us to estimate market share. We may also be able to estimate market share based on our knowledge of the market and of comparable organizations.
76. The initial market share, competition, and demand assessment would generally be adjusted favorably or unfavorably for qualitative factors in table 5. For each qualitative factor, the initial assessment would generally be adjusted favorably or unfavorably by one point on the table. However, after assessing the applicability of all qualitative adjustments, and because these factors are often interrelated, we would generally limit the adjustment to one point on the table, with a difference of two in rare circumstances, including situations where the organization has multiple hospitals, in contiguous or noncontiguous markets, which we believe adds significantly to the diversity and strength of the organization’s business position.

77. Hospitals with a primary service area population of less than 100,000 are not eligible for positive qualitative adjustments because of the risks inherent in operating in a small service area, including employment concentration, likely reliance on a small physician base, and increased turnover and recruitment risk. For the same reasons, no matter how high the market share, hospitals with small service areas will have the initial market share, demand, and competition assessment capped at '2' (if the primary service area population is between 100,000 and 150,000) or '3' (if the primary service area population is less than 100,000).

Table 5
Assessing Market Share, Competition, and Demand

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Service Area Population</td>
<td>1</td>
</tr>
<tr>
<td>&gt;1.5 million</td>
<td>&gt;10%</td>
</tr>
<tr>
<td>&gt;500,000</td>
<td>&gt;45%</td>
</tr>
<tr>
<td>&gt;350,000</td>
<td>&gt;60%</td>
</tr>
<tr>
<td>&gt;150,000</td>
<td>&gt;75%</td>
</tr>
<tr>
<td>&gt;100,000</td>
<td>N/A</td>
</tr>
<tr>
<td>&lt;100,000</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Qualitative factors with a positive impact on the initial assessment (see paragraphs 78-80; 81, 83, 90)

- Projected increase in inpatient admissions of 15% over the next five years measured on the same set of assets
- Projected increase in equivalent admissions of greater than 20% over the next five years
- Ratio of equivalent admissions to inpatient admissions is greater than 3.5
- Greater than 2.5% increase in primary service area market share over the past five years which we believe is permanent
- Sole provider of a mainstream key clinical service such as obstetrics, cardiac surgery, or oncology or an unusually broad service area definition due to the breadth of patient draw or unique services
- Certificate of need legislation that limits competition by requiring state approval for significant construction projects and equipment acquisition
- Medical staff assessment is a ‘1’

Qualitative factors with a negative impact on the initial assessment (see paragraphs 78, 80, 82, 84)

- Projected decline in inpatient admissions of greater than 5% over the next five years, or recent history of declining inpatient admissions greater than 10% over the last three years measured on the same set of assets
- No growth in historic (last three years) or projected, (next five years) equivalent admissions measured on the same set of assets
- Greater than 2.5% decline in primary service area market share over the past five years, which we believe is permanent
- Excess hospital capacity in the service area as measured by low occupancy, generally defined as less than 60%
- Narrowly drawn service area which may artificially boost market share

Each qualitative factor would change the initial assessment by one point but would be capped at a one-point change with a difference of two points possible in rare cases. N/A--Not applicable.
78. While absolute market share in a defined primary service area is important, it is also important to determine the hospital's relative strengths within the service area to better understand future trends. Hospitals with a trend of rising inpatient and outpatient volumes would be more likely to report strengthening financial performance, especially in a market with traditional payer characteristics. Conversely, an expected declining admission trend, shift to observation visits, or reduced outpatient visits, could begin to affect the financial position over the long term, especially if management does not adjust the expense base correspondingly.

79. We recognize that the percentage of revenue from inpatient admissions is declining, with outpatient volume accounting for half of total revenue at many hospitals. While the counting and reporting methodology for outpatient statistics is not comparable across hospitals, equivalent admissions can be used as a more comprehensive measure of all volume based on the relationship between inpatient and outpatient revenue. As the trend toward more outpatient care continues, we believe this will become an increasingly important predictor of future business demand and will use this metric, along with inpatient admissions, to determine the trend in overall volume. In addition, those hospitals that have an unusually strong outpatient presence, as evidenced by a high 3.5x ratio of equivalent admissions to inpatient admissions, may have a stronger business position than their inpatient market share would otherwise indicate and a favorable adjustment may be made to the initial market share, competition, and demand assessment.

80. The absolute trend of increasing or decreasing admissions usually but not always correlates to market share trends. Therefore, it is important to look at market share trends and recognize those hospitals with increasing market share, even though, in a contracting market, volumes may be declining. Conversely, in a growing market, volumes may be increasing, but if the pace is not as fast as market growth, market share will shrink. Also important is the rate of shift from inpatient to observation status, which can affect market share and may vary by individual hospital within a market or from region to region depending on physician practices.

81. The benefit to a hospital of being a sole provider of a mainstream clinical service, such as cardiac surgery or obstetrics, include negotiating power with insurance providers and the inclination of patients to use other services at the hospital once they have accessed the provider for the service where it is the sole provider. In addition, hospitals may have a very broad draw for certain specialized services, which gives them a unique advantage in their home market.

82. Excess hospital capacity in the service area, as measured by low occupancy which we consider to be generally less than 60% at all hospitals or by health care providers closing units or services, could negatively affect financial performance. Investment in health care-related property, plant, and equipment is very expensive, and to the extent that these high fixed costs must be covered by a declining or stagnant revenue base as admissions are spread among too many providers, earnings are likely to decline.

83. Certificate of need (CON) legislation in some form is enacted in almost three-quarters of U.S. states. CON rules aim to constrain costs and preclude duplication by requiring state agency approval prior to constructing new buildings, acquiring certain pieces of equipment, or adding services. While hospital strategies can be limited by the length of time the approval process takes, or by a denial, CON legislation also limits the level of competition between patient care providers, which is often a benefit to existing providers in the market.

84. At times hospitals may define their service area narrowly, resulting in artificially high market share while diminishing
that of their competitors. If the defined market area doesn't account for approximately 75% of inpatient admissions, we generally would adjust the market share assessment as we believe it would overstate the market strength of the organization.

b) Medical staff

85. Because hospitals cannot operate without physicians, a hospital's financial stability partially depends on management's relationship with its physicians and the organization's ability to attract and retain physicians. The quantity and type of physicians needed at any given hospital depend on the nature of the services provided. Being able to recruit the required number of physicians helps improve patient volume, which can contribute to improved market share and financial performance.

86. Our assessment of the medical staff considers three sub-factors:

• General medical staff characteristics;
• Medical staff competition; and
• Recruitment, retention, and employment.

87. Additional assessments apply to hospitals with fewer than 7,500 annual inpatient admissions. For those hospitals, where we consider physician concentration likely, we would focus on independent and referring physicians and would request a disaggregation of admission data relative to the ten-highest admitting physicians. Factors we could examine include the top 10 admitting physicians by specialty, age, employment status, tenure in the market, and number of admissions.

88. Each sub-factor will be assessed positive, neutral, or negative as outlined in tables 6, 7, and 8. In general, we will assess each factor in the three tables by looking at the variety of factors cited and use a preponderance of factors to determine each individual assessment. Each positive, neutral, or negative assessment then translates into numerical points of 1 for each positive factor, 2 for each neutral factor, and 3 for each negative factor.

89. When totaled, the initial medical staff assessment would be assigned as outlined in table 9. The initial medical staff assessment would generally be further adjusted favorably or unfavorably by one point for each qualitative factor met as outlined in table 9.
### Table 6

**Assessing General Medical Staff Characteristics**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive (1 point)</strong></td>
<td>The medical staff is large and growing. There is ample depth in each specialty and full-time coverage by hospital-based physicians at a level appropriate for the type and location of the hospital. Depth and coverage are measured by an assessment of the competitive market dynamics, number of physicians in each specialty, size and growth trends of the active medical staff, location of the provider, services offered, and use of temporary physician staff. The active medical staff is over 95% board certified. Key physicians participate in operational and strategic decisions along with senior lay management and governance. Concentration of admissions is limited with no single physician accounting for more than 3% of annual admissions, and no medical group accounting for more than 6% of annual admissions (excluding medical groups employed by the hospital or its wholly controlled affiliates).</td>
</tr>
<tr>
<td><strong>Neutral (2 points)</strong></td>
<td>The hospital's medical staff is adequate in size, but may lack depth in certain specialties, may have frequent turnover, or may be aging on the whole with limited young recruits. Hospital-based coverage is available for a majority of each day and night. Depth and coverage are measured by an assessment of the competitive market dynamics, number of physicians in each specialty, size and growth trends of the active medical staff, location of the provider, services offered, and use of temporary physician staff. The board certification rate for active staff physicians is over 80%. Physician involvement in management is limited to certain narrowly defined areas. No one physician accounts for greater than 3%-5% of annual admissions. No one medical group is responsible for more than 6%-20% of annual admissions (excluding medical groups employed by the hospital or its wholly controlled affiliates).</td>
</tr>
<tr>
<td><strong>Negative (3 points)</strong></td>
<td>The medical staff is static, small, and there are identifiable coverage gaps in key specialties which are either filled by temporary physicians or are unfilled, causing outmigration to other providers. Depth and coverage are measured by an assessment of the competitive market dynamics, number of physicians in each specialty, size and growth trends of the active medical staff, location of the provider, services offered, and use of temporary physician staff. Hospital-based coverage is slim or nonexistent. The board certification rate is below 80% and several key admirers are at or near retirement age. There is reliance on a single physician for greater than 5% of annual admissions, or in the case of a medical group, greater than 20% of annual admissions (excluding medical groups employed by the hospital or its wholly controlled affiliates).</td>
</tr>
</tbody>
</table>

