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What happens if financially troubled hospitals can no longer count on subsidies, philanthropy and government bail-outs to survive?

States and municipalities face slumping tax revenues as the overall economy weakens. Elected officials are being forced to consider significant cuts to offset shortfalls and balance their budgets. Consumers, forced to deal with declining home values and rising prices on everything from wheat to gasoline, are now reining in spending and pocketing more of their income.

For thousands of short-term acute care hospitals across the country, the timing could not be worse. Unless boards and hospital management abandon historic tendencies to apply a “band-aid” approach to problems and, instead, move quickly to take more aggressive measures to shore up their financial and operational foundations, the very survival of many institutions will be at stake.

A recent analysis of more than 4,500 hospitals by global professional services firm Alvarez & Marsal found that more than half are technically insolvent or at risk of insolvency. These hospitals do not make a profit treating patients and must rely, in some cases heavily, on alternate and generally unstable sources of funding, such as philanthropic donations, gift shop revenue or parking fees, and, in the worst situations, government funding, to close the gap. The analysis also found that among the “profitable” hospitals, nearly 1,000 do not generate sufficient cash flow to fund essential, non-discretionary capital expenses that are necessary to comply with regulations and/or remain competitive.

As the economy continues to cool in the wake of declining property values and diminishing consumer confidence, the financial health of many hospitals is likely to further deteriorate, with many encountering serious liquidity crises and some facing the prospect of shutting their doors. With a government safety net appearing less and less reliable, it has become critical for hospital management and boards to face these sobering realities and urgently take steps to improve their financial and operational conditions. In the absence of such action, the number of hospital insolvencies will increase and community after community could be forced to grapple with a steady decline in access to care.

DATA AND METHODOLOGY

Data, including operating expenses and net revenue, for fiscal years ending in 2005 and 2006 was gathered for each short-term acute care hospital in the U.S. with more than 25 beds. Hospitals with missing data were eliminated, reducing the final sample from 4,510 to 3,861. The sample was then compared to the universe, as published in the American Hospital Association’s directory, *Hospital Statistics*, to ensure the sample was representative and unbiased (See Appendix).

The analysis focused on two key measures of hospital performance: patient care margin (i.e., net patient revenue/operating expenses/net patient revenue) and EBITDA margin (i.e., net income + depreciation + amortization + interest + taxes) / operating revenue (net patient revenue + all other revenue).

To minimize the effects of unusually good or unusually bad years of financial performance, an average value of the metrics for 2005 and 2006 was used. The objective was to identify those hospitals that met one of the following criteria:

- **Patient Care Margin less than 0.0 percent.** If a hospital cannot earn a profit on its patient care services, it must rely on non-patient care sources of funding to remain viable. This is a financially risky business model since non-operating sources of hospital funding are more

sensitive to general economic cycles. Hospitals not earning a profit on patient care will become insolvent when they can no longer sell or borrow against assets, or receive emergency governmental aid to fund losses.

- **EBITDA Margin less than 4.0 percent.** A minimum level of profit and cash flow is required for a hospital to fund daily expenses and re-invest in necessary, non-discretionary capital expenditures. Capital investment needed to remain competitive is estimated at 6.0 percent to 8.0 percent of annual operating revenues. This analysis identified a level of 4.0 percent as the minimum level of profitability for a hospital under pressure to fund day-to-day activities, as well as a “survival” level of capital expenditures.

FINDINGS

Analysis of the sample:

- 2,044 hospitals, or 53 percent of the sample, had negative patient care profitability;
- 744 hospitals, or 19 percent of the sample, had EBITDA margins below 4 percent; and
- 737 hospitals, or 19 percent of the sample, had both negative care profitability and EBITDA margins below 4 percent.

Projecting these results to the universe of all short-term acute care hospitals revealed the following:

- 2,616 hospitals in the universe would have negative patient care profitability;
- 991 hospitals in the universe would have EBITDA margins below 4 percent; and
- 943 hospitals in the universe would have both conditions.

In analyzing the 943 hospitals projected to meet both conditions, the following observations were made:

- Potentially insolvent hospitals had a median occupancy rate of 43 percent, compared to 53 percent for the remainder of the universe.

- More than 36 percent of potentially insolvent hospitals had negative working capital (current liabilities in excess of current assets), compared to 7 percent for the remainder of the universe.
- The median ratio of total liabilities to total assets in potentially insolvent hospitals was 71 percent, compared with 43 percent for the remainder of the universe.
- The median ratio of outpatient revenue to total revenue in potentially insolvent hospitals was 47 percent, compared with 49 percent for the remainder of the universe.
- While 56 percent of all hospitals are located in urban areas, 62 percent of potentially insolvent hospitals were urban hospitals.
- Hospitals with 100 to 300 beds represented 44 percent of the universe, but 46 percent of potentially insolvent hospitals.

