U.S. Not-For-Profit Acute Health Care Ratios: Operating Performance Weakens While Balance Sheets Are Stable

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Earnings of U.S. not-for-profit acute health care organizations rated by S&P Global Ratings weakened in 2016. This reflects a combination of lower operating margins, which we believe will continue, and weak investment markets, which have improved in 2017 year-to-date. Balance sheet ratios remain strong and stable. This balance sheet strength, along with continued merger and acquisition activity which has improved the overall business profiles of many rated providers, support our stable outlook on the sector (see "U.S. Not-For-Profit Health Care Sector 2017 Outlook: Stable, Yet A Pen Stroke Away From Unprecedented Change," published Jan. 10, 2017 on RatingsDirect).

While year-to-date upgrades and downgrades are balanced, there has been a negative shift in outlooks reflecting weaker margins and maximum annual debt service coverage. Declining positive outlooks and rising negative outlooks during the first half of 2017 reflect increased uncertainty about the ability of the sector to recover and deal with the reemergence of revenue and expense pressures, and the continued evolution of the health care delivery system from volume to value, which has also constrained utilization. These pressures had been masked for the past two years, as the Affordable Care Act (ACA) driven Medicaid expansion has provided revenue and volume growth for many, as well as an improving payer mix. However, these benefits are now waning as underlying payment rates are weak and hospitalization rates are declining.

Overview

- Operating margins and maximum annual debt service coverage fell;
- Balance sheets remain strong and are a key contributor to credit stability;
- Mergers and acquisitions continue to improve enterprise profiles and also support credit quality;
- The benefits of the ACA and Medicaid expansion to providers are beginning to wane;
- Year-to-date rating changes are balanced between upgrades and downgrades; and
- The percent of positive outlooks has been steadily declining.

The most striking trend within the 2016 medians, which cover our rated stand-alone hospitals and health systems with fiscal years ending in 2016, is the sharp weakness in both operating margins and non-operating performance. Combined, these trends resulted in significantly lower maximum annual debt service coverage levels (see table 1). Balance sheet metrics continue to be broadly stable and most have recovered beyond pre-financial crisis median levels. Absolute increases in unrestricted reserves combined with slightly lower leverage bolstered unrestricted reserves relative to debt, but these trends were insufficient to keep pace with rapidly rising expenses resulting in a slight decrease in days' cash on hand.

The average age of plant has risen to its highest level in many years despite robust levels of capital spending well above depreciation expense. We believe this reflects significant investment in information technology, which raises
depreciation expense at a faster rate than traditional bricks and mortar. We expect capital spending to continue with a focus on information technology and ambulatory expansion, both of which are necessary to establish the necessary framework for population health management and meet consumer demand for more convenient and less expensive access to care. The medians also show meaningful growth in net patient service revenues. This is consistent with the mergers of small hospitals into larger systems, the mergers of large systems together, increased revenue from physician employment and in some cases, provider sponsored health plans.

We see few signs that operating pressure will moderate during this transformative period in the sector. However, we continue to monitor managements’ efforts to address expenses and find growth opportunities as we note that providers have adapted to these types of pressures in the past. The extent of the pressures and future direction of the medians will be partially influenced by the type of changes, if any, in federal legislation. Financial performance is also determined by the ability of management to appropriately respond to industry challenges which we know varies among providers and is also dependent upon the pace of change in specific regions of the country. For now, balance sheet strength offsets many of these uncertainties. In addition, our assessment of enterprise profile characteristics, including the benefits of being part of a larger organization or health care system, is critical to our rating analysis and can often lend stability to the rating.

These medians are based on fiscal year 2016 results for 420 rated stand-alone hospitals and health systems which represent approximately 93% of our rated portfolio. Excluded from these medians are organizations whose ratings are based on notching support under our group rating methodology. Our group rating methodology criteria reflects the financial performance of the system as a whole (including nonobligated affiliates) and the relationship of each individually rated entity to the entire group. As these ratings are driven in large part by their relationships to the larger group and not the individual organization’s financial profile, the metrics from these organizations are excluded from the medians. Also excluded are rated organizations where 2016 audits were not yet available.

For the specific medians and related articles covering stand-alone hospitals, health care systems, children’s hospitals, speculative grade providers, and small hospitals please see the links at the end of this article.