### Table 7

**Assessing Medical Staff Competition**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive (1 point)</strong></td>
<td>Two-thirds or more of the medical staff do not have privileges at other hospitals and do not independently offer services that compete with the hospital's clinical services.</td>
</tr>
<tr>
<td><strong>Neutral (2 points)</strong></td>
<td>There are multiple practice options in the service area. Many medical staff members have privileges at more than one hospital. Medical staff participate in ventures that compete with the hospital's clinical services.</td>
</tr>
<tr>
<td><strong>Negative (3 points)</strong></td>
<td>There is abundant competition from physicians in the service area including but not limited to physician-owned single-specialty hospitals, ambulatory surgery or imaging centers. There is evidence of a strained relationship between the medical staff and management. Physicians are members of multiple medical staffs and have demonstrated willingness to shift business between hospitals.</td>
</tr>
</tbody>
</table>

### Table 8

**Assessing Medical Staff Recruitment, Retention, And Employment**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive (1 point)</strong></td>
<td>The medical staff is largely employed, accounting for more than 90% of inpatient admissions. For academic medical centers, the faculty practice plan is under the direct control of the hospital (or the hospital's parent company) and there may be a shared management structure between the medical school and hospital. Management reports consistent and successful physician recruitment with no meaningful gaps in services and we have not observed a trend of volume declines attributable to lack of physicians. Management follows a detailed physician needs study to determine recruiting strategy and can provide details on its recruitment and retention actions as well as the expected impact on the institution's competitiveness. For those hospitals that employ physicians directly, there are demonstrated management resources, information technology, and financial support provided to the practices.</td>
</tr>
<tr>
<td><strong>Neutral (2 points)</strong></td>
<td>The employed medical staff accounts for approximately half of all inpatient admissions. For academic medical centers, the faculty practice plan is not controlled or managed by the hospital. The hospital reports that it sometimes has difficulty recruiting sufficient numbers of primary care or specialty physicians in a timely manner, leaving the hospital with service gaps or vulnerable to sudden physician departures. Management is opportunistic in determining physician needs and does not necessarily have a routinely updated recruitment and retention plan that seeks to proactively identify potential areas of physician need. For hospitals that employ physicians directly, there is not a full array of financial and operational managers exclusively dedicated to the employed physician practices, although there are managers within the hospital that are responsible for financial reporting and operational management.</td>
</tr>
<tr>
<td><strong>Negative (3 points)</strong></td>
<td>Management reports it has difficulty recruiting sufficient physicians to the employed or voluntary medical staff as evidenced by a reliance on temporary medical staff to meet the needs of its service area and by unexpected volume declines in certain services. For hospitals that employ physicians directly, the management of the physicians is not coordinated and there are limited resources available to monitor operations and financial performance.</td>
</tr>
</tbody>
</table>
### Table 9

<table>
<thead>
<tr>
<th>Aggregate Points (from tables 6, 7, and 8)</th>
<th>Initial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully employed medical staff (see paragraph 90)</td>
<td>1</td>
</tr>
<tr>
<td>3 points</td>
<td>2</td>
</tr>
<tr>
<td>4–5 points</td>
<td>3</td>
</tr>
<tr>
<td>6 points</td>
<td>4</td>
</tr>
<tr>
<td>7–8 points</td>
<td>5</td>
</tr>
<tr>
<td>9 points</td>
<td>6</td>
</tr>
</tbody>
</table>

**Qualitative factors with a positive influence on the initial assessment (see paragraphs 90-92)**

Fully integrated medical staff receive a medical staff assessment of '1' and can achieve a one-point improvement in the market share, competition, and demand assessment.

Closed faculty practice plan at an affiliated medical school that is responsible for a majority of patient volumes, even without an integrated management team, can achieve a medical staff assessment of ‘2’.

Medical staff with over 500 active physicians can improve the medical staff assessment by one point.

**Qualitative factors with a negative influence on the initial assessment (see paragraphs 93-95)**

Evidence of significant medical staff turmoil results in a medical staff assessment of ‘6’ and caps the enterprise profile assessment at ‘4’.

Physician admission concentration for hospitals with fewer than 7,500 annual admissions results in a medical staff assessment of ‘6’ and caps the enterprise profile assessment at ‘4’.

Average age of leading admitting physicians greater than 55 for hospitals with fewer than 7,500 annual admissions results in a medical staff assessment of ‘5’ or ‘6’. A assessment of ‘6’ caps the enterprise profile assessment at ‘4’.

A hospital that qualifies for multiple positive qualitative factors will receive only the single-most beneficial adjustment to the medical staff assessment.

90. An assessment of ‘1’ would generally be achieved with a fully employed medical staff where the hospital controls the physicians through direct management and by paying their salaries. For academic medical centers with faculty practice plans, the practice must be fully controlled by the hospital or its parent or have a single management team for both the hospital and academic components with the hospital possessing meaningful control over faculty activities and operations to achieve this assessment. Hospitals achieving an assessment of ‘1’ can have a one-point improvement in the market share, competition, and demand assessment.

91. An assessment of ‘2’ would generally be assigned for academic medical centers where there is a closed faculty practice plan at an affiliated medical school that is responsible for a majority of the patient volumes, even if there is no integrated management team.

92. General acute-care hospitals with very large active medical staff, which we consider to be more than 500 physicians, are likely to have significant depth and breadth of specialties, and therefore generally would achieve a one-point improvement in the initial medical staff assessment.

93. Hospitals with significant changes in medical staff, including important staff vacancies or credible threats of sizable physician departures, evidence of a strained relationship with management or governance, or litigation between the hospital and the medical staff, would generally be assessed ‘6’.

94. For hospitals with fewer than 7,500 annual inpatient admissions, if the 10 highest admitting physicians account for more than 50% of annual inpatient admissions, the medical staff assessment generally would be ‘6’. In calculating the
top 10 admitters, hospitals with hospitalist programs should look to the referring physician as the admitter, not the hospitalist. In addition, hospitals where the average age of the top 10 admitters is 55 or higher will have the medical staff assessment capped at '5', with a '6' assessment likely if several of the leading admitters are older than 60 and do not have an identified successor.

95. For a hospital with a medical staff assessment of '6', the enterprise profile assessment will be capped at '4' (see table 3).

c) Payer mix
96. The assessment of a hospital's payer mix considers five sub-factors relative to net patient service revenue (NPSR):

- Reliance on Medicare;
- Reliance on Medicaid;
- Reliance on commercial and managed care payers;
- Reliance on a single nongovernmental payer; and
- Diversity of payment methodologies and preparation for future delivery system payment methodologies.

97. A hospital's payer mix is dictated by its location, services provided, mission, physicians, and characteristics of the service area population. Payer mix directly affects earnings and its trend identifies potential risks for the hospital.

98. Medicaid and Medicare, both government-run payers, typically have reimbursement rates far below commercial insurers. Medicaid is often subject to cuts or eligibility changes as a result of state policy changes. Medicare in general offers rates that are below commercial payers, although not typically as low as Medicaid rates. Reliance on Medicare and Medicaid for a majority of revenue when both payers typically pay at levels below cost is a risk because costs must then be covered by substantially higher rates from commercial and managed care payers.

99. A high concentration of NPSR in a single payer represents a credit risk because a contract could be terminated, the insurer could exit the market or be acquired by another insurer, and the payment terms can change materially from contract to contract. Conversely, a well-dispersed payer mix represents a credit strength because providers are not reliant on any one payer for too much revenue, and the loss of a contract, while disruptive, can usually be managed over time. When evaluating reliance on a single nongovernmental payer, we will include the hospital's NPSR from all contracts with that payer, regardless of the basis of payment. For example, revenue from a commercial fee-for-service contract with Blue Cross, a Blue Cross Medicaid managed care contract, and a capitated contract with Blue Cross will be evaluated together as Blue Cross revenue.

100. Under health care reform, each state has a health care exchange or insurance marketplace. In some cases, these are state-run and in others federally run. We expect a considerable part of the initial business mix coming out of exchanges will be subsidized by the federal government and expect the rates will be closer to governmental rates than existing commercial rates.

101. In assessing the payer mix, contract negotiation strategies, payment basis of the contract, and any demographic changes that are likely to shift the payer mix such as an aging population, will be considered.

102. We view positively providers pursuing, preparing for, and entering into performance-based contracts, including capitated, bundled accountable care, or quality-based contracts. Because we believe these contracts are becoming more prevalent, providers starting early by signing such contracts on a smaller scale can gain experience in putting the
necessary processes, controls, and procedures in place to maximize potential incentives. While there may be short-term transition risk associated with this strategy -- for example, incentives to reduce hospitalization could in turn reduce NPSR -- we believe organizations that experiment with these contracts now will be better prepared in the future. While treated as a positive in this payer mix section, if these contracts are unprofitable, the downside would be captured in the financial profile analysis.

103. Each payer mix sub-factor will be assessed positive, neutral, or negative as outlined in table 10. Each positive, neutral, or negative assessment then translates into numerical points of 1 for each positive factor, 2 for each neutral factor, and 3 for each negative factor. The initial payer mix assessment would then be assigned as outlined in table 11.

104. The initial payer mix assessment generally would be further adjusted for each qualitative factor met as outlined in table 11 to determine the final payer mix assessment.

