HEALTH CARE INDUSTRY MARKET UPDATE

Acute Care Hospitals

July 14, 2003

Dear Friends of CMS:

As the regulators of over $500 billion per year of Medicare, Medicaid, and S-CHIP funds, we believe it is incumbent on us to better understand the finances of our contractors, health providers, and other related businesses that provide services to the more than 70 million beneficiaries these programs serve. Health plans, hospitals, nursing homes, home health agencies, medical device manufacturers, and pharmaceutical companies are just some of those whose finances depend heavily on these public programs.

I have always been surprised at how little Wall Street and Washington interact—and how companies often paint different financial pictures for each audience. I am a strong believer in adequate funding for our major partners in these programs, but I do not think they should be saying one thing to investors and another to regulators (as it is occasionally in their interest to do). If health plans or providers are struggling to serve our beneficiaries, we should have a thorough understanding of their real financial status to assess the true level of need. Many investment banking firms conduct detailed analyses of major health providers, both for the equity investors in for-profit companies, and for the debt holders of for-profit and not-for-profit entities. Health systems typically provide these investors with clear financial data. These data can be used by regulators and legislators to assess funding adequacy or the need for regulatory reforms.

CMS' Office of Research, Development & Information (ORDI) has gathered research reports from the major investment firms, summarized their analyses, and condensed them into a short, and hopefully, understandable format. Our goal is to provide objective summary information that can be quickly used by CMS, HHS, Congress, and their staffs that oversee these programs. The primary person at CMS assigned to this task is Lambert van der Walde. Lambert previously worked for Salomon Smith Barney in New York and is experienced with corporate financial analysis and research review. Also contributing to this report is Kristen Choi who has Wall Street experience as well. Kristen has left CMS to attend Columbia Law School in the fall.

This Market Update focuses on acute care hospitals, updating our first report about this sector published April 29, 2002. Medicare is the single largest payor for hospital care, covering $135 billion or 30% of hospital care expenditures in 2001. Medicaid paid for an additional $77 billion or 17% of hospital care expenditures in 2001. In coming months, we will continue to review the major provider and supplier sectors. Though I am proud of this effort, and believe it will add to understanding of the programs, we welcome comments on the content and format of this report. We want to make this as consumer friendly as possible for everyone who reads it. Please provide comments to Lambert van der Walde at Lvanderwalde@cms.hhs.gov.

Sincerely,

Tom Scully

HEALTH CARE INDUSTRY MARKET UPDATE

Acute Care Hospitals

July 14, 2003

Tom Scully
Administrator

Office of Research, Development & Information:

Lambert van der Walde
Lvanderwalde@cms.hhs.gov

Kristen Choi

Wall Street's View of Hospitals

Following a general industry recovery over the last few years, analysts are uncertain regarding near-term performance.

- **Hospital profit margins average 3% to 5%, which is about the historical average, but individual hospital performance varies.**
- **Credit analysts have grown increasingly pessimistic regarding not-for-profit hospitals.**
- **Despite 2002 margin improvement for publicly traded hospital chains, analysts believe stock prices are depressed due to a recent decline in admissions and eroded investor confidence following controversy over Medicare outlier payments.**
- **Analysts note that well capitalized hospitals continue to grow stronger while weak hospitals grow weaker.**
- **Hospital construction is increasing. Inpatient hospital bed capacity grew in 2001, the first time since 1983.**

CONTENTS

EXECUTIVE SUMMARY

Wall Street analysts have a mixed outlook on the hospital industry. In the long-term, most analysts expect successful financial performance to be driven by an increase in demand for hospital services due to aging baby boomers, increased access to medical treatment, and longer life spans. In the near-term, analysts are generally optimistic that hospitals will continue to secure healthy rate increases from managed care payors and that Medicare rate increases will remain stable, although concerns regarding Medicaid rates remain. The growth rate of labor costs has slowed, although hospitals remain pressured by a nursing shortage. Hospitals also face increasing medical malpractice expenses, which decrease profitability.

Hospital stocks have declined over the last year.

The hospital industry has faced a number of stresses over the past year that have resulted in depressed stock prices for the publicly traded, for-profit hospital companies and more negative than positive revisions to credit ratings for the not-for-profit companies. After posting solid gains in the first half of 2002, hospital stocks began to slide in July due to broader concern about the economy and increased Federal Trade Commission (FTC) scrutiny of hospital mergers. In October, hospital stocks declined further as investors grew concerned about the threat to certain Medicare payments as a small number of hospitals were discovered to have exploited Medicare rules resulting in the receipt of inappropriate "outlier" payments for cases that greatly exceeded the average cost. Recently, Wall Street has become very focused on low hospital admissions volume in the first quarter of 2003, which decreased profit margins. Analysts continue to look for explanations as second quarter admission trends also appear weak.

Profit margins are near their historical average.

Despite their low stock prices, publicly traded, for-profit hospital companies have improved average profit margins, from 5.1% in 2001 to 5.7% in 2002. Broader indicators of both the not-for-profit (85% of facilities) and for-profit hospitals (15%), such as the National Hospital Indicators Survey, show margins holding relatively steady since 1999. An annual survey conducted by the American Hospital Association (AHA), an industry association for both for-profit and not-for-profit hospitals, shows that hospital profit margins are near their historical average.

Inpatient bed capacity has reversed its downward trend.

Financial performance of a hospital affects both internal capital (*i.e.*, cash flow) and access to external capital sources (*e.g.*, bank loans and the public debt and equity markets). Analysts note that access to capital has improved for those hospitals that have strong financial performance and has become more restricted for those that are performing poorly. Hospitals that can, and do, commit substantial capital to maintain and upgrade facilities seem to be gaining market share at the expense of less well-capitalized hospitals. Acquisition activity has increased, which may be driven by improved access to capital for the (mostly for-profit) acquirors as well as the need for access to capital by the (mostly not-for-profit) acquired hospitals that seek strong partners. Other consolidation drivers are the growth strategies of the rural for-profit companies (which focus on buying and improving hospitals in one- or two-hospital rural markets in order to reduce the number of patients who might otherwise travel to nearby metropolitan areas), the desire of hospital systems to shed non-core facilities (asset rationalization), and efficiency gains. Hospitals have also begun to raise capital spending targets to take advantage of emerging development opportunities. For the first time since implementation of the inpatient prospective payment system (PPS) in 1984, inpatient bed capacity rose in 2001.

WALL STREET'S VIEW

Note: This report seeks to give the reader a general understanding of conditions and trends in the hospital industry. Because most publicly-available information comes from the for-profit sector (which comprises only 15% of all facilities), the extent to which the for-profit data applies to the rest of the industry may vary.

Hospital industry analysts expect demand for hospital services to increase over the long-term. Lori Price of J.P. Morgan notes:

> We believe longer-term trends continue to favor robust demand for hospital services. Specifically, as the population grows, as new health products and services become available to the market, and as the baby boomers come of age, we expect demand for hospital-based care to grow.

Analysts expect hospitals to continue to negotiate strong price increases from managed care. They also foresee a stable rate outlook from Medicare and a greater threat from Medicaid. A.J. Rice of Merrill Lynch writes, "The hospital chains, particularly those in urban markets, have clearly benefited in recent years from a favorable commercial pricing backdrop." John Hindelong of Credit Suisse First Boston notes that hospitals have been enjoying solid managed care rate increases after a difficult time in the late 1990s:

Managed care contract rates continue to increase.

> Well-positioned hospitals and hospital networks continue to achieve solid rate increases on managed care contracts, as they play 'catch-up' after almost no pricing increases in the late 1990s. In recent quarters this trend has yielded strong increases in revenues per admission across the group…. We have seen no signal whatsoever of any weakness in managed care pricing. Well-positioned hospitals are sustaining revenue per admission increases in the mid to high single digits. We expect these trends to continue through 2003, and many contracts are now running strong well into 2004.

Adam Feinstein of Lehman Brothers describes the presentations of several publicly traded hospital chains at a conference in March: "Companies spoke about recent meetings in Washington that suggest a continuation of the status quo [for Medicare payment rates]. However, there was caution by several companies with respect to Medicaid." Rice describes how investors are sensitive to the effect of Medicare payment updates on the hospital sector:

Stable Medicare payment levels are important to investors.

> Every year, there is likely to be tremendous debate and wrangling over where within that spread the industry will end up, but generally speaking the investor-owned segment of the hospital industry will be able to manage if Medicare remains a reliable player offering steady annual increases.

Although investors have been concerned about the effect of state fiscal deficits on Medicaid, Price notes:

[W]hile virtually all states are taking steps to slow the rate of increase in Medicaid spending during fiscal 2004 and beyond, they tend to be protective of hospitals as a provider class, preferring to achieve savings in other areas, where possible. More particularly, we found that most states typically view hospital payment cuts as an expense control measure of last resort.

Despite long-term demand and pricing strength, some investors are less optimistic, mostly due to a mysterious slow-down in hospital admissions volume. Hospital stocks are trading close to the floor of historical valuation levels. In April, John Ransom of Raymond James noted that hospital stocks reached new lows: "[M]any names in the hospital sector have overshot the last valuation trough (the BBA-driven 1999 collapse) by a good 15 to 20%."