**Rating And Outlook Changes**

For all acute health care ratings, there were relatively minor shifts among the rating levels between June 30, 2016 and June 30, 2017 (see chart 1) with some decline at the ‘A-‘ level offset by growth at higher rating levels. Most of these shifts are relatively minor as the overall rating category distribution remains in line with recent levels; almost half of all ratings are in the ‘A’ category (‘A+’, ‘A’, and ‘A-‘) and slightly less than one-quarter each are in the ‘AA’ (‘AA+‘, ‘AA’, and ‘AA-‘) and ‘BBB’ (‘BBB+‘, ‘BBB’, and ‘BBB-‘) categories. Speculative grade credits have traditionally constituted less than 10% of the overall portfolio. Looking over the longer term we see a relatively level percentage of ratings in the ‘A’ category, growth in the ‘AA’ category and fewer ‘BBB’ category and speculative grade ratings (‘BB+‘ and below). We believe this reflects the merger and acquisition trend which has created larger and, sometimes, more highly rated systems. In addition, many acquisitions are typically of weaker providers that subsequently have their debt repaid or assume the credit ratings of the larger system, which reduces the number of lower rated credits.
While the rating distribution shows limited change, there has been a material weakening of the outlook distribution reflecting the drop in earnings and margins we have observed in many 2016 audits and in year-to-date 2017 performance (see chart 2). While the percent of our rated organizations that carry negative outlooks at June 30, 2017 is comparable to June 30, 2016, there has been a material shift in momentum as the number of organizations with positive outlooks steadily dipped in that period. In addition, while the second half of 2016 saw a slightly improved outlook distribution, the number of negative outlooks has risen significantly during the first half of this year. In many cases, weaker margins are paired with management plans to address underperformance, and our rating and outlook decisions encompass our opinion about whether these plans could be successful or if lower performance represents a new normal for the organization. Also, in the past six to nine months, many cases of weaker operating margins have been tempered by strong non-operating revenues, which at times results in an outlook change to negative or to stable from positive, rather than a downgrade.

The pace of rating changes through the first half of 2017 is similar to the pace during 2016 as well as prior years and shows 19 upgrades approximately equal to 21 downgrades (see chart 3). The number of stand-alone hospital and health care system rating actions does not mirror the overall portfolio—which consists of two-thirds stand-alone hospitals and one-third health care systems—as almost three-quarters of 2017 downgrades have been concentrated in the stand-alone hospital portfolio. This is in line with our belief that it can often be more difficult for a stand-alone provider to respond effectively to highly volatile and challenging industry trends.

Despite an essentially equal number of year-to-date upgrades and downgrades, which seem to paint a picture of relative stability, we believe the recent increase in negative outlooks and steady decline in positive outlooks are potentially more accurate predictors of possible future rating changes. For investment-grade credits, a nonstable outlook indicates we believe there is a one in three chance of a rating change during our two year outlook period. During the first half of 2017, and for the first time since 2013, negative outlook changes unaccompanied by a rating change exceed the number of positive outlook changes unaccompanied by a rating change (see chart 4). A negative outlook change includes both positive to stable and stable to negative, although the vast majority were changes from stable to negative. In addition, the shift in outlooks from stable to negative was concentrated among stand-alone providers although systems were not entirely immune. A positive outlook change encompasses both negative to stable and stable to positive. For the first half of 2017 most of the positive actions were changes from stable to positive which indicates that there are certain credits which continue to perform strongly despite broad industry risks. The credits with positive outlook revisions were split relatively evenly between stand-alone providers and health care systems.

Health care systems in general continue to have a much more favorable rating distribution than stand-alone hospitals, reflecting strong enterprise profiles which benefit from revenue and geographic diversity, overall scale, and the ability to attract and retain top-tier physicians and management (see chart 5). Our ratings recognize that these enterprise strengths reduce overall rating risk for systems as compared to individual stand-alone providers. As a result stand-alone providers generally must have more robust financial metrics than comparably rated systems to achieve the same ratings.
Industry Trends Influencing These Medians

Expense and revenue pressure
While the medians showed continued growth in revenue, the pace of growth between 2015 and 2016 slowed dramatically when compared with the double digit rise between 2014 and 2015, which we believe was influenced by Medicaid expansion as well as consolidation which resulted in fewer but larger organizations. We believe much of the revenue growth in 2016 was due to increased physician employment as well as some residual benefits from Medicaid expansion, partly constrained by the shift from volume to value and from inpatient to outpatient. We do not expect to see robust revenue growth for the next several years due to an aging population which increases reliance on Medicare, a payer which typically offers slimmer rate increases than commercial payers and reimburses at levels which are generally below commercial rates. In addition, commercial payer rates have been constrained and restructured with the shift to value from volume which provides limited upside, at least during this transition period, to offset losses from Medicare and Medicaid.