Table 10
Assessing The Payer Mix

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial and Managed Care Plans</th>
<th>Reliance on a Single Nongovernmental Payer</th>
<th>Payment Method Diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive (1 point)</td>
<td>Medicare NPSR is less than 25% of total NPSR</td>
<td>Medicaid NPSR is less than 5% of total NPSR</td>
<td>Contracts signed with all material insurance plans in the market which together account for greater than 55% of NPSR</td>
<td>NPSR from the largest nongovernmental payer is less than 15% of total NPSR</td>
<td>The hospital has incentive- and performance-based contracts which represent a meaningful amount of annual NPSR</td>
</tr>
<tr>
<td>Neutral (2 points)</td>
<td>Medicare NPSR is between 25% and 50% of total NPSR</td>
<td>Medicaid NPSR is between 5% and 20% of total NPSR</td>
<td>Contracts signed with most material insurance plans in the market which together account for 30%-55% of NPSR</td>
<td>NPSR from the largest nongovernmental payer is between 15% and 30% of total NPSR</td>
<td>The hospital has a modest amount of incentive- and performance-based contracts, but most payments remain fee-for-service</td>
</tr>
<tr>
<td>Negative (3 points)</td>
<td>Medicare NPSR exceeds 50% of total NPSR</td>
<td>Medicaid NPSR exceeds 20% of total NPSR</td>
<td>There are a limited number of insurance companies doing business with the hospital and NPSR from commercial payers is 30% or less</td>
<td>NPSR from the largest nongovernmental payer exceeds 30% of total NPSR</td>
<td>The hospital's contracts are largely fee for service and consequently, the organization has little or no experience with incentive- or performance-based contracts</td>
</tr>
</tbody>
</table>

Medicare and Medicaid managed care revenue are classified as Medicare and Medicaid revenue even if the revenue comes from a Medicare or Medicaid managed care product. Revenue from a health plan owned by the hospital or its controlled affiliates is excluded from the concentration measures under reliance on a single nongovernmental payer. NPSR—Net patient service revenue.

Table 11
Determining The Payer Mix Assessment

<table>
<thead>
<tr>
<th>Aggregate Points (from table 10)</th>
<th>Initial Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-6 points, Hospital-owned health plan or located in a rate regulated state</td>
<td>1</td>
</tr>
<tr>
<td>7-8 points</td>
<td>2</td>
</tr>
<tr>
<td>9-10 points</td>
<td>3</td>
</tr>
<tr>
<td>11 points</td>
<td>4</td>
</tr>
<tr>
<td>12–13 points</td>
<td>5</td>
</tr>
<tr>
<td>14-15 points</td>
<td>6</td>
</tr>
</tbody>
</table>

Qualitative factors with a positive impact on the initial assessment (see paragraphs 105-106)

Ownership of health plan which accounts for a sizable percentage of an organization’s revenue as long as all other payer mix component assessments are at least neutral results in a assessment of ‘1’
Table 11

Determining The Payer Mix Assessment (cont.)

If a hospital operates in a state where rates are set for all payers by the legislature or state commission, the payer mix assessment could be a ‘1’

Qualitative factors with a negative impact on the initial assessment (see paragraphs 107-109)

If a hospital does not have a contract with the leading health insurer in the market, as measured by enrollees, the assessment could be negatively adjusted by one point

When Medicare and Medicaid account for a combined 70% or more of annual NPSR, or Medicaid accounts for more than 30% of annual NPSR, the payer mix assessment is ‘6’

Reliance on a single nongovernment payer for more than 40% of NPSR could result in a payer mix assessment of ‘6’

105. In the emerging health care reform environment, more and more payments are expected to reflect successful management of insurance risk. Ownership of a health plan allows the provider to gather experience in managing insurance risk and is considered a benefit. An assessment of ‘1’ would be possible for hospitals that own their own health plans, as long as the plan’s revenue is greater than 25% of the hospital’s total operating revenue, if it is generally profitable, and if the hospital has at least a neutral assessment on all five measures in table 10.

106. A hospital generally would receive a payer mix assessment of ‘1’ if it operates in a state where rates for all payers are set by the legislature. This can be accomplished by having a state commission annually set the rates that all hospitals can charge and by requiring that all payers for a given hospital provide payment at the same rate. In 2014, Maryland was the only state that exhibited these characteristics.

107. A provider that does not contract with a meaningful health insurer in its market is likely to have difficulty attracting both patients and physicians, especially as incentives to remain in network are increasingly important as a cost-saving measure for consumers and, therefore, the payer mix assessment generally would be negatively adjusted by one point.

108. A payer mix assessment of ‘6’ generally would be assigned to a hospital with high reliance on governmental payers as defined by Medicare and Medicaid combined accounting for 70% or more of annual NPSR or by Medicaid accounting for more than 30% of annual NPSR. In these cases, where payments and benefits are unilaterally established by state and federal governments with many competing priorities, a provider may find it more difficult to predict revenue, do strategic and financial planning, and manage daily operations. The issues are further exacerbated by the fact that Medicaid and Medicare typically pay among the lowest rates to hospitals and other health care providers.

109. A payer mix assessment of ‘6’ generally would be assigned if a single nongovernmental payer accounts for more than 40% of NPSR.

d) Clinical quality and information technology

110. Performance on clinical quality metrics, the ability to track and document clinical actions through information technology, and dissemination of quality results to physicians, payers, regulators, and the general public are becoming increasingly important, not only from a consumer perspective, but also because reimbursement levels increasingly depend on a provider’s ability to document quality.

111. Medicare, commercial payers and states, through Medicaid, are increasingly adding performance-based bonuses and penalties to their reimbursement arrangements.

112. Transparency related to clinical quality performance and patient satisfaction is increasing, with numerous freely
available sources of information now available to consumers. The availability of information and the growing amount of out-of-pocket expenses borne by consumers, including those in rapidly growing high-deductible health plans, increase the likelihood that a hospital's performance on reported quality measures will drive consumer decisions about where to seek health care.

113. As payments to hospitals become increasingly tied to quality performance measures, and transparency makes it easier for consumers to use reported information to make decisions about where to seek health care, a hospital's patient volumes and revenues could be positively or negatively affected.

114. The assessment of quality is based on five factors:

- Process of care;
- Patient satisfaction and reputation;
- Mortality and readmission;
- Quality management and oversight; and
- Information technology and electronic health record implementation.

115. All five measures are aligned with nationally recognized standards that are consistently calculated and reported by hospitals across the country. All or a portion of the first three factors are part of The Centers for Medicare and Medicaid Services' (CMS) Value Based Purchasing initiatives. To the extent that CMS changes or updates its measures from year to year, we may adjust our measures to match, while also maintaining the same assessment protocols.

116. The five clinical quality and information technology factors as outlined in table 12 and further defined in Appendix 3 will be assessed from zero to 100 potential points. The initial clinical quality and information technology assessment would then be assigned as outlined in table 13.

117. The initial assessment would generally be further adjusted for each qualitative factor met as outlined in table 13. These qualitative factors do not represent an endorsement of the sponsoring organizations, but rather recognize management's commitment to quality improvement or the potential favorable business implications of industry-recognized awards and recognitions.

118. We recognize that hospitals may also receive additional industry awards and our view of these awards will likely be used as a determining factor for those hospitals that are at or near a cut-off point in table 13.

119. The process of care, patient satisfaction and reputation, and mortality and readmissions factors apply to general acute-care hospitals only and exclude specialty hospitals, including pediatrics, rehabilitation, cancer, long-term acute-care hospitals, and critical access hospitals. The excluded hospitals will be assessed based on the other two factors and their demonstrated performance on quality measures specific to their specialty. Without specific evidence, we will assume the hospital is on par with national averages for the three excluded factors. Hospitals that do not report to CMS on a measure included in the process of care, patient satisfaction and reputation, and mortality and readmissions factors will be treated as if it is on par with national average unless we have evidence to believe otherwise. Hospitals that are not excluded as described above and do not report on 12 or more of the 26 measures included in these three factors of the assessment likely have a limited clinical range, and their clinical quality and information technology assessment will be capped at '3'.

www.standardandpoors.com/ratingsdirect
Table 12

Assessing Clinical Quality And Information Technology

<table>
<thead>
<tr>
<th>Key measures</th>
<th>Total available points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process of care</strong></td>
<td>CMS hospital value-based purchasing process of care measures</td>
</tr>
<tr>
<td><strong>Patient satisfaction and reputation</strong></td>
<td>CMS hospital value based purchasing patient experience of care measures</td>
</tr>
<tr>
<td><strong>Mortality and readmission</strong></td>
<td>CMS outcome of care measures</td>
</tr>
<tr>
<td><strong>Quality management and oversight</strong></td>
<td>Quality management and oversight</td>
</tr>
<tr>
<td><strong>IT and electronic health record implementation</strong></td>
<td>Qualification for meaningful use</td>
</tr>
</tbody>
</table>

For hospitals classified as stand-alone but which own more than one hospital, the assessment would be based on the acute care hospital with the largest revenue base. For each qualitative factor met per table 13, an additional five points will be deducted. See Appendix 3 for the complete list of measures.

Table 13

Determining The Clinical Quality And Information Technology Assessment

<table>
<thead>
<tr>
<th>Aggregate Points</th>
<th>Initial Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20</td>
<td>1</td>
</tr>
<tr>
<td>20-30</td>
<td>2</td>
</tr>
<tr>
<td>30-45</td>
<td>3</td>
</tr>
<tr>
<td>45-55</td>
<td>4</td>
</tr>
<tr>
<td>55-65</td>
<td>5</td>
</tr>
<tr>
<td>&gt;65</td>
<td>6</td>
</tr>
</tbody>
</table>

**Qualitative factors with a positive impact on the initial assessment (see paragraph 120)**

- Malcolm Baldrige National Quality Award within the last 10 years
- Recognized on The Joint Commission's Top Performers on Key Quality Measures list for the most recently reported year
- Providers with exceptional awards for extraordinary quality performance and commitment by management to clinical quality, information technology, and transparency may deduct up to five points for the two qualitative factors outlined in table 13 for a total benefit of 10 fewer points

120. For providers with exceptional awards for extraordinary quality performance and commitment by management to clinical quality, information technology, and transparency, we would generally deduct up to five points for the two qualitative factors outlined in table 13 for a total benefit of 10 fewer points.