Lower patient volumes have investors concerned.

Because of the high fixed-cost nature of the hospital business, reports of low first quarter patient volume resulted in lower operating and profit margins. Price writes, "[G]enerally disappointing [1Q03] results were led by a deceleration in the industry average same-store admission trend, with same-store adjusted admissions growth having come down meaningfully from 4.1% in 4Q02 to 0.4% on average in 1Q03." Most analysts attributed the low admissions trends to a very mild flu season and severe weather. Other suggested reasons include war concerns, the economy, unemployment, and the possible delay of procedures due to anticipation of new medical technologies such as drug-eluting stents. Gary Taylor of Banc of America Securities noted, "Most respondents [of his 2003 hospital survey] cite the economy—not managed care—for softer admissions forecasts." Other long-term trends that may be decreasing demand are benefit redesigns (by health plans that demand higher deductibles and co-payments for hospital services) and the proliferation of competing physician-owned ambulatory surgery centers, outpatient clinics, and specialty hospitals.

Analysts do not agree on the causes of low admission trends

Gary Lieberman of Morgan Stanley describes the general lack of consensus on the subject. He writes, "What is clear to us is the confusion as to the specific reason for the weakness. While companies provided a laundry list of potential reasons, no one explanation stood out as being more likely than the other." Analysts have continued to clamor for explanations as recent commentary by public hospital companies suggest that low patient volumes continue in the second quarter.

Analysts note that hospitals that have the capital to invest in their facilities are more likely to gain market share from those hospitals that do not. Price notes that this divergence in performance of well-capitalized (typically for-profit) and under-capitalized (typically not-for-profit) hospitals has already begun to become apparent:

> Notwithstanding the weak patient volume trends of 1Q03, we believe publicly traded hospital companies are continuing to gain market share at the expense of many of their weaker (typically not-for-profit) peers. By way of background, the BBA of 1997 dealt a significant blow to the hospital industry overall but had a disproportionately negative impact on smaller, typically not-for-profit facilities, a number of which were crippled by the payment reductions imposed. As a result, many not-for-profit facilities began to under invest in their hospitals, leading to a loss of market share and diminished access to capital (as evidenced by 161 hospital downgrades by Moody's since January 2000, versus just 60 hospitals upgraded in that time frame), which limits their flexibility to reinvigorate investment in maintaining and expanding their facilities. Publicly traded hospital companies, on the other hand, have had ample access to capital (at progressively more attractive interest rates/share prices during most of this time frame), as evidenced by the 33 public debt or equity offerings valued at $14.0 billion that have been completed by the eight publicly traded hospital chains [from January 2000 to May 2003]. Importantly, in contrast to many of the not-for-profits,

Access to capital has enabled strong hospitals to get stronger by investing in facility maintenance and expansion.

> the public companies are aggressively using capital to improve/enhance their facilities, allowing them to draw patient flow away from weak local competitors. We note that incremental market share gains that manifest as volume increases are disproportionately profitable, given the high fixed-cost nature of the industry.

Capital expenditures by the publicly traded hospital companies have been rising, which analysts view as a positive sign. Price says, "From 2000 to 2002, six of the eight publicly traded hospital companies increased the proportion of EBITDA that they devoted to capital expenditures, with the aggregate percentage of EBITDA allocated to capital expenditures (among all publicly traded hospital companies) rising from 35% in calendar 2000 to 37% in calendar 2001 to 40% in calendar 2002." Investments that are made to attract medical specialists and purchase sophisticated medical equipment and expertise can attract high acuity patient cases that tend to result in higher revenues per admission and expand operating margins, according to Price.

Despite a moderation in labor cost increases, a nursing shortage continues to be problematic.

Hospital expenses continue to rise, although some analysts have observed a moderation in labor cost growth. Adam Feinstein of Lehman Brothers observes, "The rate of growth in labor costs is starting to moderate for hospitals. Although labor shortages continue to plague hospitals, we believe that hospitals are doing a better job of managing labor costs." Price cautions against premature expectations of relief: "Although publicly traded hospital companies are beginning to make progress in addressing the cost issues created by the ongoing nursing shortage, we expect the potential for a nursing crisis to remain an ongoing issue for the industry over the next several years."

Feinstein notes that every publicly traded hospital company experienced increased medical malpractice expense in the first quarter. He writes, "…[A]ll hospitals highlighted [increased medical malpractice expense] as a major source of concern. We estimate malpractice expense increased in excess of 20% in the quarter for hospitals…."

Acquisition activity among hospitals has increased over the past year. John Hindelong of Credit Suisse First Boston believes, "The combination of continuing pain at many not-for-profit facilities and improving balance sheets in the publicly-traded group has contributed to the surge [in acquisition activity]." Rice writes:

Acquisition of poorly-capitalized hospitals continues.

> The hospital management companies continue to uncover an ample supply of non-profit hospitals looking to link up with a well-capitalized partner.… Given the weak stock market of the last few years, the endowments of many not-for-profits have been strained, and we believe not-for-profit systems will continue to be net sellers, rather than buyers, of assets for the foreseeable future.

Price notes that the non-urban hospitals tend to be more acquisitive than urban hospitals**:**

> Notably, the companies pursuing a non-urban strategy (which involves ownership and operation of hospitals that are the sole hospital or one of two in a rural market, with the goal of stemming out migration to nearby metropolitan markets) tend to be particularly acquisitive, with most having a stated intent to add two to four hospitals each year…. The urban hospital companies have tended to be less acquisitive… focusing instead on rationalizing their asset portfolios, selling facilities in unattractive markets and/or that are otherwise deemed non-strategic.

INDUSTRY OVERVIEW

In 2001, there were 4,908 acute care community hospitals in the United States.[1] Of these, approximately 85% were not-for-profit.

Figure 1: Community Hospitals, 2001

	Number of Facilities	Percent of Facilities	Number of Beds	Percent of Beds
Total Community Hospitals	4,908	100%	825,966	100%
Total Not-for-profit Community Hospitals	4,154	85%	717,248	87%
Nongovernment Not-for-profit	2,998	61%	585,070	71%
State and Local Government	1,156	24%	132,178	16%
For-profit Community Hospitals	754	15%	108,718	13%

Source: American Hospital Association.

The hospital industry is largely composed of not-for-profit hospitals.

The for-profit segment of the hospital industry comprises only 15% of the total industry. There are eight publicly traded, for-profit hospital companies. These companies, listed in Figure 2, together operate approximately 550 hospitals. The major non-publicly traded private for-profit hospital companies include Vanguard Health Systems, Ardent, and Iasis Healthcare.

Figure 2: Publicly Traded Hospital Companies

($ in millions)

Hospital Company	Ticker	Market Cap	Number of Facilities	Number of Beds
HCA, Inc.	HCA	$15,886	173	38,617
Tenet Healthcare	THC	5,600	116	28,667
Health Management Associates, Inc.	HMA	4,502	43	5,756
Universal Health Services	UHS	2,321	63	9,563
Community Health Systems	CYH	1,940	63	4,676
Triad Hospitals	TRI	1,903	61	7,008
LifePoint Hospitals	LPNT	893	28	2,660
Province Healthcare	PRV	560	20	2,267

Sources: Bloomberg as of July 9, 2003 and company filings.
Notes: Market capitalization is a measure of a company's value or size, calculated by multiplying share price by the number of shares outstanding. Facility and bed count as of end of each company's fiscal year 2002. Triad facilities include both acute care hospitals (47) and ambulatory surgery centers (14). Universal facilities include both acute care hospitals (26) and behavioral hospitals (37).

Revenue Sources

Hospitals generate their revenue from multiple (and variable) product lines. While a substantial portion comes from inpatient and outpatient services, other income streams come from product lines including skilled nursing, home health services, medical equipment sales, hospice, rural health clinics, physician office rental, gift shops, and parking garages.

Hospital expenditures consume nearly one-third of the nation's health care spending.

According to CMS' Office of the Actuary, national health expenditures totaled $1.4 trillion in 2001. Hospital care expenditures accounted for $451 billion or 31.7% of national health expenditures. The three largest payers of hospital care were private insurance ($152 billion), Medicare ($135 billion), and Medicaid ($77 billion).

[1] Community hospitals are nonfederal short-term general and special hospitals whose facilities and services are available to the public.

Figure 3: Hospital Care Expenditures, by Payor

($ in millions)

	2001	% of Hospital Care Expenditures
Total National Health Expenditures	**$1,424,541**	**NA**
Hospital Care Expenditures	**$451,220**	**100%**
Private	**$188,113**	**42%**
Private Insurance	152,148	34%
Out of Pocket	13,828	3%
Other	22,137	5%
Public	**$263,107**	**58%**
Medicare	134,953	30%
Medicaid	77,424	17%
Federal	45,025	10%
State and Local	32,399	7%
Other	50,729	11%
Federal	29,387	7%
State and Local	21,342	5%

Source: CMS, Office of the Actuary.