Limited revenue and utilization growth coupled with rising expenses is likely to continue to weaken operating margins. Management teams have reported widespread cost issues around information technology, pharmaceuticals, labor (especially nursing), and physician employment. Offsetting these pressures is the continued favorable interest rates with many organizations benefitting from refinancing and low cost of capital for new money projects.

Government and regulatory uncertainty
In addition to uncertainty at the federal level around the ACA, hospitals are also beginning to experience pressure from the broader economic climate, as many states struggle to balance their budgets given pension issues and generally modest growth nationally. We expect that these issues could result in a range of outcomes which could affect Medicaid funding, availability of insurance, and bad debt and charity care levels. Although these issues have yet to meaningfully affect health care ratings we believe they are beginning to affect outlooks.

On the positive side, providers are generally unanimous that despite regulatory and economic conditions, the focus on cost containment and support of the shift from volume to value must continue. There is also some legislation that could accelerate this trend, such as the Medicare Access and CHIP Reauthorization Act. Although we recognize that the pace of change and resulting financial impact can vary depending where on the evolutionary volume-to-value spectrum a particular organization and market may fall, we view this as a critical component for longer term health of the industry.

Mergers and acquisitions
We expect continued merger and acquisition activity with stand-alone providers joining already established systems and an increasing number of system to system mergers. In general, merger partners are seeking both size and scale to better navigate the shift to population health management and additional opportunities to control expenses in light of continued federal, state, and payer reimbursement pressures. We recognize that not all mergers and acquisitions accomplish these goals however, as there have been a number of negative rating actions taken on several large and prominent providers during the first half of fiscal year 2017. Nevertheless, we still believe that consolidation, size, and scale can be a contributor to stronger financial performance.
Median Highlights

After a steady trend of improved margins and related coverage ratios between 2013 and 2015, these metrics dropped materially between 2015 and 2016 including a substantial full percentage point drop in both the median operating and operating EBIDA margins. Exacerbating weak operating metrics, and contributing to declining debt service coverage ratios, was significantly lower non-operating revenue in 2016. Although the investment markets appear to be improving in 2017, the volatility of non-operating income remains a credit risk which directly influences maximum annual debt service coverage. The weakness in these ratios is the main contributor, in our opinion, to the increase in negative outlooks assigned in 2017 year-to-date.

Despite operating pressure, balance sheet ratios remained remarkably stable between 2015 and 2016 and have generally shown slow and steady improvement over the past seven years. Absolute unrestricted reserves continue to grow, and although there has been some diminution in days’ cash on hand due to outsized expense growth, cash to debt continues to rise and was a solid 1.7x in 2016. Debt levels have been steady, including the amount of contingent liability debt, which has consistently accounted for slightly above one-third of the debt portfolios since we began publishing related medians in 2014. While we recognize specific credit risks associated with contingent liability transactions, we also recognize that most organizations in the not-for-profit health care sector have ample unrestricted reserves, covenant headroom, and market access which can temper the risks.

Consistent with the capital intensive health care industry, capital spending has consistently exceeded depreciation expense and rose for the third year in a row relative to depreciation expense. Despite this spending, the average age of plant also ticked up slightly to 11 years in 2016. We expect to see continued pressure on unrestricted reserves associated with defined-benefit pension plan funding, capital spending, information technology, and investments in strategic initiatives including the development of population health infrastructure. However, we also note that the significant and broad improvement in balance sheet metrics demonstrated since the last recession remains an important stabilizing rating factor for the sector.