4. Management and governance

121. The management and governance assessment is consistent with principles outlined in in "Methodology: Management and Governance Credit Factors For Corporate Entities and Insurers", published Nov. 13, 2012. In these criteria, we assess only the relevant sub-factors that apply to U.S. not-for-profit acute-care stand-alone hospitals.

122. The applicable measures are broadly divided into eight management measures (under strategic positioning, risk and financial management, and organizational effectiveness), and five governance measures.

123. The eight management-oriented sub-factors in table 14 are assessed as positive, neutral, or negative (see table 1 and
Each positive, neutral, or negative assessment of management translates into numerical points of 1 for each positive factor, 2 for each neutral factor, and 3 for each negative factor. In most cases, when added together, the initial management assessment would be assigned as outlined in table 16.

Table 14

<table>
<thead>
<tr>
<th>Assessing Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Positioning</strong></td>
</tr>
<tr>
<td>Strategic planning process</td>
</tr>
<tr>
<td>Consistency of strategy with organizational capabilities and marketplace conditions</td>
</tr>
<tr>
<td>Ability to track, adjust, and control execution of strategy</td>
</tr>
<tr>
<td><strong>Risk Management</strong></td>
</tr>
<tr>
<td>Comprehensiveness of risk management standards and tolerances</td>
</tr>
<tr>
<td>Standards for operational performance</td>
</tr>
<tr>
<td><strong>Organizational Effectiveness</strong></td>
</tr>
<tr>
<td>Management’s operational effectiveness</td>
</tr>
<tr>
<td>Management expertise and effectiveness</td>
</tr>
<tr>
<td>Management’s depth and breadth</td>
</tr>
</tbody>
</table>

Table 15

<table>
<thead>
<tr>
<th>Assessing Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance</strong></td>
</tr>
<tr>
<td>Board effectiveness</td>
</tr>
<tr>
<td>Management culture</td>
</tr>
<tr>
<td>Regulatory, tax, or legal infractions</td>
</tr>
<tr>
<td>Internal controls</td>
</tr>
<tr>
<td>Financial reporting and transparency</td>
</tr>
<tr>
<td>Qualitative factors with a negative impact on the initial assessment (see paragraphs 126-127)</td>
</tr>
<tr>
<td>Parent board does not hold all key reserve powers</td>
</tr>
<tr>
<td>Board is not self-perpetuating, lacks independence, and affects the ability to make decisions in the best interest of the hospital</td>
</tr>
</tbody>
</table>

The governance measures as outlined in table 15 are assessed as neutral or negative with four or more neutral assessments resulting in a neutral governance assessment and two or more negative assessments resulting in a negative governance assessment (see table 2, paragraphs 42, 44, 46 to 47, and 49 to 52 of the "Management And Governance Credit Factors" criteria).

A negative governance assessment will be assigned unless a parent board holds all key reserve powers over its subsidiaries, including the ability to remove management and approve all meaningful financial transactions.

Boards that are self-perpetuating and have little or no requirement for outside appointees, or requirements that outside entities approve board membership, have the most control over the organization's strategic direction and are less likely to be influenced by competing forces, including politics. A negative governance assessment would generally be assigned if more than 20% of board members must be approved by an outside entity or an outside entity appoints...
more than 20% of board members, if we believe such requirements result in the board not acting in the best interests of the organization. Examples of such outside entities include governments, universities, and religious sponsors.

Table 16

<table>
<thead>
<tr>
<th>Aggregate Points</th>
<th>Initial Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-10</td>
<td>1</td>
</tr>
<tr>
<td>11-13</td>
<td>2</td>
</tr>
<tr>
<td>14-17</td>
<td>3</td>
</tr>
<tr>
<td>18-20</td>
<td>4</td>
</tr>
<tr>
<td>21-22</td>
<td>5</td>
</tr>
<tr>
<td>23-24</td>
<td>6</td>
</tr>
</tbody>
</table>

**Qualitative factors with negative impact on initial assessment (see paragraphs 128-129)**

Negative assessment on any one of the eight management sub-factors may cap the management and governance assessment at ‘5’

Negative governance assessment may cap the management and governance assessment at ‘4’

128. Because of the direct impact that management and governance practices have on an organization's credit profile, any one negative sub-factor that is materially deficient could potentially be harmful to credit quality. If we view any one negative sub-factor as presenting sufficient risk to the enterprise's credit profile, we would generally cap the management and governance assessment at ‘5’ even if the remaining sub-factors are assessed positive or neutral.

129. Similarly, a negative governance assessment generally would cap the management and governance assessment at ‘4’.

130. Finally, a neutral governance assessment would not positively influence the management and governance assessment.

**D. The Financial Profile Assessment**

131. The financial profile assesses the financial strength of the hospital. Four factors are assessed as part of the initial financial profile assessment (see chart 4):

- Financial policies;
- Financial performance;
- Liquidity and financial flexibility; and
- Debt and contingent liabilities.
132. The assessment of financial policies can be neutral or negatively influence the overall financial profile assessment, but would not positively influence the assessment.

133. Assessments for the remaining three factors range from '1' (the strongest) to '6' (the weakest). The criteria then average each of the three sub-scores according to the weights described in paragraph 13 to determine the overall financial profile assessment, which will subsequently be applied in table 1 to arrive at the initial indicative rating.

134. When scoring the financial profile or any component of the financial profile, if the assessment falls at or near a cut-off or midpoint, we generally would assign the lower assessment if trends are improving or we believe future performance will improve. We would also generally use the higher assessment if trends are weakening or we believe future performance will be weaker.

135. Our assessment of a hospital’s financial metrics is based on ratios and numbers derived from interim, audited, budgeted, and forecasted financial statements. These statements should reflect the operations of the hospital and all other related companies under common control (the group), in accordance with “Group Rating Methodology”, published Nov. 19, 2013. The rating will be based on our view of the group credit profile, which reflects the credit strength of the consolidated organization, and the obligated group’s status, which reflects its importance to the group. In cases where an organization has multiple obligated groups, we would generally assign a rating to each obligated group based on the group credit profile and each obligated group’s status within the larger consolidated organization. Absent structural enhancements like additional collateral, a closed lien, or ring-fencing, our assessment of the group credit profile will be the highest rating an obligated group could achieve.

136. In most cases, the ratio calculations are based on the three most recent periods of financial information as defined by three audits or two audits and interim data as long as at least one quarter of interim data (in a format comparable to the audit) is available.
137. If interim-period data is included, the interim data would be weighted at 20%, the previous year’s audit at 45%, and the audited period before that at 35%. When interim-period data is not representative of expected future performance, only includes the obligated group, or is less than three months of the fiscal year, three audited periods will typically be used and weighted 45%, 35%, and 20%, respectively from most to least current.

138. Pro forma numbers would be used for those ratios affected by additional debt issuance or equity spending on a project, or when we believe that historic performance is not representative of expected future performance.

139. In calculating the ratios, we typically use audited and interim results if we believe they are reflective of future results. If we believe future performance will deviate from historic results, we will use pro forma or projected data. Pro forma or projected data will be used based on our analytical assessment of the global and local health care environment and may but do not have to be informed by a review of the hospital’s internal projections or pro forma expectations. Examples of such instances are when a hospital has a potentially large debt issuance, pending liability, likely acquisition, merger, or divestiture, or plans to draw down internal reserves.

140. In a previous commentary, we indicated that the change in accounting rules for bad debt as outlined by the Financial Accounting Standards Board (FASB 2011-07) effective for most hospitals in fiscal year 2012 will be credit neutral as we view the change in standards as purely accounting-based and not reflective of an underlying change in the fundamentals of the business (see “How U.S. Not-for-Profit Health Providers’ Financial Ratios Will Change Under The New Bad Debt Accounting Rules”, published Oct. 10, 2012). This accounting change affects six ratios included in these criteria: net patient service revenue, EBIDA margin*, operating margin*, excess margin*, days’ cash on hand*, and debt burden* (see tables 19, 20, and 21). To ensure that all financial periods are assessed in a consistent way, when using 2011 and prior audits as a component of our scoring, we will adjust the audited results to account for bad debt as a contractual allowance rather than an expense.

141. Table 17 outlines three situations where we generally would adjust the initial financial profile assessment to arrive at the final financial profile assessment. For organizations qualifying for one or more, but not all adjustments, we would generally limit the initial financial profile assessment adjustment to one point on the table, with an adjustment of two points possible in rare circumstances.

<table>
<thead>
<tr>
<th>Adjustment Factor</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business disruption such as failure to attain accreditation, permanent loss of a material payer contract or reimbursement designation, excessive liability, or labor issues that threaten operations (see paragraphs 142–145)</td>
<td>Financial profile assessment may be adjusted negatively by one point</td>
</tr>
<tr>
<td>Potentially sizable but as yet unspecified capital plans expected to result in a measurable adverse change in debt and/or unrestricted reserves (see paragraph 146)</td>
<td>Financial profile assessment may be adjusted negatively by one point</td>
</tr>
<tr>
<td>Negative financial policy assessment (see paragraph 148)</td>
<td>Financial profile assessment may be adjusted negatively by one point</td>
</tr>
</tbody>
</table>

Each qualitative factor would change the initial assessment by one point. However, for organizations qualifying for one or more, but not all adjustments, we would generally limit the initial financial profile assessment adjustment to one point, with two points possible in rare circumstances.