Private Insurance

The private or commercial insurance industry paid for 34% of the nation's hospital expenditures in 2001. The average publicly traded, for-profit hospital company generated 39% of 2002 revenues from managed care contracts. Hospital chains located in urban areas depend more heavily on managed care revenue streams than do hospital chains in rural areas.

As noted on page 4, Wall Street analysts have observed how hospital chains have enjoyed solid rate increases from private health plans after receiving virtually none in the late 1990s. Gary Lieberman of Morgan Stanley describes consensus among a panel of hospital and managed care industry members who recently explained the major reasons for hospital price increases to managed care payors:

> The panel agreed that significant increases in medical costs along with cross-subsidization of Medicare and Medicaid were two legitimate reasons for substantial hospital price increases to payors over the past several years. However, hospital consolidation in some markets (we believe primarily among the not-for-profit hospitals) has contributed to overly aggressive price increases put through by some hospitals [according to the panel].

Wall Street analysts note that some investors are concerned that hospitals are facing a weaker pricing cycle, as managed care companies begin to feel pushback from employers who are being faced with double-digit premium hikes. As premiums rise, employers continue to shift more health care costs onto employees.[2] Demand for hospital services may be affected by higher co-payments for more expensive resources (*e.g.*, emergency room visits) and could experience the impact in the future of price incentives used to direct patients to preferred facilities (*e.g.*, tiering) although analysts have seen no evidence of this occurring yet.

[2] For further description of managed care, see the March 24, 2003 *Health Care Industry Market Update*.

Still, most analysts and hospital companies note there are no near-term signs of weakness in managed care pricing to date, with positive trends expected to continue through 2003 and into 2004. Charles Lynch of CIBC writes, "Commercial pricing updates are persisting in the mid- to high-single digit range for both 2003 and 2004." Regarding the effect of benefit redesigns on hospital service volume, Lieberman writes:

Analysts do not expect employer pressure on managed care rates to affect hospital rates in the near-term.

> In our view, new benefit designs that increase consumer sensitivity to the cost of health care services could negatively impact volumes, particularly elective outpatient procedures. We expect that slowdown will be gradual and take a few years to gain traction because employers are now just experimenting with new plan designs. Taking a longer-term perspective… we believe that demand, even with pressures on utilization, will far outstrip supply.

Medicare

Medicare is the largest single payor for hospital services, responsible for 30% of all hospital care expenditures in 2001. The average publicly traded, for-profit hospital company generated 34% of total 2001 revenues from Medicare. Hospital chains in rural areas depend more heavily on Medicare revenue streams than do hospital chains in urban areas.

Most Medicare funds for hospitals are now paid under several prospective payment systems (PPSs). The hospital inpatient PPS phase-in began in 1984. Since then, the skilled nursing facility (1998), home health (2000), outpatient hospital (2000), and rehabilitation hospital (2002) PPSs have also been implemented.[3] Each time a new PPS was introduced, the capital markets became very nervous about the resulting financial performance of providers. In addition, hospital investors closely follow the annual update to the PPS base payments. Merrill Lynch's Rice states that reliable payment increases are the most important aspect of the Medicare payment update to hospitals:

Changes in PPSs affect market and investor behavior.

> We believe the [hospital] industry is in an environment, similar to that observed in the 1993 through 1997 time period, when the hospitals consistently obtained modest annual inpatient reimbursement increases from Medicare, generally in the 1.5-2.5% range. Every year, there is likely to be tremendous debate and wrangling over where within that spread the industry will end up, but generally speaking the investor-owned segment of the hospital industry will be able to manage if Medicare remains a reliable player offering steady annual increases.

In the case of the inpatient PPS, these rates are updated annually by statutory cost factors based on a "market basket" of hospital costs that reflects hospital input price inflation. The "market basket percentage increase," or "market basket," is the inflation factor applied each year to these prospective rates. Figure 4 shows the actual historical inpatient PPS payment updates compared to the annual market basket increase. In the past, Congress has set the payment update at a discount to the full market basket increase. Since the transition to full inpatient PPS in 1988, there has been only one year (2001) when the payment update was equal to the full market basket increase. The proposed update for fiscal year 2004 is also a full market basket update, although possible modification by Congress is under consideration.

Under current Medicare statute, hospitals will receive a full market basket increase in FY2004.

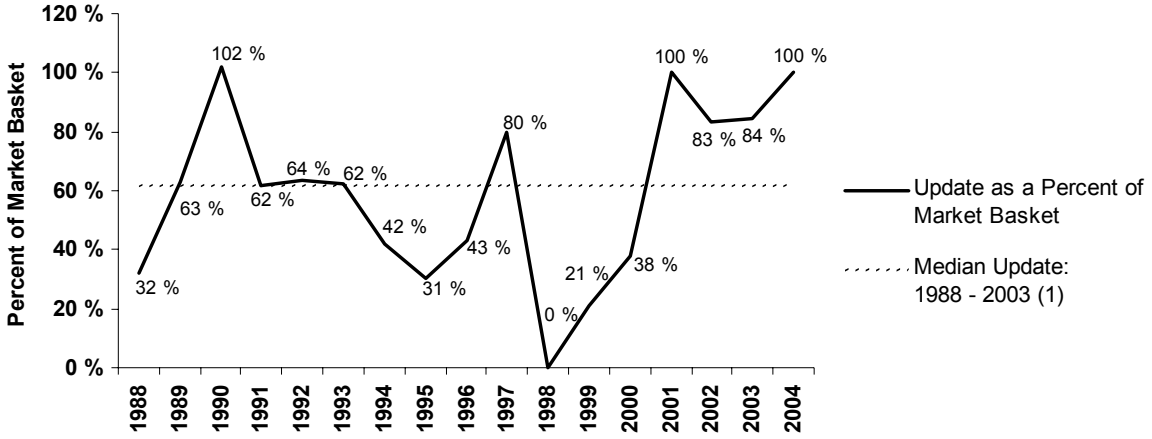
[3] Further explanation of these systems can be found in the Appendix to the April 29, 2002 *Health Care Industry Market Update* on hospitals.

Figure 4: Historical Inpatient PPS Payment Updates

Fiscal Year	Actual Inpatient PPS Payment Update: Large Urban	Actual Inpatient PPS Payment Update: Other Urban	Actual Inpatient PPS Payment Update: Rural	Full Market Basket Increase	Actual Update (Discount) / Premium to Full Market Basket Increase	Actual Update as a Percent of Full Market Basket Increase
1988[1]	1.50 %	1.00 %	3.00 %	4.7 %	(1.70)% - (3.70)%	**21 % - 64 %**
1989	3.40 %	2.90 %	3.90 %	5.4 %	(1.50)% - (2.50)%	**54 % - 72 %**
1990[2]	5.62 %	4.97 %	9.72 %	5.5 %	4.22 % - (0.53)%	**90 % - 177 %**
1991[3]	3.20 %	3.20 %	4.50 %	5.2 %	(0.70)% - (2.00)%	**62 % - 87 %**
1992	2.80 %	2.80 %	3.80 %	4.4 %	(0.60)% - (1.60)%	**64 % - 86 %**
1993	2.55 %	2.55 %	3.55 %	4.1 %	(0.55)% - (1.55)%	**62 % - 87 %**
1994	1.80 %	1.80 %	3.30 %	4.3 %	(1.00)% - (2.50)%	**42 % - 77 %**
1995	1.10 %	1.10 %	8.40 %	3.6 %	4.80 % - (2.50)%	**31 % - 233 %**
1996	1.50 %	1.50 %	1.50 %	3.5 %	(2.00)%	**42.9 %**
1997	2.00 %	2.00 %	2.00 %	2.5 %	(0.50)%	**80.0 %**
1998	0.00 %	0.00 %	0.00 %	2.7 %	(2.70)%	**0.0 %**
1999	0.50 %	0.50 %	0.50 %	2.4 %	(1.90)%	**20.8 %**
2000	1.10 %	1.10 %	1.10 %	2.9 %	(1.80)%	**37.9 %**
2001	3.40 %	3.40 %	3.40 %	3.4 %	0.00 %	**100.0 %**
2002	2.75 %	2.75 %	2.75 %	3.3 %	(0.55)%	**83.3 %**
2003	2.95 %	2.95 %	2.95 %	3.5 %	(0.55)%	**84.3 %**
2004 proposed	3.50 %	3.50 %	3.50 %	3.5 %	0.00 %	**100.0 %**
Median (4)					**(1.8)%**	**62.2 %**
Mean (4)					**(1.5)%**	**59.2 %**

Source: CMS, Center for Medicare Management & Office of the Actuary.
Note: The annual inpatient PPS payment update is applied to the standardized operating and capital amounts. Currently standardized amounts differ for hospitals in large urban versus other areas.
(1) Inpatient PPS was implemented in 1984, but was not fully phased in until 1988. 1988 updates were in effect from April 1, 1988 to September 30, 1988. Prior to that, the updates were zero from October 1, 1987 to November 21, 1987, and 2.7% from November 21, 1987 to March 31, 1988.
(2) 1990 updates were in effect from January 1, 1990 to September 30, 1990. Prior to that, the update was 5.5% from October 1, 1989 to December 31, 1989.
(3) 1991 updates were in effect from January 1, 1991 to September 30, 1991. Prior to that, the updates were 5.2% from October 1, 1990 to October 21, 1990, and zero from October 21, 1990 to December 31, 1990.
(4) Median and mean for 1988-1995 Update as a Percent of Market Basket use the large urban payment update.