Ratio Analysis

While we view ratio analysis as an important tool in our assessment of the credit quality of not-for-profit hospitals and health care systems, it is only one of several factors that we take into consideration. Our analysis of the enterprise profile is as important. However, median ratios offer a snapshot of the financial position of our rated hospitals and help in the comparison of credits across rating categories. In addition, we believe tracking median ratios over time allows for a clearer understanding of industrywide trends and provides a tool to better assess the sector's future credit quality. Because of the intertwining of mission and operations among all members of an organization, the financial statements we generally use for the medians and our analyses are the system wide results, which include results for obligated and nonobligated group members.
Table 1

Six-Year Comparison Of Not-For-Profit Acute Health Care Overall Medians (Stand-Alone Hospitals And Health Care Systems)

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td></td>
<td>420</td>
<td>436</td>
<td>476</td>
<td>501</td>
<td>517</td>
<td>551</td>
</tr>
<tr>
<td>Net patient revenue (NPR; $000)</td>
<td></td>
<td>656,518</td>
<td>605,869</td>
<td>494,464</td>
<td>474,871</td>
<td>453,329</td>
<td>406,214</td>
</tr>
<tr>
<td>Salaries &amp; benefits/NPR (%)</td>
<td></td>
<td>56.1</td>
<td>55.2</td>
<td>56.2</td>
<td>56.3</td>
<td>55.7</td>
<td>55.0</td>
</tr>
<tr>
<td>Maximum annual debt service coverage (x)</td>
<td></td>
<td>3.9</td>
<td>4.3</td>
<td>4.1</td>
<td>3.6</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Operating lease-adjusted coverage (x)*</td>
<td></td>
<td>3.1</td>
<td>3.4</td>
<td>3.3</td>
<td>3.1</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Debt burden (%)</td>
<td></td>
<td>2.6</td>
<td>2.7</td>
<td>2.9</td>
<td>3.0</td>
<td>3.0</td>
<td>3.1</td>
</tr>
<tr>
<td>EBIDA ($000)</td>
<td></td>
<td>72,965</td>
<td>77,957</td>
<td>64,463</td>
<td>55,900</td>
<td>53,383</td>
<td>49,506</td>
</tr>
<tr>
<td>Nonoperating revenue/total revenue (%)</td>
<td></td>
<td>1.3</td>
<td>2.0</td>
<td>2.4</td>
<td>2.2</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>EBIDA margin (%)</td>
<td></td>
<td>10.5</td>
<td>12.2</td>
<td>12.0</td>
<td>11.1</td>
<td>11.6</td>
<td>11.8</td>
</tr>
<tr>
<td>Operating EBIDA margin (%)</td>
<td></td>
<td>9.3</td>
<td>10.3</td>
<td>9.8</td>
<td>9.2</td>
<td>9.8</td>
<td>10.2</td>
</tr>
<tr>
<td>Operating margin (%)</td>
<td></td>
<td>2.4</td>
<td>3.4</td>
<td>2.7</td>
<td>2.1</td>
<td>2.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Excess margin (%)</td>
<td></td>
<td>4.1</td>
<td>5.3</td>
<td>5.0</td>
<td>4.1</td>
<td>4.5</td>
<td>4.7</td>
</tr>
<tr>
<td>Capital expenditures/depr. &amp; amort. exp. (%)</td>
<td></td>
<td>120.2</td>
<td>112.6</td>
<td>110.9</td>
<td>118.4</td>
<td>121.2</td>
<td>115.7</td>
</tr>
</tbody>
</table>