142. There are several events that could cause significant business disruption for an extended period. These could include...
failure to attain accreditation or loss of accreditation – whether it was voluntarily sought or required as a condition of participation for Medicare or Medicaid. Hospitals are required to be accredited by outside agencies to ensure compliance with various rules and regulations, including the ability to receive governmental reimbursement under state and federal programs.

143. Similarly, if a hospital loses a material payer contract, a payment designation such as sole community provider status, or resides in a state where a provider tax program expires, these events would probably lead to an immediate and substantial decline in revenue, which would likely be very difficult to reverse in the near to medium term. In such a situation, the financial profile assessment generally would be negatively adjusted by one point on the table. In determining whether to apply this factor, a total revenue loss of at least 3% would generally be required. In addition, we would also consider the hospital's plan to replace the revenue and, if it was credible, generally would not make this adjustment.

144. If we become aware, based on conversations with management or governance, reports in the press, public disclosure, or other informational sources we judge to be relevant, that a hospital has been exposed to a liability risk above insurance coverage levels, or is facing a judgment that is likely to result in a significant financial settlement, the financial profile assessment generally would be negatively adjusted. The adjustment would be predicated on the magnitude of the potential liability compared to the resources available to the hospital to meet the liability, including internal reserves, insurance coverage, and other parties that may be assigned a portion of the ultimate liability. Furthermore, the adjustment would be made if there is sufficient understanding to believe that the liability will be significant enough to potentially result in sharply reduced credit quality, perhaps to the point of missed debt service payments or bankruptcy filing. Routine lawsuits, which are likely to be covered within insurance limits or by a relatively small settlement from hospital reserves, are not likely to result in an adjustment to the financial profile assessment.

145. If a hospital's operations are in jeopardy because of labor issues, the financial profile assessment generally would be negatively adjusted by one point on the table. Factors determining the extent of the adjustment, if any, include whether a strike is threatened or ongoing, management's expectations for the length of the strike, whether replacement personnel can be brought in at a reasonable cost to prevent revenue loss, and whether or not the striking workers are involved in direct patient care. We also consider the organization's history of labor relations with a record of contentious relations likely to result in a pessimistic view of the current labor situation.

146. If a hospital has potentially sizable, but as yet unspecified, capital plans which could result in material additional debt or use of reserves, and we determine that such plans have a reasonable likelihood of occurrence but are not specific enough yet to determine pro forma or projected financial metrics, we generally would negatively adjust the financial profile by one point.

1. Financial policies

147. The financial policies assessment consists of five equally weighted sub-factors:

- Transparency and disclosure;
- Investment allocations and liquidity;
- Debt profile;
• Contingent liability principles; and
• Legal structure.

148. This assessment measures how a hospital's financial management and policies have affected and are likely to affect an organization’s ability to pay debt service. When evaluating these five sub-factors, we rely on documentation provided by the hospital, in addition to our periodic discussions with management. Relevant documents typically include audited financial statements, interim financial statements, budget documents, financial forecasts, and various policy documents related to treasury and risk management. Each factor is assessed neutral or negative according to the characteristics outlined in table 18. If a majority of the sub-factors are assessed negative, the financial policies assessment will be negative. If a majority of the sub-factors are neutral, the financial policies assessment will be neutral.

### Table 18

<table>
<thead>
<tr>
<th>Assessing Financial Policies</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transparency and Disclosure (see paragraph 150)</strong></td>
<td>A final unqualified audit is performed by an independent firm and is released within four months of the fiscal year-end.</td>
<td>The audit is qualified or may be typically late (not published within four months of the fiscal year-end). Interim financial statements are not at the comprehensive entity level or not representative of actual performance</td>
</tr>
<tr>
<td><strong>Investment Allocations and Liquidity (see paragraph 151)</strong></td>
<td>The investment management policy is appropriate relative to the hospital’s liabilities, investment office sophistication, and potential capital needs. The hospital does not need to use short-term lines of credit and has ample liquidity to meet working capital needs</td>
<td>The investment management policy is more aggressive than that of the hospital’s peers. The hospital needs to access lines of credit regularly to meet working capital needs</td>
</tr>
<tr>
<td><strong>Debt Profile (see paragraph 152)</strong></td>
<td>Contingent liability debt is less than 50% of total debt</td>
<td>Contingent liability debt is more than 50% of total debt</td>
</tr>
<tr>
<td><strong>Contingent Liability Principles (see paragraph 153)</strong></td>
<td>The hospital has at least as much liquidity as would be required to meet any potential liabilities associated with contingent liabilities, such as a failed remarketing or acceleration in the event of a covenant default. The hospital has no swaps or the total notional amount of swaps outstanding including basis swaps is less than 50% of long-term debt</td>
<td>Liquidity is below the level of its potential liabilities under its contingent liability documents. The hospital is reliant on swaps, with the total notional amount outstanding, including basis swaps, greater than 50% of long-term debt</td>
</tr>
<tr>
<td><strong>Legal Structure (see paragraph 154)</strong></td>
<td>The legal package provided with the hospital’s bond issue includes, at a minimum, a rate covenant, additional bonds test, and consultant call-in requirements for covenant violations</td>
<td>The legal and security covenants may exclude, or have unusually favorable calculations, for one or more traditional covenant tests</td>
</tr>
</tbody>
</table>

149. We believe that the financial policies assessment does not positively affect the rating as good policies are reflected in results which are measured. For hospitals with a negative financial policies assessment, the financial profile assessment generally would be negatively adjusted by one point on the table to reflect the risk of potential weakening future performance.

150. Frequent and comprehensive disclosure reflects favorably on management’s reporting and monitoring capabilities. Conversely, organizations that do not report frequently or comprehensively may lack the reporting and monitoring capabilities necessary to proactively manage their business. A qualified audit opinion represents a serious concern for the auditor about the organization’s viability. Audits and interims must be provided based on the comprehensive entity and not just the obligated group to receive a neutral assessment.

151. Investment allocations should be reflective of a hospital’s unique needs and capabilities. The investment allocation...
appropriate for that organization should reflect the potential need to liquidate securities to fund a portion of the capital program, including consideration given to the time when the securities will need to be liquidated and the potential volatility of those securities' value. Other considerations in asset allocation include the investment office's staffing and capabilities and any potential contingent liquidity needs based on the nature of the organization's liabilities. Organizations that regularly tap lines of credit for working capital are dependent on the uncertainties of the periodic rollover of the line.

152. Hospitals with a high proportion of debt in noncommitted structures like variable-rate demand bonds, commercial paper, direct purchase debt with acceleration features beyond those found in typical master trust indentures, and bonds with mandatory tenders over the near to medium term have greater risk related to the periodic renewal of liquidity facilities, need to frequently access the capital markets to roll over short-term debt, and potential acceleration due to events of default under various financing documents like letters of credit or direct purchase debt. Conversely, organizations with committed debt like fixed-rate bonds have less exposure to renewal risks, interest-rate fluctuations, and unexpected acceleration.

153. Hospitals that have liquid investment portfolios in excess of their contingent liabilities have greater ability to cover unexpected events, including swap or liquidity facility terminations and events of default causing acceleration of the instrument. Organizations whose liquid investment portfolios are smaller than contingent liabilities may face a fiscal crisis if an unexpected event occurs.

154. While legal covenants typically do not improve the credit quality of an organization or its business fundamentals, a minimum set of covenants provides at least a modest framework constraining the behavior of the borrower that could weaken bondholder security. We believe that in the acute-care hospital sector those minimums include a rate covenant of 1x or higher, an additional bonds test, and provisions requiring the borrower to call in a consultant when a covenant is violated. For more information and definitions on the legal structure, please refer to the criteria article "Methodology: Definitions And Related Analytic Practices For Covenant And Payment Provisions In U.S. Public Finance Revenue Obligations", published Nov. 29, 2011.

2. Financial performance

155. The financial performance assessment measures how a hospital's absolute level and volatility of recent and projected earnings and cash flow could affect its debt servicing capability. These criteria use six measures to evaluate financial performance and combine them according to the weighted averages below to determine the initial financial performance assessment:

- Net patient service revenue (NPSR) 16.7%
- EBIDA margin 16.7%
- Operating margin 16.7%
- Excess margin 16.7%
- Maximum annual debt service (MADS) coverage* 16.7%
- Lease-adjusted MADS coverage* 16.7%

156. Table 19 details the measuring and scoring practices for the financial performance section.
### Table 19

**Assessing Financial Performance**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net patient service revenue (Mil. $)</td>
<td>&gt;1,000</td>
<td>600-1,000</td>
<td>400-600</td>
<td>200-400</td>
<td>125-200</td>
<td>&lt;125</td>
</tr>
<tr>
<td>EBIDA margin (%)</td>
<td>&gt;18</td>
<td>14.0-18.0</td>
<td>12.0-14.0</td>
<td>10.5-12.0</td>
<td>9.0-10.5</td>
<td>&lt;9.0</td>
</tr>
<tr>
<td>Operating margin (%)</td>
<td>&gt;6.0</td>
<td>4.0-6.0</td>
<td>2.5-4.0</td>
<td>1.0-2.5</td>
<td>0-1.0</td>
<td>&lt;0</td>
</tr>
<tr>
<td>Excess margin (%)</td>
<td>&gt;9.5</td>
<td>7.5-9.5</td>
<td>5.0-7.5</td>
<td>2.5-5.0</td>
<td>1.0-2.5</td>
<td>&lt;1.0</td>
</tr>
<tr>
<td>Maximum annual debt service (MADS) coverage (x)</td>
<td>&gt;6.5</td>
<td>4.5-6.5</td>
<td>3.5-4.5</td>
<td>2.5-3.5</td>
<td>1.8-2.5</td>
<td>&lt;1.8</td>
</tr>
<tr>
<td>Lease-adjusted MADS coverage (x)</td>
<td>&gt;5.5</td>
<td>3.5-5.5</td>
<td>2.5-3.5</td>
<td>2.0-2.5</td>
<td>1.5-2.0</td>
<td>&lt;1.5</td>
</tr>
</tbody>
</table>

**Qualitative factor positively affecting the assessment (see paragraph 163)**

Revenue dispersion among hospital subsidiaries

**Qualitative factors negatively affecting the assessment (see paragraphs 164–167)**

Reliance on special funding sources for operating income

Assessment of '5' or '6' on three or more metrics may cap the financial performance assessment at '5'

MADS coverage less than 1x may cap the financial performance assessment at '5' or '6'

MADS coverage assessment is two points or more greater than the financial performance assessment

Each qualitative factor would change the initial assessment by one point. However, for organizations qualifying for one or more, but not all adjustments, we would generally limit the anchor assessment adjustment to one point, with two points possible in rare circumstances.