Figure 5: Historical Inpatient PPS Payment Update as a Percent of Market Basket



Source: CMS, Center for Medicare Management and Office of the Actuary.
(1) The median update is calculated from the large urban payment update and equals 62% of the market basket, or market basket minus 48 basis points.

Medicare Outlier Payments

Over the last few years a number of hospitals manipulated Medicare's payment formula for cases whose costs greatly exceeded the average. This abuse of the payment formula by a small number of hospitals made it progressively more difficult for non-abusers to receive additional payment for unusually high-cost outlier cases.

Background
Under the hospital inpatient PPS (IPPS), Medicare pays hospitals a fixed amount for inpatient services based on the diagnosis related group (DRG) which reflects a patient's diagnosis and the procedures performed. For any given case, a hospital's costs may be somewhat more or less than the DRG payment, but overall DRG payment rates are set at a level that should yield a reasonable margin to an efficiently operated hospital.

For cases that generate extremely high costs above the DRG payment, Medicare makes additional outlier payments to offset the financial impact to hospitals. To qualify for an outlier payment, the cost of a case must exceed the DRG payment by an amount set each year by CMS in the IPPS update rule–the outlier threshold. Each DRG is reduced by 5.1% to finance these outlier payments. These payments are calculated based on a formula that estimates the cost of an individual case.

Under previous outlier policy CMS had been multiplying the current charges for the case by an older cost-to-charge ratio (CCR) to calculate the case's cost to determine the outlier payment. This CCR was calculated from the most recently settled cost report because CMS did not use the hospital's current cost report since it would typically take one to three years to audit and settle. So long as the hospital's costs and charges changed at roughly the same rate, this formula would have yielded a reasonable approximation of the hospital's costs for the outlier case.

The Problem
Last year, CMS discovered that a few hundred hospitals had been manipulating the outlier formula by aggressively increasing their charges at a much higher rate than their costs, resulting in a higher payment when the old CCR was multiplied by the increased charge. The resulting excessive outlier payments caused CMS to significantly exceed the budget target for outlier payments of 5.1% of total DRG payments. These overpayments totaled over $2 billion in fiscal year (FY) 2002, and between $1 and $2 billion a year for each of the previous three years. The repeated overpayments also caused the outlier threshold to rise from $14,500 in FY 2000 to $33,560 in FY 2003. It is tentatively set at $50,645 in the proposed IPPS rule for FY 2004.

The Solution
To clamp down on abusive manipulation of the outlier payment formula, CMS recently finalized changes to the outlier policy. The rule was published in the June 9, 2003 Federal Register and will be effective August 8, 2003. The rule will be applied in setting the final high-cost outlier threshold for inpatient acute care hospitals for FY 2004, but did not change the current FY 2003 outlier threshold. Key provisions of this rule include:

- Eliminating the use of statewide average CCRs to determine a hospital's costs. Under previous policy, statewide average CCRs were used when the hospital's own CCR fell outside of established parameters.
- Using the latest of either the most recent submitted or most recent settled cost report to calculate the CCR. This change will not take effect until October 1, 2003 in order to provide relief to some hospitals that were not chronic abusers of the system.
- Issuing separate instructions by CMS to fiscal intermediaries with specific criteria to use to identify hospitals that may have received inappropriately high outlier payments. Outlier payments to these hospitals may be subject to reconciliation based on the hospital's settled cost reports.
- Allowing fiscal intermediaries to review and, if necessary, reconcile outlier payments if there are other indications of potential abuse.
- Authorizing fiscal intermediaries to adjust reconciled amounts to account for the time value of money.
- Allowing a hospital to request the fiscal intermediary to change its CCR to adjust its outlier payments, in much the same way that an individual taxpayer can adjust the amount of withholding from income, to avoid over- or underpayments for outlier cases.

Medicaid

Medicaid covered 17.2% of all hospital care expenditures in 2001. The average publicly traded, for-profit hospital company generated 10% of total 2002 revenues from Medicaid. Hospital chains in rural areas depend more heavily on Medicaid revenue streams than do hospital chains in urban areas.

Medicaid is administered and financed by state governments with significant funding support from the federal government. In 2001, the federal contribution was 58% of total Medicaid hospital expenditures. Because of the variations in state programs, it is difficult for investors to forecast Medicaid trends on a nationwide basis. Investors are especially concerned about Medicaid rates in the wake of shrinking state budgets. According to Moody's, "In order to balance their budgets, many states are likely to reduce their Medicaid expenditures, which account for nearly 20% of most state budgets and represent the second largest expenditure after education." Reduced Medicaid spending could result in reduced payment rates as well as reduced eligibility—potentially increasing the number of uninsured and the overall cost of uncompensated care. The most recent tax bill will offset some of this pressure as it provides for an additional $10 billion in Medicaid funds for the states.

INDUSTRY PERFORMANCE

Background

The late 1990s challenged the hospital industry on three major fronts. The Balanced Budget Act (BBA) of 1997 significantly reduced Medicare payment increases, hospitals accepted low payment from managed care organizations, and several major defaults and bankruptcies shook the investment community (notably the July 1998 bankruptcy of Allegheny Health Education and Research Foundation (AHERF), the largest default ever by a not-for-profit health care organization). These challenges caused performance problems (as profit margins contracted) and also limited access to capital (as investors left the sector). In addition to these three challenges, some hospitals found themselves struggling with poorly performing non-core business acquisitions, such as physician practices and HMOs. Some hospitals responded by divesting these businesses.

Following the BBA declines in Medicare payment increases, the Balanced Budget Refinement Act (BBRA) of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000 were passed. This legislation moderated the impact of the BBA by providing more modest reductions in Medicare payment increases to the industry. Hospitals, which have regained market power, have also been able to renegotiate contracts with private payors to secure significant rate increases in recent years.

Profits

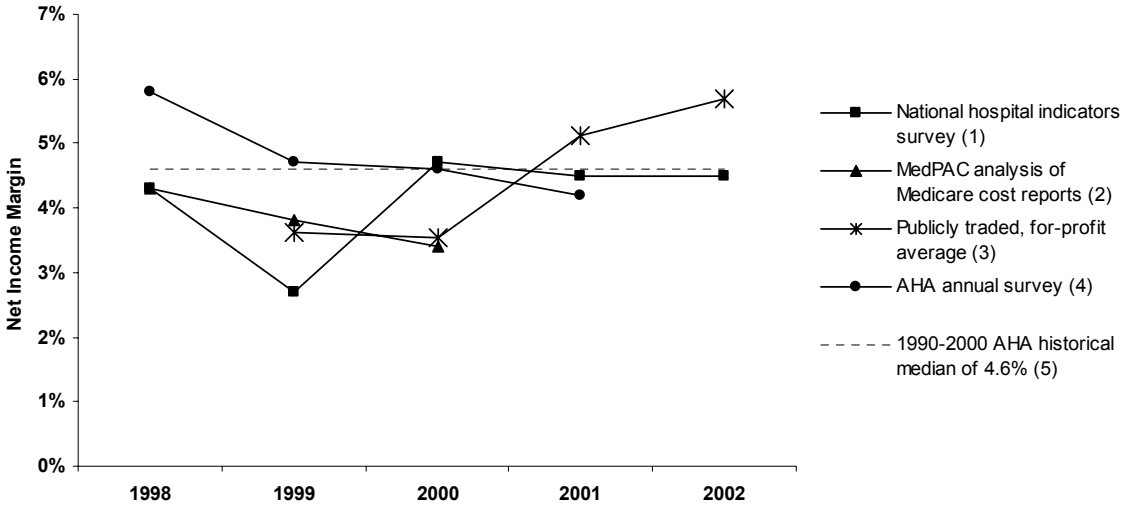
Net income is the revenue that remains after all operating and non-operating expenses (such as interest, taxes, depreciation, and amortization) have been subtracted. This is the total profit or "bottom line." Net income is the amount a business can reinvest in itself and, in the case of a for-profit company, may distribute to shareholders.

Hospital profit margins are near their historical averages.

Several studies of hospital net income margins are shown in the Figure 6 below. While methodology and sample selection create some variation, most results fall in the 3-5% range. Despite these differences, the data are a good indicator on a directional basis. One will note that for the last three years, although only 15% of the industry, public for-profit companies appear to be increasing their profitability. Broader indicators of both not-for-profit and for-profit hospitals like the National Hospital Indicators Survey show margins holding relatively steady since 1999. Further, and not surprisingly, the publicly traded for-profit hospitals have outperformed the hospital group as a whole. An annual survey conducted by the American Hospital Association (AHA), an industry association for both for-profit and not-for-profit hospitals, shows that hospital profit margins are near their historical average.

Figure 6: Hospital Industry Profit Margins

While methodology and sample selection create some variation, most results fall in the 3% - 5% range.