CONCLUSIONS AND IMPLICATIONS

- Hospitals supported by state and local governments have become a significant drain on state and county tax dollars. In some cases, budget shortfalls at small, county-supported community hospitals could threaten the financial viability of the entire county.
- Similar to competitive markets in other industries, second and third-tier competitors (small and mid-size urban hospitals) are rapidly losing ground to the dominant medical centers and integrated delivery systems in their service areas. A “flight to (perceived) quality” is occurring by both physicians and patients creating a bigger gap between the fiscally strong and fiscally weak hospitals in a given market. Lower-tier hospitals cannot offer the competitive equipment and amenities available from their larger, better-capitalized rivals. Physicians cannot justify admitting to second- and third-tier facilities when the market leading hospital have beds available. Contrary to conventional wisdom,

Contrary to conventional wisdom, urban hospitals have a greater chance of being insolvent than rural hospitals.

urban hospitals have a greater chance of being insolvent than rural hospitals. While rural hospitals enjoy quasi-monopolistic markets, the 100 to 300 bed urban hospital must face the brutal competition offered by well-capitalized academic medical centers and integrated delivery systems located in population centers. It is this group of hospitals where decisive and immediate strategic decisions must be made to ensure survival.

- In an effort to preserve income levels, physicians are banding together and stripping profitable services out of hospitals and establishing alternate settings. Services such as MRI and day surgery, once big money-makers for hospitals are now cash cows for physicians. Hospitals and physicians have long managed a tenuous relationship. With dwindling reimbursement, a Darwinian drama may play out as physicians will be more inclined to satisfy their own income demands, regardless of the consequences to the hospital. For the over-leveraged group of potentially insolvent hospitals (Debt to Assets of 71 percent, compared with 43 percent for all other hospitals), it will be difficult-to-impossible to find the investment dollars needed to improve amenities and re-attract physicians. Hospitals must explore alternate organizational structures that create an alignment of physician and hospital incentives with institutional mission.
- Physical plants at many community hospitals have deteriorated since capital spending has been necessarily curtailed due to lack of funds. We estimate that capital expenses in the hospital industry are \$10 to \$20 billion underfunded. Like it or not, the practice of medicine is a consumer-facing business. The lack of attractive – or even acceptable – physical facilities is a contributing factor to the decline of many hospitals. There are scores of hospitals that are slowly asphyxiating and slipping into insolvency as they divert capital dollars to fund operations. For most of these hospitals, it is only a matter of time before they hit a “sudden” liquidity

crisis and cannot make payroll without entering insolvency and being forced into restructuring their finances and operations.

- As a result of the predominantly non-profit nature of the hospital industry (and the corresponding lack of equity-based compensation), the industry has not attracted the best and the brightest management talent. Without true economic stakeholders, management and boards across the industry have been accountable to typically only to themselves and more vaguely, their “community missions.” This has created a situation where distressed hospitals limp along on life support at 43 percent occupancy. In most industries, a plant running at 43 percent capacity would be closed or consolidated. Not so in healthcare. The tangle of religious, governmental and community missions allows the industry to tolerate excess capacity that would be unheard of in rational economic markets.

The hospital industry, for the most part, has tolerated decades of incremental performance change, with few institutions showing the willingness to embark on more significant change-driven measures, such as restructurings, mergers or recapitalizations, that occur regularly in other industries to turnaround troubled organizations and improve financial and operational performance. Soon they may no longer have a choice – unless the choice is to simply shut down.

Today there is a large – and growing – number of hospitals at risk for insolvency if their sources of non-patient funding falter. While such subsidies have been easily accessible and almost guaranteed during the boom times of the past two decades, strains on government coffers and broader economic forces will put an end to the trend. Management and boards of hospitals must take action quickly to ensure long-term solvency. The alternative – as experienced in New York State – is that the government will take steps independently to deal with over-leverage, underutilization and excess capacity.

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APPENDIX

TABLE 1. BED SIZE CATEGORIES

	Sample		Universe	
Urban	2277	59%	2749	56%
Rural	1584	41%	2178	44%
	3861		4927	

TABLE 2. OWNERSHIP CATEGORIES

	Sample		Universe	
Investor	667	17%	766	16%
NFP	2351	61%	3025	61%
Gov	843	22%	1136	23%
	3861		4927	

TABLE 3. LOCATION CATEGORIES

	Sample		Universe	
Urban	2277	59%	2749	56%
Rural	1584	41%	2178	44%
	3861		4927	

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