157. A hospital's NPSR reflects the relative size of the organization's business. A larger revenue base indicates that revenues are drawn from a larger pool of patients and physicians and related businesses, thus indicating greater revenue diversity. Conversely, a smaller revenue base points to more narrowly defined sources of revenues, which intrinsically leaves the hospital more susceptible to wider revenue fluctuations from physician turnover, problems in key service lines, or disruption in the local economy. In addition, larger hospitals may have greater negotiating clout with payers and vendors, especially if they have a large share of key services. Revenue trends are also important as they may be indicative of business growth.

158. The EBIDA margin illustrates a hospital's cash flow generation from total revenues, which provides an indication of the organization's ability to produce cash flow to sufficiently cover debt service and to fund other strategic objectives, including capital spending and building reserves.

159. The operating margin shows a hospital's capability to generate profits from its business. The level of operating margin can demonstrate a hospital's ability to control expenses, attract patients, and manage the revenue cycle.

160. The excess margin factors in both operating performance and other revenues and expenses that the hospital incurs outside the scope of its core clinical operations. This ratio displays the organization's ability to effectively manage operations and its investment portfolio, fundraising capabilities, and other nonoperating activities.

161. MADS coverage represents the number of times that an organization is able to cover its MADS from cash flow generated through operating and nonoperating activities. This ratio calculates coverage of all financing costs incurred through debt issuance, capital leases, and other obligations classified as long-term debt. A higher metric reflects greater flexibility in covering debt service particularly in times of occasional cash flow deterioration.
Lease-adjusted MADS coverage takes into account a hospital's ability to cover all financing payments regardless of the vehicle chosen. This ratio calculates coverage of all financing costs incurred through debt issuance, capital leases, other obligations classified as long-term debt, and operating leases.

A hospital with multiple business lines or more than one hospital which does not qualify as a health care system per the definition in Appendix 2, generally would receive a positive one-point adjustment to the financial performance assessment if the acute-care flagship and physician subsidiaries account for 75% or less of total operating revenue, or up to 85% of operating revenue if total operating revenue exceeds $600 million. For this measure, operating revenue includes revenue from employed physicians -- even if physician revenue is accrued in a separate corporation -- because of the inherent link between the two revenue streams. This adjustment recognizes the benefit of revenue and business diversity that often is reflective of stronger organizations.

A hospital that receives revenue from special funding sources such as disproportionate share, upper payment limit, a statewide charity care pool, or provider fee mechanisms generally would receive a one-point negative adjustment to the financial performance assessment if the amount of special revenue is material to revenue and if earnings shift from positive to negative under a scenario in which 50% of the special revenues were eliminated. This adjustment reflects appropriation, budgetary, and sunset risks associated with most of these programs. Where we believe a cut of more than 50% in special revenue sources is highly likely, we generally would use a scenario that includes a special revenue cut of greater than 50%. In states where provider fees are uneven due to renewal or approval timing, and thus may be very high one year and low the next, we would likely smooth special revenues for purposes of this adjustment.

Regardless of other adjustments, when a hospital is assessed as '5' or '6' on three or more metrics in table 19, the financial performance assessment will be capped at '5'. Since the initial financial performance assessment is an average of six metrics, it is possible for a weak credit to tally three or more assessments of '5' or '6', but have a stronger initial financial performance assessment. While a hospital will retain its initial financial performance assessment in those instances where the assessment appropriately represents the financial performance of the hospital, we believe that when a hospital exhibits mixed performance and where the average yields a strong overall assessment despite three or more weak assessments of '5' or '6', the final financial performance assessment will be capped at '5' to reflect the higher level of risk associated with the weak assessments.

If a hospital's MADS coverage, as calculated by Standard & Poor's, was or is expected to be below 1x, and we believe this is an indicator that future cash flow and credit quality could be jeopardized, we generally would cap the financial performance assessment at '5' or '6'. We generally would not apply this adjustment in cases where the weak coverage is driven by short-term nonoperating losses or one-time events. However, in those cases where we do not apply this adjustment, we expect that coverage will exceed 1x in the near term, generally defined as the next one to two years. Prior to making an adjustment, we will consider the causes of the coverage drop, whether they are one-time in nature, and management's actions to rectify the situation.

Because we consider debt service coverage to be a fundamentally important ratio, an assessment that is abnormally weak relative to the other financial performance component assessments could be an indication that an organization's capability to service its debt obligations is in jeopardy despite other stronger metrics. Therefore, when a hospital's MADS coverage assessment is two or more points above the rounded initial financial performance assessment, the
financial performance assessment generally would be negatively adjusted by one point. We would consider not making this adjustment if we believe that a provider’s other financial profile attributes are sufficiently strong to compensate for the MADS coverage shortcoming or if we believe that historical performance is not indicative of likely future performance.

3. Liquidity and financial flexibility

168. The liquidity and financial flexibility assessment measures how a hospital’s cash flow and internal sources of unrestricted reserves may affect its debt servicing capability. These criteria use five measures to evaluate liquidity and financial flexibility according to the weightings below to determine the initial liquidity and financial flexibility assessment:

- Average age of plant* 15%
- Capital expenditures/depreciation expense* 15%
- Cash on hand* 30%
- Unrestricted reserves/long-term debt* 30%
- Unrestricted reserves/contingent liabilities* 10%

169. Following are the detailed measuring and scoring practices for the liquidity and financial flexibility section.

Table 20

<table>
<thead>
<tr>
<th>Assessment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age of plant (years)</td>
<td>&lt;8.5</td>
<td>8.5–10.0</td>
<td>10.0–11.0</td>
<td>11.0–12.0</td>
<td>12.0–14.0</td>
<td>&gt;14.0</td>
</tr>
<tr>
<td>Capital expenditures/depreciation expense (%)</td>
<td>&gt;175</td>
<td>140–175</td>
<td>120–140</td>
<td>100–120</td>
<td>80–100</td>
<td>&lt;80</td>
</tr>
<tr>
<td>Cash on hand (days)</td>
<td>&gt;275</td>
<td>205–275</td>
<td>160–205</td>
<td>110–160</td>
<td>80–110</td>
<td>&lt;80</td>
</tr>
<tr>
<td>Unrestricted reserves/long-term debt (%)</td>
<td>&gt;225</td>
<td>175–225</td>
<td>120–175</td>
<td>85–120</td>
<td>60–85</td>
<td>&lt;60</td>
</tr>
<tr>
<td>Unrestricted reserves/contingent liabilities (%)</td>
<td>&gt;400</td>
<td>300–400</td>
<td>200–300</td>
<td>100–200</td>
<td>90–100</td>
<td>&lt;90</td>
</tr>
</tbody>
</table>

Qualitative factors positively affecting the assessment (see paragraph 175-176)

- The liquidity and financial flexibility assessment could improve by one point if there are significant philanthropic expectations based on actual gifts or historic record, or if the hospital has a significant off balance sheet dedicated foundation
- Hospitals without contingent liabilities will be assessed a ‘1’ on the unrestricted reserves/contingent liabilities metric

Qualitative factors negatively affecting the assessment (see paragraph 177-179)

- Unrestricted reserves less than 1x contingent liabilities may cap the liquidity and financial flexibility assessment at ‘5’ or ‘6’
- Days’ cash on hand assessment is two points or more than the liquidity and financial flexibility assessment
- Unrestricted reserves/long-term debt assessment is two points or more than the liquidity and financial flexibility assessment
- Assessment of ‘5’ or ‘6’ on three or more metrics may cap the liquidity and financial flexibility assessment at ‘5’

170. A hospital’s average age of plant can be an indicator of future capital needs. If a hospital has a lower average age of plant, it may indicate that there is limited capital spending on the horizon, which could provide for strengthening of other balance-sheet metrics over time. Conversely, a higher age of plant may signal major capital needs resulting in future debt plans or depletion of cash reserves. Furthermore, organizations with lower average age of plant have more up-to-date facilities that may often be more attractive to patients and physicians. This can be particularly important in competitive markets or when recruiting physicians.
171. A hospital's investment in property, plant and equipment, as measured by capital expenditures/depreciation expense, is important in maintaining equipment, appropriate capacity for services, and attractive campuses, all of which can affect patient preference, physician recruiting, quality and safety. Gauging a hospital's investment in its plant can be an indicator of increased future spending if investment is low, resulting in pent-up capital demand or potentially a sign of reduced capital needs following a period of aggressive spending.