Balance sheet

<table>
<thead>
<tr>
<th>Average age of plant (years)</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cushion ratio (x)</td>
<td>20.7</td>
<td>19.7</td>
<td>18.6</td>
<td>17.1</td>
<td>15.9</td>
<td>14.4</td>
</tr>
<tr>
<td>Days' cash on hand</td>
<td>210.3</td>
<td>217.0</td>
<td>214.0</td>
<td>197.6</td>
<td>191.7</td>
<td>186.7</td>
</tr>
<tr>
<td>Days in accounts receivable</td>
<td>47.4</td>
<td>48.3</td>
<td>49.3</td>
<td>49.2</td>
<td>49.9</td>
<td>48.3</td>
</tr>
<tr>
<td>Cash flow/total liabilities (%)</td>
<td>15.1</td>
<td>17.2</td>
<td>17.4</td>
<td>16.0</td>
<td>15.3</td>
<td>15.9</td>
</tr>
<tr>
<td>Unrestricted reserves ($000)</td>
<td>409,896</td>
<td>382,573</td>
<td>314,414</td>
<td>273,634</td>
<td>230,870</td>
<td>200,873</td>
</tr>
<tr>
<td>Unrestricted reserves/long-term debt (%)</td>
<td>171.8</td>
<td>161.0</td>
<td>156.9</td>
<td>143.5</td>
<td>135.1</td>
<td>123.6</td>
</tr>
<tr>
<td>Unrestricted reserves/contingent liabilities (%)*</td>
<td>507.0</td>
<td>460.5</td>
<td>448.8</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A.</td>
</tr>
<tr>
<td>Contingent liabilities/long-term debt (%)*</td>
<td>34.7</td>
<td>35.9</td>
<td>35.5</td>
<td>N.A.</td>
<td>N.A.</td>
<td>N.A.</td>
</tr>
<tr>
<td>Long-term debt/capitalization (%)</td>
<td>32.0</td>
<td>32.1</td>
<td>31.8</td>
<td>33.6</td>
<td>36.4</td>
<td>37.0</td>
</tr>
<tr>
<td>DB pension funded status (%)*</td>
<td>74.4</td>
<td>77.6</td>
<td>81.0</td>
<td>81.3</td>
<td>69.0</td>
<td>72.9</td>
</tr>
<tr>
<td>Pension-adjusted long-term debt/capitalization (%)*</td>
<td>35.1</td>
<td>35.8</td>
<td>34.7</td>
<td>35.7</td>
<td>40.2</td>
<td>40.2</td>
</tr>
</tbody>
</table>

*These five ratios are only for organizations that have defined-benefit (DB) pension plans, operating leases, or contingent liabilities. N.A.--not available.
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Chart 1
U.S. Not-For-Profit Acute Health Care Sector Rating Distribution

As of June 30, 2017 and June 30, 2016 for all outstanding ratings. S.O.—speculative grade.

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Chart 2
U.S. Not-For-Profit Acute Health Care Sector Outlook Distribution

As of June 30 or Dec. 31 for all outstanding ratings.

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Chart 3
U.S. Not-For-Profit Acute Health Care Sector Rating Actions


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Chart 4
U.S. Not-For-Profit Acute Health Care Sector Outlook Revisions

Data is for outlook changes unaccompanied by a rating change. *Through June 30, 2017.

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Related Research

- U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios -- 2016 vs. 2015, Aug. 24, 2017
- U.S. Not-For-Profit Health Care System Median Financial Ratios -- 2016 vs. 2015, Aug. 24, 2017
- U.S. Not-For-Profit Health Care Small Stand-Alone Hospital Median Financial Ratios – 2016 vs. 2015, Aug. 24, 2017
- U.S. Not-For-Profit Health Care Children's Hospital Median Financial Ratios – 2016 vs. 2015, Aug. 24, 2017
- U.S. Not-For-Profit Acute Health Care Speculative Grade Median Financial Ratios – 2016 vs. 2015, Aug. 24, 2017

Glossary of our ratios

- Monthly rating changes
- U.S. Not-For-Profit Health Care Rating Actions, December 2016, Jan. 18, 2017
- U.S. Not-For-Profit Health Care Rating Actions, November 2016, Jan. 6, 2017
- U.S. Not-For-Profit Health Care Rating Actions, October 2016, Nov. 18, 2016
- U.S. Not-For-Profit Health Care Rating Actions, August 2016, Sept. 15, 2016
- U.S. Not-For-Profit Health Care Rating Actions, July 2016, Aug. 29, 2016
- U.S. Not-For-Profit Health Care Rating Actions, June 2016, July 15, 2016
- U.S. Not-For-Profit Health Care Rating Actions, May 2016, June 17, 2016
- U.S. Not-For-Profit Health Care Rating Actions, April 2016, May 13, 2016
- U.S. Not-For-Profit Health Care Rating Actions, March 2016, May 6, 2016
- U.S. Not-For-Profit Health Care Rating Actions, February 2016, March 29, 2016
- U.S. Not-For-Profit Health Care Rating Actions, January 2016, Feb. 12, 2016

For a list of outstanding acute care stand-alone and health system ratings and outlooks please see:

- U.S. Not-For-Profit Acute Health Care Outstanding Ratings And Outlooks As Of June 30, 2017, Aug. 24, 2017

Only a rating committee may determine a rating action and this report does not constitute a rating action.