Sources:
(1) National hospital indicator survey (NHIS) commissioned by CMS and MedPAC and conducted by the American Hospital Association and the Lewin Group, current methodology began in 1998. NHIS surveys nearly 1,900 community (for-profit and not-for-profit) hospitals in the U.S.
(2) MedPAC analysis of CMS cost reports through 2000. Data are imputed for hospitals whose 2000 cost reports were not available (about 27 percent of observations). Excludes critical access hospitals.
(3) Based on JPMorgan historical financial models based on company reports. Companies include HCA, Inc., Tenet Healthcare, Health Management Associates, Universal Health Services, Community Health Systems, Triad Hospitals, LifePoint Hospitals, and Province Healthcare. Fiscal years end December, except for September fiscal year end for Health Management Associates for all years and May fiscal year end for Tenet for years prior to 2002. Excludes all extraordinary/one time charges.
(4) American Hospital Association (AHA) annual survey of hospitals.
(5) Lewin Group analysis of AHA annual survey, 1990-2000.

Costs

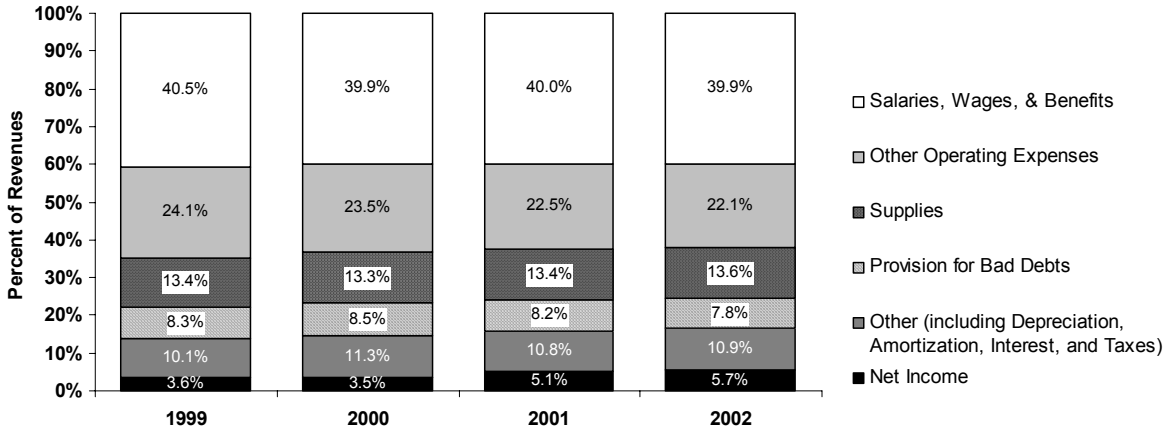
In general, the hospital industry is a high fixed-cost business, according to CSFB's Hindelong. He makes two major points about cost structure:

1) Hospitals are able to leverage small incremental revenue increases over a large fixed cost base. In other words, small increases in revenue can cause significant margin expansion.

2) Well-run hospital companies are able to transform a portion of their fixed costs (particularly labor) into variable costs, mitigating the seasonality and variability of the hospital business.

Hospital companies typically break out different operating costs into four groups: labor (salaries, wages, and benefits), provision for doubtful accounts (bad debt), supplies, and other. These expenses as a percent of total revenues for the publicly traded companies are shown in Figure 7.

Figure 7: Expenses and Profits for Publicly Traded Hospital Companies



Source: Company reports and JPMorgan estimates.
Notes: Companies include HCA, Inc., Tenet Healthcare, Health Management Associates, Universal Health Services, Community Health Systems, Triad Hospitals, LifePoint Hospitals, and Province Healthcare. Other operating expenses include expenses such as contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and non-income taxes. Fiscal years end December, except for September fiscal year end for Health Management Associates for all years and May fiscal year end for Tenet for years prior to 2002. Figures presented on an equal-weighted average basis. Excludes all extraordinary/one time charges. Other operating expenses include supply expense for HMA as the company does not separately report its supply costs.

Expenses as a percent of revenues have been relatively stable.

Labor (Salaries, Wages, and Benefits)

Labor costs account for approximately half of a hospital's operating costs or about 40% of total 2002 revenues among the publicly traded, for-profit companies. Nursing accounts for about half of labor costs. Rising nursing costs, in particular, have troubled investors due to pressures raised by the nursing shortage. As noted on page 6, some Wall Street analysts have begun to see early signs that the publicly traded hospital companies seem to have successfully been addressing rising labor costs. Adam Feinstein of Lehman Brothers noted, "Almost every hospital company spoke about reduction in labor costs due to less utilization of [nursing staffing agencies]" at an investor conference in March 2003. Price cautions against premature expectations of relief:

Despite a moderation in labor cost increases, a nursing shortage continues to be problematic.

> Although publicly traded hospital companies are beginning to make progress in addressing the cost issues created by the ongoing nursing shortage, we expect the potential for a nursing crisis to remain an ongoing issue for the industry over the next several years. Specifically, we believe there is a risk that resurgences in pressure on nursing costs could cause periodic volatility in the labor cost ratio going forward.

Hospital companies have also noted the effect of rising health insurance premiums for hospital employees that partially offset improvements in other labor costs.

Standard & Poor's (S&P), a credit rating agency, has paid increasing attention to the effect of increased pension expense on the not-for-profit hospitals. Weak investment markets are requiring funding contributions to hospital pension plans for the first time in many years. When providers must fund pensions, this decreases profitability and restricts cash availability to either fund capital projects or the financial strength to access the capital markets at desirable rates.

Provision for Doubtful Accounts (Bad Debt)

Hospitals are sometimes unable to collect payments, particularly from uninsured patients and from patients who are unable to pay the deductible and co-insurance payments required by the primary payer. Unless classified as charity care, for which hospitals do not pursue collection, hospitals record as an "expense" the amount of care for which the hospital does not expect to collect payment. This is called the provision for doubtful accounts. (Medicare sometimes reimburses hospitals for its share of these uncollectible accounts, known as "bad debt." The reimbursement generally depends on the method by which an entity is paid for providing services. Hospitals must show that they have made a reasonable effort to recover these payments before considering them unrecoverable.)

A shift in the commercial market to higher co-pays and deductibles could increase hospital bad debt.

Provision for doubtful accounts has decreased slightly from 8.2% in 2001 to 7.8% in 2002 on average for the publicly traded, for-profit hospital companies. Rice of Merrill Lynch expects this expense to increase during 2003 and 2004, reflecting a higher level of co-pays and deductible levels by health plans. Price notes that bad debts expense may increase in a weak economy, although hospitals seem to be mitigating this risk as much as possible:

> The percentage of revenues derived from self-pay sources is rising for many hospital companies as the lingering soft economy is causing the proportion of uninsured and underinsured patients to increase. This could lead to higher bad debt levels over time. Having said that, we believe that most of the publicly traded hospital companies are stepping up their front-end collection efforts and are more aggressively pursuing past-due receivables in order to mitigate the risks associated with greater reliance on this revenue source.

Supplies

Supply costs can include pharmaceuticals, medical devices, chemicals, medical instruments, surgical supplies, apparel, machinery, and equipment. Supply costs as a percent of revenues rose from 13.4% in 2001 to 13.6% in 2002 on average for the publicly traded, for-profit hospital companies. Merrill Lynch expects this rise to continue into 2003. CMS estimates that prescription drugs are the largest contributor to supply costs, comprising about 5-6% of total hospital costs in 1997 and having grown since. Goldman Sachs has estimated that this cost component grew by 20% in 2002.

Other Operating Expenses

Rising liability insurance premiums concern investors.

Other operating expenses include contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance, and non-income taxes. Most of these items tend to have a high fixed cost nature so that as volume grows, these costs as a percent of revenues typically decline. Other operating expense as a percent of total revenues has declined from an average of 22.5% in 2001 to 22.1% in 2002 for the publicly traded, for-profit hospital companies. This declining ratio, however, does not capture a growing concern of hospitals and Wall Street analysts: liability insurance premiums.