172. The days' cash on hand metric reflects a hospital's financial flexibility and capability to withstand operating challenges while still covering its operating expenditures. A higher days' cash metric may also indicate greater resources available to fund other investment or debt service needs, while still maintaining sufficient operating reserves.

173. The ratio of unrestricted reserves to long-term debt measures a hospital's financial flexibility and is a way to assess a hospital's debt capacity and debt servicing ability.

174. A hospital's debt profile may include instruments that could result in liquidity events due to provisions that allow investors to tender debt following prescribed events or when certain occurrences permit or require the early prepayment of principal. Such events can stress a hospital's unrestricted reserves. This measurement provides a means for assessing a hospital's potential exposure to such liabilities and its capacity to tap internal reserves while also maintaining sufficient reserves for operating purposes.

175. A hospital which expects or has already received a significant one-time philanthropic gift, or whose pending capital campaign is expected to yield substantial unrestricted reserves, generally would achieve an improved liquidity and financial flexibility assessment. If receipt of the funds can be quantified, then the amount is included in the financial ratio calculations on a pro forma basis and there is no adjustment to the assessment. If, however, the amounts are less specific, but based on historical results, the hospital has demonstrated an ability to fund raise either annually or for a specific project, or has identified and has a commitment from a large donor, then the liquidity and financial flexibility assessment generally would be positively adjusted by one point on the table. The adjustment will not be made if we believe philanthropic history and potential are already effectively reflected in balance sheet and income statement metrics. In addition, a hospital with a significant off-balance-sheet-dedicated foundation with a history of measurable support for hospital operations or capital projects, or a hospital with an alternate source of revenue such as state support for capital, can achieve a one-point improvement in the liquidity and financial flexibility assessment.

176. Hospitals without contingent liabilities are assessed a '1' on the unrestricted reserves/contingent liabilities metric.

177. Provisions in certain financial instruments create potential additional claims on the liquidity of obligors upon the occurrence of certain events or conditions specified in the instrument's terms. For obligors with unrestricted reserves below the amount of contingent liabilities, such an event could materially weaken our assessment of the obligor's reserves and we generally would cap the liquidity and financial flexibility assessment at '5' or '6'. In addition, our assessment of a hospital's financial policies considers the extent to which management and governance understands these risks and has plans or policies to mitigate them. For more information, see the article "Contingent Liquidity Risks", published March 5, 2012.

178. We consider low days' cash on hand and low unrestricted reserves/long-term debt to be particular risks if either metric's assessment is abnormally worse than the overall liquidity and financial flexibility assessment because these
metrics can be indicators of a limited cash cushion in times of occasional financial duress or a sign of limited balance-sheet flexibility. When a hospital's days' cash on hand assessment or unrestricted reserves to long-term debt assessment is two points or more worse than the rounded initial liquidity and financial flexibility assessment, the assessment generally would be negatively adjusted by one point. We generally would not make the adjustment if we believe the strengths of other aspects of the hospital's financial profile offset the risk of either of these weaker metrics. Also, if we believe either metric is trending materially upward or if we think historical metrics are not representative of the future, we generally would not adjust the assessment.

179. Regardless of other adjustments, when a hospital is assessed '5' or '6' on three or more metrics in table 20, the liquidity and financial flexibility assessment generally would be capped at '5'. Since the initial liquidity and financial flexibility assessment is an average of five metrics, it could be possible for a weak credit to tally three or more assessments of '5' or '6', but have a stronger initial liquidity and financial flexibility assessment. While a hospital could retain its initial liquidity and financial flexibility assessment in those instances where the high assessment appropriately represents the liquidity and financial flexibility of the hospital, we believe that when a hospital exhibits mixed performance and where the average yields a strong overall assessment despite three or more very weak assessments of '5' or '6', the final liquidity and financial flexibility assessment generally would be capped at '5' to reflect the higher level of risk associated with a majority of lower assessments.

4. Debt and contingent liabilities

180. The debt and contingent liabilities assessment measures the extent current, proposed, contingent, and off-balance-sheet liabilities may affect a hospital's debt servicing capability. These criteria use four measures to evaluate the debt and contingent liabilities burden according to the weighted averages below to determine the initial debt and contingent liabilities assessment:

- Debt burden 25%
- Long-term debt/capitalization* 25%
- Contingent liabilities/long-term debt 25%
- Funded status of defined-benefit pension plan* 25%

181. Following are the detailed measuring and scoring practices for the debt and contingent liability section.

Table 21

<table>
<thead>
<tr>
<th>Assessment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt burden (%)</td>
<td>&lt;2.2</td>
<td>2.2-2.9</td>
<td>2.9-3.7</td>
<td>3.7-4.8</td>
<td>4.8-5.8</td>
<td>&gt;5.8</td>
</tr>
<tr>
<td>Long-term debt/capitalization (%)</td>
<td>&lt;25%</td>
<td>25–35</td>
<td>35–42</td>
<td>42–50</td>
<td>50–60</td>
<td>&gt;60</td>
</tr>
<tr>
<td>Contingent liabilities/long-term debt (%)</td>
<td>&lt;20%</td>
<td>20–30</td>
<td>30–40</td>
<td>40–50</td>
<td>50–60</td>
<td>&gt;60</td>
</tr>
<tr>
<td>Funded status of defined-benefit pension plan (%)</td>
<td>&gt;100</td>
<td>85-100</td>
<td>75-85</td>
<td>65-75</td>
<td>55-65</td>
<td>&lt;55</td>
</tr>
</tbody>
</table>

Qualitative factors positively affecting the assessment (see paragraph 184-185)

Hospitals without contingent liabilities will be assessed a '1' on the contingent liabilities/long-term debt metric
Hospitals without a defined-benefit pension plan will be assessed a '1' on the funded status of the defined-benefit pension plan metric

Qualitative factor negatively affecting the assessment (see paragraph 186)

Assessment of '5' or '6' on two or more metrics may cap the debt and contingent liabilities assessment at '5'
182. The debt burden reflects the demand that a hospital's debt service has on total revenues. A hospital's debt burden indicates its flexibility to service its future debt service in times of diminished financial performance.

183. A hospital's long-term debt to capitalization is used to determine how heavily leveraged the organization is and provides a means to assess debt capacity.

184. A component of our assessment of a hospital's debt profile is the level of conservatism of the debt structure. The percentage of contingent liabilities to total long-term debt reflects the riskiness of the total capital structure as it relates to debt with potential liquidity events that could affect an organization's financial flexibility and capacity to service future debt. Hospitals without contingent liabilities will be assessed a '1' on the contingent liabilities/long-term debt assessment.

185. The funding of defined-benefit pension plans can be volatile and can often result in significant cash demands that directly compete with other strategic priorities such as capital spending and building reserves. The funded status of such plans is a forward-looking assessment of potential demands for cash to meet required pension funding levels. Hospitals without a defined-benefit pension plan will be assessed a '1' on the funded status of defined-benefit pension plan measure.

186. Regardless of other adjustments, when a hospital is assessed at '5' or '6' on two or more metrics in table 21, the final debt and contingent liabilities assessment generally would be capped at '5'. Since the initial debt and contingent liabilities assessment is an average of four metrics, it could be possible for a weak credit to tally two or more assessments of '5' or '6', but have a much stronger initial debt and contingent liabilities assessment. Furthermore, since the assessment is an average of four metrics equally weighted, the hospital cannot get a debt and liabilities assessment of '6' if it does not have a defined-benefit pension plan or does not have any contingent liabilities, even though the other two sub-factor assessments might be very weak. While a hospital will retain its initial debt and contingent liabilities assessment in those instances where the assessment appropriately represents the debt and contingent liabilities performance of the hospital, we believe that when a hospital exhibits mixed performance and where the average yields a strong overall assessment despite two or more sub-factor assessments of '5' or '6', the final debt and contingent liabilities assessment generally would be capped at '5' to reflect the higher level of risk associated with the two lower assessments.

VI. APPENDIX 1: GLOSSARY OF RATIOS

Average age of plant: accumulated depreciation/depreciation expense.

Capital expenditures/depreciation and amortization: (purchases of property, plant, and equipment/depreciation and amortization expense) x 100.

Cash on hand (days): unrestricted reserves/[(operating expense minus depreciation and amortization expenses)/365].

Contingent liabilities: variable-rate demand bonds, commercial paper, bullet payments due within five years, bonds with mandatory tender dates in five years or less, direct bank debt with acceleration clauses, debt guaranteed for parties outside the hospital and its consolidated affiliates, swap or other termination payments if the current rating is...
two notches or less from the termination trigger, and other identifiable contingencies.

Contingent liability debt: contingent liabilities excluding swaps and other termination payments, self-supporting guarantees, and other identifiable contingencies.

Debt burden: \( \frac{\text{maximum annual debt service}}{\text{total revenue}} \times 100 \).

EBIDA margin: \( \frac{\text{net income before interest, depreciation, and amortization expenses}}{\text{total revenue}} \times 100 \).

Equivalent admissions: \( \frac{\text{inpatient admissions}}{\text{inpatient gross revenue/total gross revenue}} \).

Excess margin: \( \frac{\text{net income}}{\text{total revenue}} \times 100 \).

Funded status of defined-benefit pension plan: \( \frac{\text{fair value of pension plan assets}}{\text{projected benefit obligation}} \times 100 \).

Lease-adjusted maximum annual debt service (MADS) coverage: \( \frac{\text{net available for debt service} + \text{operating lease expense}}{\text{MADS} + \text{operating lease expense}} \).