The rising cost of liability insurance has plagued all healthcare providers in recent years. Feinstein describes the situation disclosed by the publicly traded hospital companies:

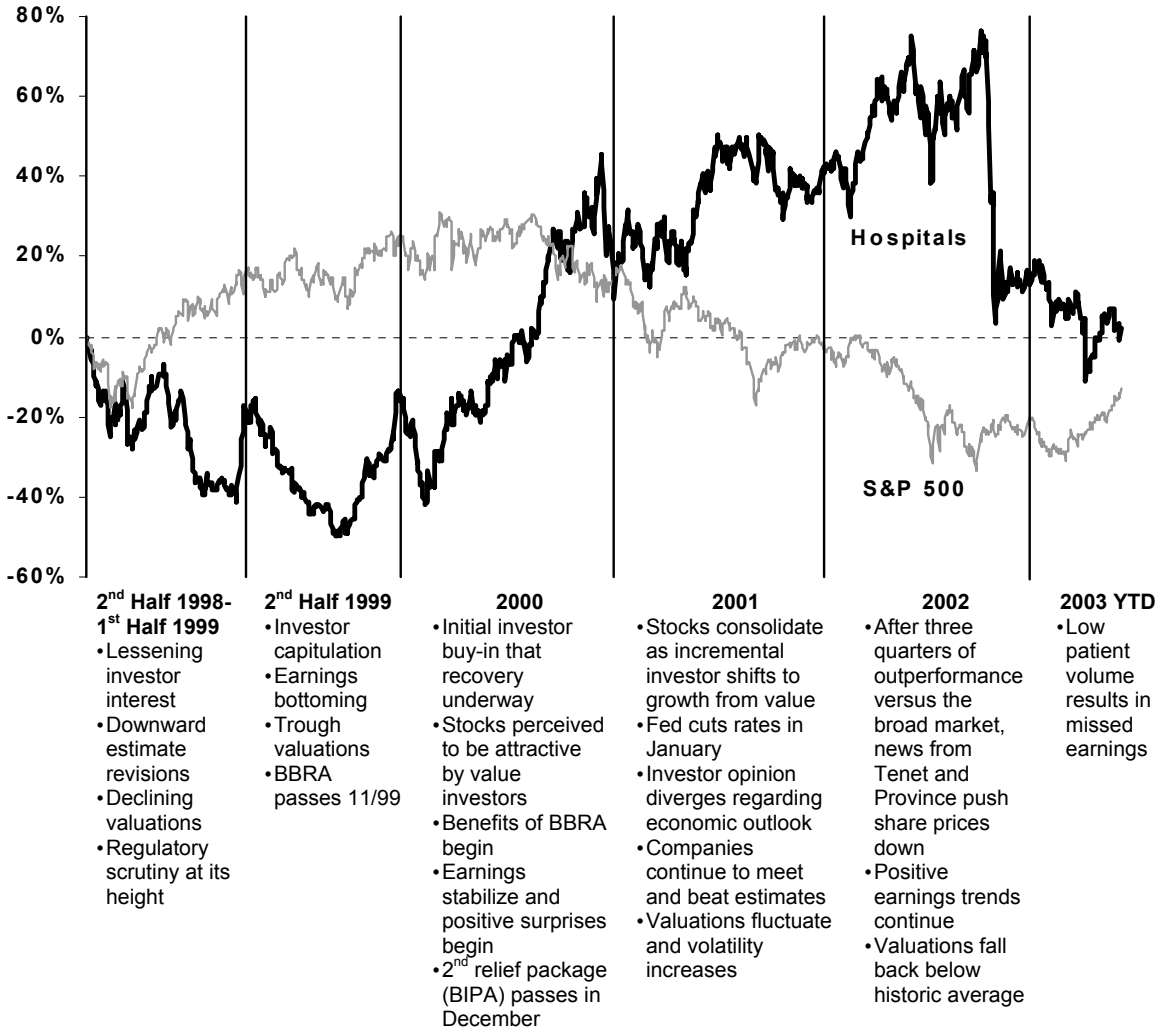
> Increased medical malpractice expense was highlighted by every company during the [first quarter of 2003], following similar disclosure over the past quarter. However, this did not create earnings misses since medical malpractice expense only represents 1.5%-2.0% of revenues, on average, for the industry. Nonetheless, all hospitals highlighted this as a major source of concern. We estimate malpractice expense increased in excess of 20% in the quarter for hospitals….

Increased liability premiums have negatively impacted profitability, and in some instances, service offerings.

The not-for-profit health care providers are also "facing steep premium increases, often for less coverage than they previously had maintained," according to Standard & Poor's. In addition to affecting profitability, S&P writes, "Rising insurance premiums are causing some health care providers to raise their exposure limits, and even to curtail or eliminate certain high-risk services, such as obstetrics, to limit liability exposure."

Investor expectations regarding financial performance and other factors are reflected in stock market performance. Below, in Figure 8, A.J. Rice of Merrill Lynch explains the ups and downs of the hospital stocks over the last five years.

Figure 8: Hospital Stock Market Performance vs. S&P 500, July 1998 – June 2003



Source: Merrill Lynch.

ACCESS TO CAPITAL

Capital access is critical to the financial health of a hospital.

Access to capital is a key indicator of how an industry is performing. Without access to external sources of funds, a business is limited to only the excess cash flow it generates to fund its operations, maintain and expand its facilities, and invest in new tools and technology. The ability to access capital is critical for a hospital's future ability to serve its patients, build market share, and remain financially viable. As noted on page 5, Wall Street analysts point out the interrelationship of improving operating performance with better access to capital.

Both for-profit and not-for-profit hospitals have the ability to raise capital from external sources. Unlike for-profit entities, not-for-profits do not have access to the stock (equity) markets and are not allowed to distribute their profits as dividends to shareholders. Not-for-profits are able to raise money through charitable donations and build endowments to fund operating and capital expenses. Like the for-profits, not-for-profits may borrow money by issuing debt securities to investors in the bond market or by taking loans from commercial lending institutions.

Bonds issued by not-for-profit hospitals are often municipal bonds, the same type typically offered by municipalities to fund projects such as the construction of schools and roads. Government-owned hospitals also have access to bonds backed by tax revenues known as "general obligation" bonds. Both municipal bonds and general obligation bonds are often tax-exempt, meaning that the investor does not pay tax on the interest earned on the bonds. This is an advantage to the issuing hospital, as it can issue debt at a lower interest rate because of the reduced tax burden on the bondholder.

Public Debt and Equity Issuance

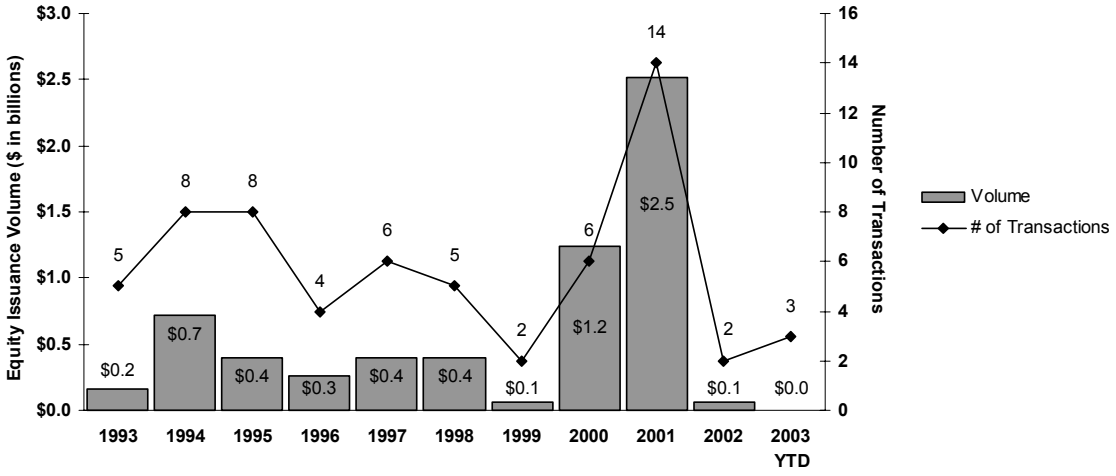
Equity and debt issuance trends in the public markets are shown on the next pages in Figures 9, 10, and 13. As a result of the sector's recovery following the BBA, public market equity issuance picked up again in 2000 and peaked in 2001. According to Lori Price of JPMorgan, the large cash war-chests built up in 2001 and strong operating cash flow are carrying the sector through what is presently a difficult equity market. Charles Lynch of CIBC World Markets notes:

> There has been some concern in the marketplace that, given the performance of hospital company stocks over the past nine months, these companies have limited access to the equity markets with which to fund growth initiatives. However, we point out that the primary sources of such funding have been, and will likely continue to be, internally generated cash and secondarily, debt financing.

Publicly-traded hospital companies have improved their debt ratios.

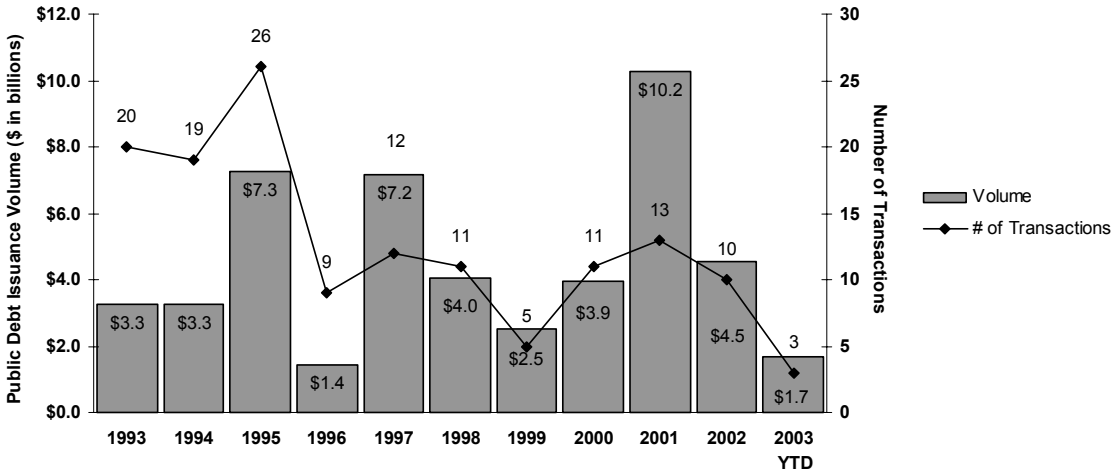
Among the publicly traded, for-profit hospital companies, Rice writes, "Over the last several years, the hospital industry has seen an improvement in its leverage, a trend that we expect to continue over the longer-term…. Looking out to 2004, we believe that cash flow generated by newly opened development and expansion projects should further strengthen the industry's financial position." In addition to funding operations and expansion, this cash flow provides sufficient capital to pay off outstanding debt or support the issuance of new debt. Charles Lynch notes, "Balance sheets are at their strongest level in almost ten years." These trends typically lower the cost of capital, all other things being equal.

Figure 9: Public Equity Issuance for For-Profit Hospital Chains, 1993-2003 YTD



Source: SDC and Credit Suisse First Boston. As of June 9, 2003.

Figure 10: Public Debt Issuance for For-Profit Hospital Chains, 1993-2003 YTD



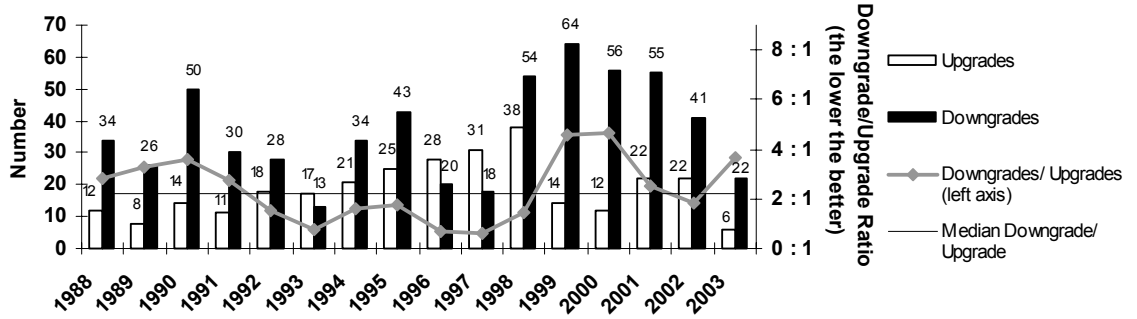
Source: SDC and Credit Suisse First Boston. As of June 9, 2003.

Credit rating agencies such as Moody's, Standard & Poor's (S&P), and FitchRatings issue bond ratings. Bond ratings are tools that bond investors use in evaluating the risk in investing in these securities. The ratios of credit rating upgrades to downgrades within an industry are often used to evaluate an industry–especially by the credit rating agencies that give them.

During 2002, Moody's downgraded 41 not-for-profit hospital ratings and upgraded 22, a ratio of 1.9:1. This continued a trend in improvement, compared to downgrade-to-upgrade ratios of 2.5 in 2001, 4.7 in 2000, and 4.6 in 1999. The ratio improvement is even more dramatic when looking at debt figures on a total value basis. In 2002, for the first time in six years, the total value of upgraded debt ($12 billion) *exceeded* downgraded debt ($7 billion).

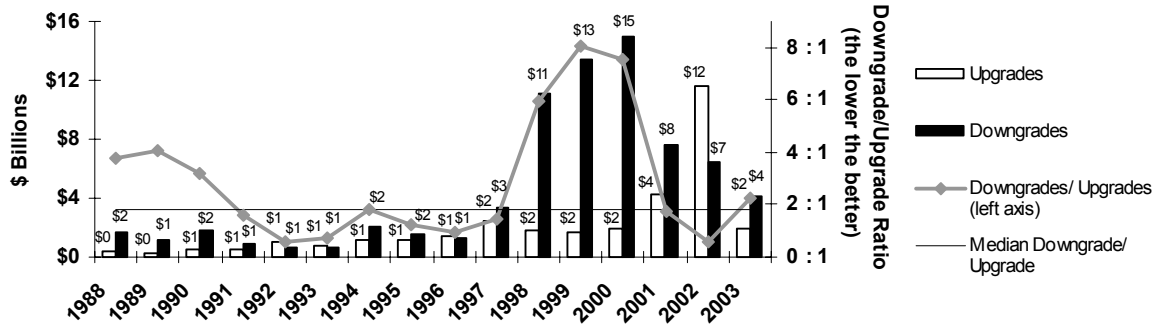
This year's ratio, however, has worsened to 3.7:1 with 22 downgrades and 6 upgrades as of June 10, 2003. In January, Bruce Gordon of Moody's wrote, "We believe not-for-profit hospitals will maintain overall stable credit quality over the course of 2003…. However, we also expect the industry to face strong pressure in 2004 and beyond…." Recently, however, he has noted that stresses on the not-for-profit hospital sectors—including a slowdown in patient volume and declining payment rate growth—may be accelerating faster than expected, which could result in a revision of Moody's credit outlook for the entire not-for-profit hospital sector from "stable" to "negative."

Figure 11: Number of Moody's Not-for-Profit Hospital Rating Downgrades vs. Upgrades 1988-2003YTD



Source: Moody's Investors Services as of June 10, 2003.

Figure 12: Total Value of Moody's NFP Hospital Rating Downgrades vs. Upgrades 1988-2003YTD



Source: Moody's Investors Services as of June 10, 2003.

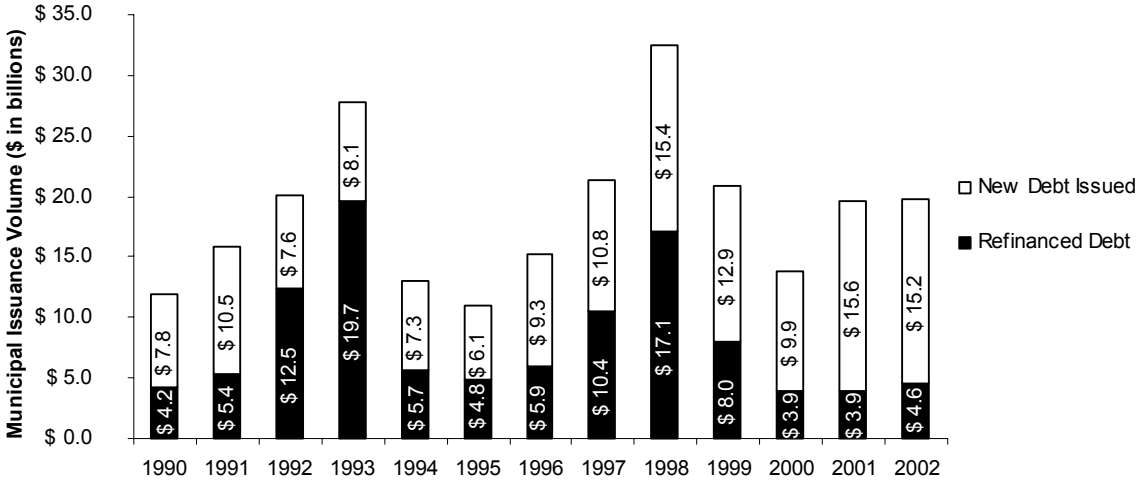
Like Moody's, the ratio of S&P rating upgrades to downgrades improved in 2002, although the number of downgrades exceeded the number of upgrades for the fourth year in a row. In the first quarter of 2003, downgrades continued to outpace upgrades. S&P notes the relationship between access to capital and operating performance: "The continuing pattern of debt issuance within the not-for-profit health care sector indicates that access to capital remains strong for organizations that continue to perform well. However, capital access is increasingly difficult for weaker credits, and especially those in the midst of a downturn in performance." S&P notes, "Many hospitals are struggling with burgeoning capital plans and the need to raise capital for necessary expansion. A number of hospitals are curtailing capital plans and are not coming to the debt market because low cost of capital is either not affordable or not available."

Some not-for-profit hospitals are finding it necessary to issue debt, in order to fund needed investments in facilities, technology, and information systems, despite the negative impact to their credit ratings and the resulting increase in the interest rate demanded by investors. S&P observes:

> [N]ot-for-profit health care and senior living providers must continually make difficult choices, balancing emerging reimbursement and cost pressures with the need to maintain a sound financial profile. For many health care providers, growing demand and the need to replace aging physical plants will force tough decisions about capital allocation and capital market access as well.

Figure 13: Municipal Bond Issuance by Not-for-Profit Hospitals, 1990-2002

Municipal bond issuance has remained nearly flat for the last two years.