Long-term debt/capitalization: \( \frac{\text{long-term debt}}{\text{unrestricted net assets} + \text{long term debt}} \times 100 \).

MADS: principal and interest payments on all obligated and nonobligated group debt, including long-term bonds, capital leases, mortgages, and bank debt. For variable-rate debt, assume a 3.5% interest rate. For draws on lines of credit and commercial paper, assume the actual fixed rate or a 3.5% variable interest rate with principal payments spread over 30 years. Guaranteed debt is included at 100% if the guarantor has made any payments over the past five years, or the guaranteed entity is currently generating less than 1x coverage of its MADS. Variable-rate debt swapped to fixed should be run at the swap rate.

MADS coverage: \( \frac{\text{net available for debt service}}{\text{MADS}} \).

Net available for debt service: \( \text{net income} + \text{depreciation and amortization expenses} + \text{interest expense} \).

Net income: \( \text{operating income} + \text{net nonoperating revenue} \).

Net nonoperating revenue: \( \text{nonoperating revenue} - \text{nonoperating expenses} \).

Nonoperating revenue: investment earnings, unrestricted contributions, equity in earnings from unconsolidated organizations, discontinued operations, and other nonoperating revenue. Excluded from nonoperating revenue are unrealized gains or losses on investments, gains or losses from debt refinancing, unrealized gains or losses from annual swap valuation, asset impairment, and other one-time financial events. However, in certain circumstances, we may include items reported as nonrecurring into operations if we believe these costs have been or will be an ongoing part of the hospital's annual financial performance. In cases where a hospital has substantial equity earnings from unconsolidated organizations relative to its net income and there is no cash distribution from the equity venture, we may adjust this ratio and others to exclude these earnings as they do not provide a cash benefit to the organization.

Operating income: \( \text{total operating revenue} - \text{total operating expenses} \).

Operating margin: \( \frac{\text{operating income}}{\text{total operating revenue}} \times 100 \).
Total revenue: total operating revenue + net nonoperating revenue*.

Unrestricted reserves/contingent liabilities: (unrestricted reserves/contingent liabilities) x 100.

Unrestricted reserves/long-term debt: (unrestricted reserves/long-term debt) x 100.

Unrestricted reserves: unrestricted cash + unrestricted board designated + unrestricted investments. Unrestricted reserves exclude debt service funds, donor restricted amounts, funds designated for pension, temporarily or permanently restricted funds, other funds that are legally restricted, and funds required to meet actuarially determined malpractice liabilities. Unrestricted reserves may also be reduced by the shortfall of restricted funds relative to the malpractice liability and conversely, may be increased by the amount of restricted funds set aside in excess of the liability, if such funds are quickly accessible.

VII. APPENDIX 2: DEFINITION OF MULTIHOSPITAL HEALTH SYSTEM

Hospitals and health systems that do not meet the following definition will be rated under these criteria. A multihospital health system (health system) must meet one of the following definitions:

1. Three or more hospitals and operating revenue in excess of $1.5 billion; or
2. At least $750 million operating revenue and at least one of the following characteristics:
   a. Three or more hospitals in two or more states;
   b. Three or more hospitals in a single state where the largest hospital's operating revenue does not exceed 65% of total operating revenue;
   c. Four or more hospitals in a single state with about 15% of total operating revenue from non-acute care businesses including but not limited to psychiatry, rehabilitation, health insurance plan, or long term care; or
   d. Ten or more hospitals

For purposes of this definition, "hospital" means a general acute care hospital on a distinct campus. Multiple facilities on a single campus will be considered one hospital. Organizations that combine hospitals on distinct campuses under one Medicare provider number may consider them separate hospitals for purposes of this definition, as long as they are each general acute care hospitals. Hospitals that are considered "specialty" hospitals under paragraph 50 will not be counted as hospitals, but may be counted as "non-acute" care businesses under section 2c.

VIII. APPENDIX 3: MEASURES FOR CLINICAL QUALITY AND INFORMATION TECHNOLOGY

Process of care measures:
- Percent of heart attack patients given fibrinolytic medication within 30 minutes of arrival;
- Heart attack patients given percutaneous coronary intervention (PCI or angioplasty) within 90 minutes of arrival;
- Percent of heart failure patients given discharge instructions;
• Percent of pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics;
• Pneumonia patients given the most appropriate initial antibiotic(s);
• Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection;
• Surgery patients who were given the right kind of antibiotic to help prevent infection;
• Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery);
• Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery;
• Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery;
• Surgery patients whose urinary catheters were removed on the first or second day after surgery; and
• Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.

Patient satisfaction and reputation:
• How well nurses communicated with patients;
• How well doctors communicated with patients;
• How responsive hospital staff were to patients’ needs;
• How well caregivers managed patient's pain;
• How well caregivers explained patients' medications to them;
• The patient's overall satisfaction rating of their hospital stay is a '9' or '10';
• How clean and quiet the hospital was; and
• How well caregivers explained the steps patients and families need to take to care for themselves outside the hospital.

Mortality and readmission:
• Death rate for heart attack patients;
• Death rate for heart failure patients;
• Death rate for pneumonia patients;
• Rate of readmission for heart attack patients;
• Rate of readmission for heart failure patients; and
• Rate of readmission for pneumonia patients.

Quality management and oversight measures:
• Full-time chief medical officer;
• Full-time (24 hours per day) coverage of intensive care units by employed or contracted intensivists;
• Full-time (24 hours per day) coverage by employed or contracted hospitalists;
• Clinical quality goals are approved by the board annually and are presented and discussed at every board meeting; and
• Senior management, including the chief executive officer, has specific compensation goals tied to performance on quality and patient safety metrics.

Information technology and electronic health record implementation:
• The hospital has attested to stage 1 or 2 for meaningful use of electronic health records per CMS regulations.
IX. RELATED CRITERIA AND RESEARCH

Article to be partially superseded by these criteria:

- Not-For-Profit Health Care, June 14, 2007

Related criteria
- Group Rating Methodology, Nov. 19, 2013
- Ratings Above The Sovereign: Corporate And Government Ratings—Methodology And Assumptions, Nov. 19, 2013
- General Criteria: Country Risk Assessment Methodology and Assumptions, Nov. 19, 2013
- Methodology: Timeliness Of Payments: Grace Periods, Guarantees, And Use Of 'D' And 'SD' Ratings, Oct. 24, 2013
- Methodology: Management And Governance Credit Factors For Corporate Entities And Insurers, Nov. 13, 2012
- Contingent Liquidity Risks, March 5, 2012
- Principles Of Credit Ratings, Feb. 16, 2011
- Rating Government-Related Entities: Methodology And Assumptions, Dec. 9, 2010
- The Time Dimension of Standard & Poor’s Credit Ratings, Sept. 22, 2010
- Credit Stability Criteria, May 3, 2010
- Understanding Standard & Poor’s Rating Definitions, June 3, 2009
- Tax-Secured Hospital Debt, May 3, 2007

Related Research
- RFC Process Summary: Rating Methodology And Assumptions For U.S. Not-For-Profit Acute-Care Stand-Alone Hospitals, Dec. 15, 2014
- Credit FAQ: An Overview of Standard & Poor’s Updated Methodology For Rating U.S. Not-For-Profit Acute-Care Stand-Alone Hospitals, Dec. 15, 2014
- How Standard & Poor’s Intends To Implement Its U.S. Not-For-Profit Acute-Care Stand-Alone Hospital Criteria And Apply Them To Ratings, Dec. 15, 2014
- U.S. Public Finance Defaults And Rating Transition Data: 2013 Update, March 31, 2014
- Standard & Poor’s Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries, Nov. 20, 2013
- Standard & Poor’s Publishes Finalized Country Risk Assessments For 103 Countries, Nov. 19, 2013
- New Bad Debt Accounting Rules Will Alter Some U.S. Not-for-Profit Health Care Ratios But Won't Affect Ratings, Jan. 19, 2012

These criteria represent the specific application of fundamental principles that define credit risk and ratings opinions. Their use is determined by issuer- or issue-specific attributes as well as Standard & Poor's Ratings Services' assessment of the credit and, if applicable, structural risks for a given issuer or issue rating. Methodology and assumptions may change from time to time as a result of market and economic conditions, issuer- or issue-specific factors, or new
empirical evidence that would affect our credit judgment.
S&P may receive compensation for its ratings and certain analyses, normally from issuers or underwriters of securities or from obligors. S&P reserves the right to disseminate its opinions and analyses. S&P's public ratings and analyses are made available on its Web sites, www.standardandpoors.com (free of charge), and www.ratingsdirect.com and www.globalcreditportal.com (subscription) and www.spcapitaliq.com (subscription) and may be distributed through other means, including via S&P publications and third-party redistributors. Additional information about our ratings fees is available at www.standardandpoors.com/usratingsfees.

S&P keeps certain activities of its business units separate from each other in order to preserve the independence and objectivity of their respective activities. As a result, certain business units of S&P may have information that is not available to other S&P business units. S&P has established policies and procedures to maintain the confidentiality of certain nonpublic information received in connection with each analytical process.

S&P may receive compensation for its ratings and certain analyses, normally from issuers or underwriters of securities or from obligors. S&P reserves the right to disseminate its opinions and analyses. S&P's public ratings and analyses are made available on its Web sites, www.standardandpoors.com (free of charge), and www.ratingsdirect.com and www.globalcreditportal.com (subscription) and www.spcapitaliq.com (subscription) and may be distributed through other means, including via S&P publications and third-party redistributors. Additional information about our ratings fees is available at www.standardandpoors.com/usratingsfees.