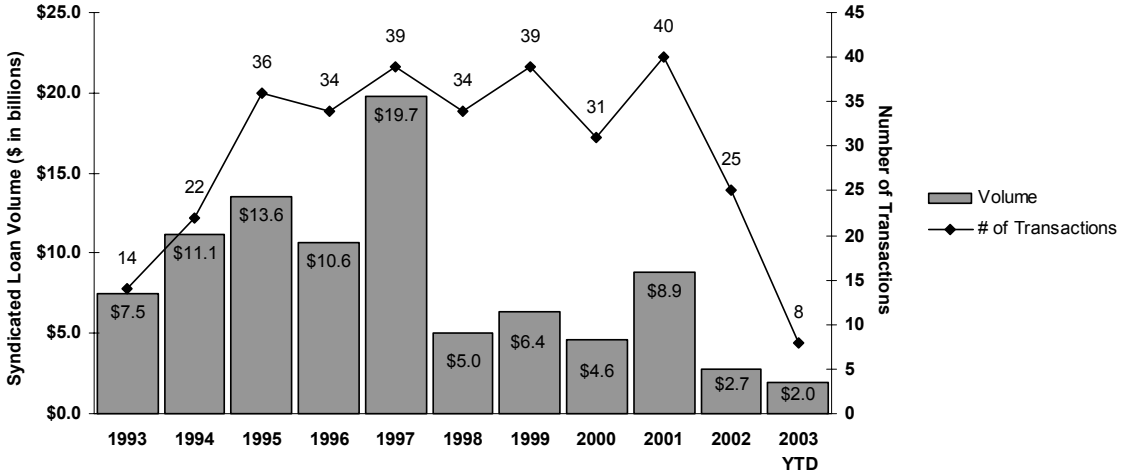
Source: Banc of America Securities.

Bank Loans

In addition to accessing the bond market for capital, hospitals have also historically looked to commercial banks for loans, letters of credit, and similar products. Due to recent consolidation of commercial banks and a decreased willingness by commercial lenders to extend credit to health care borrowers, syndicated loans for hospitals declined in 2002.

Figure 14: Bank Loan Volume

Like equity and debt issuance, bank loan volume declined following an increase in 2001.



Source: SDC and Credit Suisse First Boston. As of June 27, 2003.

Mergers and Acquisitions

After a slow acquisition environment in the late 1990s, some analysts expect consolidation among hospitals to increase. As noted on page 6, Wall Street analysts have noticed an increase in acquisition activity by for-profit hospitals over the past year. CSFB's Hindelong writes, "After a few years of relatively low acquisition activity, the volume has been turned up substantially over the past year. The combination of continuing pain at many not-for-profit facilities and improving balance sheets in the publicly-traded group has contributed to the surge."

Figure 15: M&A Activity by Publicly Traded For-Profit Companies

	1998	1999	2000	2001	2002
Rural					
Community Health Systems	4	4	7	5	6
Health Management Associates, Inc.	6	4	3	2	5
LifePoint Hospitals	n/a	0	2	2	5
Province Healthcare	2	5	2	5	2
Total Rural	**12**	**13**	**14**	**14**	**18**
Urban					
HCA, Inc.	6	0	7	2	1
Tenet Healthcare	6	12	1	2	5
Triad Hospitals	n/a	0	2	23	1
Universal Health Services	5	4	3	7	3
Total Urban	**17**	**16**	**13**	**34**	**10**
Total Rural and Urban	**29**	**29**	**27**	**48**	**28**

Source: Merrill Lynch.
Note: In 2001 Triad acquired Quorum, which was previously a publicly traded company. Facility divestitures are not reflected in this figure.

Compared to the late 1990s, acquisitions are fueled by improved capital access for the (mostly for-profit) acquirors and the need for access to capital by the (mostly not-for-profit) acquired hospitals that seek strong partners. Morgan Stanley's Lieberman observes that a few hospital companies have commented that the quality of the assets for sale is improving, a trend that is partially attributable to a shift in not-for-profits' mindset. Lieberman writes, "We believe that the promise of significant capital investment is probably the most attractive attribute to not-for-profit hospitals when considering a for-profit bidder." The acquisition of a few dozen hospitals each year, however, is relatively insignificant compared to the total of nearly 5,000 hospitals nationwide. It is also important to note that despite the acquisitions shown in Figure 15 above, the size of the for-profit sector remains within its historical range of the last twenty-five years at about 15% of total facilities and about 13% of total beds.

Merrill Lynch's Rice observes, "For the investor-owned chains, acquisition activity has been strong since 2000 and has been increasingly broad based" among both rural and urban providers. Rice notes that the availability of properties remains high and investment returns are attractive.

Other drivers of consolidation are the growth strategies of the rural for-profit companies (which focus on buying hospitals in a one- or two-hospital rural market and infusing capital in order to reduce the outmigration of patients that might otherwise travel to nearby metropolitan areas), the desire of hospital systems to shed non-core facilities (asset rationalization), and efficiency gains.

Development

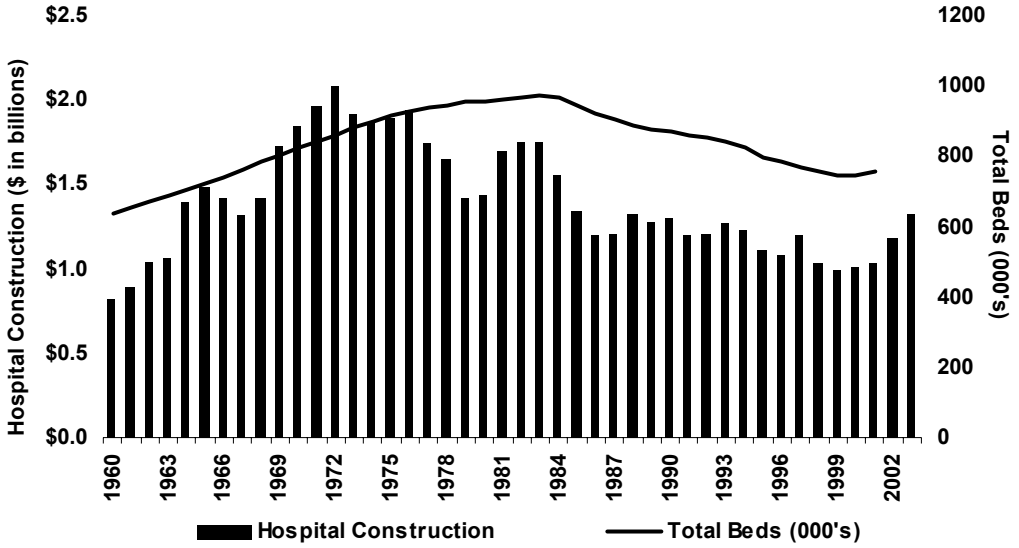
Hospitals have begun to raise capital spending targets to take advantage of emerging development opportunities. In addition to mergers and acquisitions, development activity, such as the building or expansion of emergency wards, operating rooms, parking facilities, or entirely new hospital facilities, has increased dramatically. Rice notes:

Development activity has increased dramatically.

> For the first time in recent memory, development opportunities have emerged as a significant source of high return investments. We find that that many investors are struggling to know how to think about this opportunity. We believe this is because few in the financial community were in the business the last time the hospital industry stood on the cusp of a positive development cycle. However, we believe that development projects can offer attractive risk/return profiles for companies, and they provide another leg to the growth strategy.

As shown in Figure 16, hospital construction rose about 20% in 2002 and inpatient bed capacity (excluding hospital-based SNF beds) rose for the first time in 2001 since 1983. Increased construction activity is happening across the industry, by both for-profit and not-for-profit hospital construction. Gary Taylor of Banc of America Securities offers, "We speculate that stabilized operating margins are providing a basis for accelerating non-profit hospital capital spending."

Figure 16: Hospital Construction and Bed Capacity, 1960-2003YTD



Source: Banc of America Securities, inflation adjusted.

SUMMARY

- The publicly traded, for-profit hospital companies have improved average profit margins, from 5.1% in 2001 to 5.7% in 2002. Broader indicators of both the not-for-profit and for-profit hospitals show stable average margins in the 3% to 5% range.

- Analysts have noted that labor cost growth has slowed, although hospitals remain pressured by a nursing shortage. Increasing medical malpractice expenses decrease profitability. In the near-term, most analysts see healthy rate increases from managed care payors and expect Medicare rate increases to remain stable, although concerns remain regarding Medicaid rates.

- Wall Street analysts have been recently troubled by mysteriously weak hospital admissions volume, which decreased profit margins in the first quarter of 2003. In the long-term, analysts expect demand for hospital services to increase as the population ages.

- The ratio of negative to positive revisions to credit ratings for the not-for-profit companies improved in 2001 and 2002, but has worsened in 2003 year-to-date. One credit rating agency has warned that increasing stress may cause a negative outlook revision for the not-for-profit hospital sector.

- Analysts note that strong hospitals (with improved access to capital to maintain, upgrade, and acquire facilities) are getting stronger while weak hospitals are getting weaker (making access to capital increasingly more difficult and costly). Analysts note that capital investment has been critical to maintaining share in a given market.

- Hospital construction is growing. Inpatient bed capacity increased in 2001, a reversal in the downward trend since 1984 when Medicare inpatient PPS was implemented.

- Analysts generally believe that strong hospital systems will continue to gain market share and will successfully deal with revenue and cost pressures over the long term.

If you would like to receive the CMS Health Care Industry Market Update via email, please send a request to: capitalmarkets@cms.hhs.gov, Subject: Market Update Distribution

The CMS Health Care Industry Market Update is also available on the web at: www.cms.hhs.gov/marketupdate