HEALTH CARE INDUSTRY MARKET UPDATE

Nursing Facilities

February 6, 2002

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, DME suppliers, medical device manufacturers, and pharmaceutical companies are just some of those whose finances are heavily reliant on these public programs.

As a lawyer and former trade association CEO, I represented many of these companies, both shareholder owned and non-profit. I was always surprised at how little Wall Street and Washington interacted—and how these companies often provided different financial information to each. 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 need help, we should have a thorough understanding of their real financial status to assess the true level of need.

With that in mind, when I joined CMS, I decided the agency should review the vast array of data available from Wall Street analysts that is not widely reviewed in Washington. 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 non-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.

I asked CMS' Office of Research, Development & Information (ORDI) to get research reports from the major investment firms, summarize their analyses, and condense 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, an ORDI analyst who previously worked for Salomon Smith Barney in New York and is experienced with corporate financial analysis and reviewing corporate research.

This, our second report, focuses on nursing facility companies. In coming months, we will review the financial and market performance of hospitals, home health agencies, and virtually every other major provider sector. 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 or Rob Sweezy at dsweezy@cms.hhs.gov.

Sincerely,

Tom Scully

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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February 6, 2002

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Wall Street's View of Nursing Facilities

Troubled sector performs better but its future remains uncertain

- **Several publicly-held nursing facility companies struggle to emerge from bankruptcy**
- **Investors expect that demographic trends will bring long-term stability and returns in the nursing facility sector**
- **Troubled companies were often over-leveraged or aggressively pursuing highly reimbursed ancillary services, or both**
- **Following irrational pre-BBA Medicare policy incentives led to the downfall of many chains**
- **Post-bankruptcy, de-leveraged companies are emerging with improved net income margins**
- **Companies emerging from bankruptcy with clean balance sheets have a competitive advantage over those that do not**
- **Companies that stuck to basics survived the SNF PPS implementation**
- **Not-for-profits still struggle to access capital**
- **Medicare reimbursement is more than sufficient**
- **Medicaid reimbursement is insufficient in most states**
- **Should the add-on payments continue in Medicare? How much should Medicare cross-subsidize other payors?**

State of the Industry—Equity Market Perspective

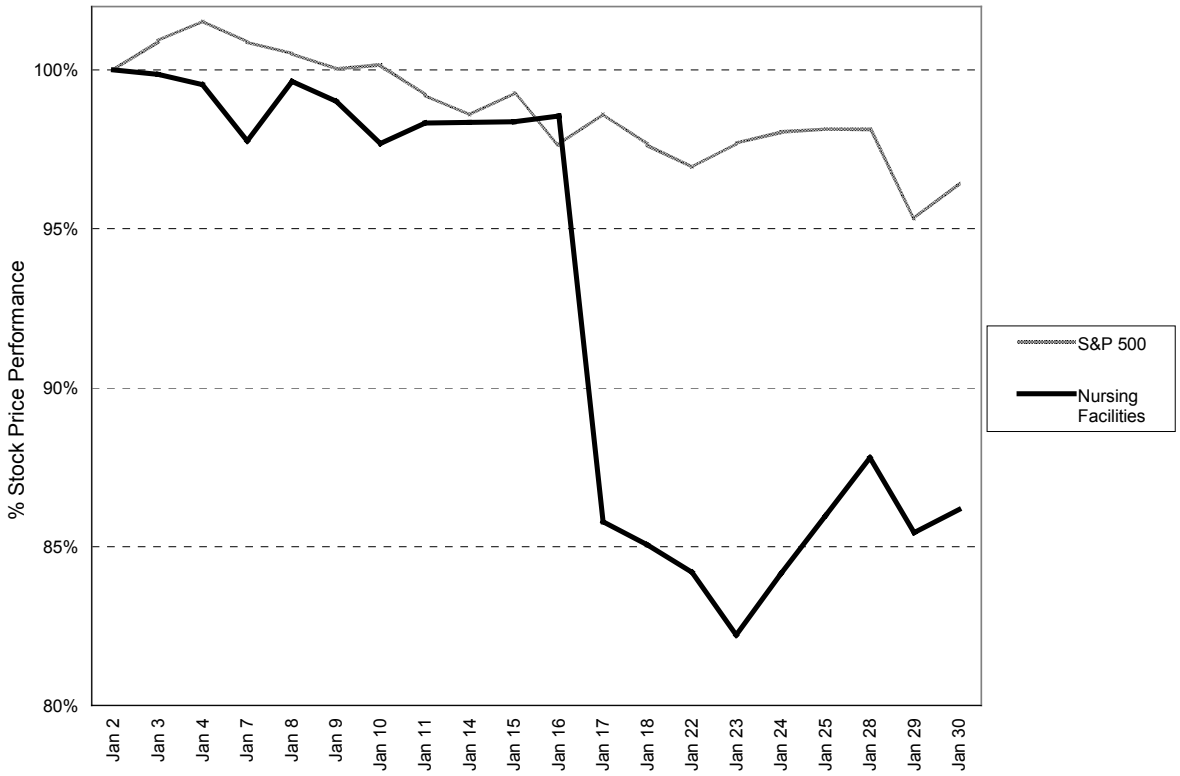
Wall Street remains skittish about the nursing facility sector. Investors watched nursing facilities struggle and often fail through the late 1990's and 2000 as the Skilled Nursing Facility (SNF) Medicare prospective payment system (PPS) was implemented as part of the Balanced Budget Act of 1997 (BBA). Congress temporarily added-on some of the per diem reimbursement SNFs lost under PPS with the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Patient Protection Act of 2000 (BIPA). Wall Street believes that these add-ons were critical in helping the industry get back on its feet. Investors fear that the industry may suffer further turmoil if the add-on payments are not extended—repeating the industry struggle through PPS implementation.

Wall Street reacted very poorly to news that MedPAC will advise Congress to allow $1.7 billion in additional SNF payments to expire at the end of the fiscal year.

The stock prices for publicly-traded nursing facilities recently traded down on news that the Medicare Payment Advisory Commission (MedPAC)[1] intends to recommend that Congress allow the expiration of two of the three key provisions of the BBRA and BIPA add-ons. (See Add-On Sunset summary on page 4.) These two specific provisions will be worth an estimated $1.7 billion to the sector in fiscal year 2003.[2] Shares for publicly-held nursing facilities dropped 12.9% on January 17, 2002 when the MedPAC recommendation was announced and by the 23rd had fallen by 16.6%. (see Figure 1). MedPAC did, however, recommend that Congress incorporate the 20% add-on to Resource Utilization Groups (RUG) into the base rate for fiscal year 2003—retaining an estimated $1.0 billion in aggregate payments.[2]

Figure 1: Nursing Facility Index vs. Standard & Poor's 500 Index, January 2002

Nursing Facility stocks fell 12.9% on January 17, 2002.



Source: NYSE, NASDAQ, TSO, and company filings.
Nursing Facilities: Beverly, Extendicare, Genesis, Kindred, and Manor Care, on a market capitalization weighted basis.

[1] MedPAC is an independent federal body that advises the U.S. Congress on issues affecting the Medicare program.
[2] CMS Office of the Actuary

Subsequent to the MedPAC announcement, Jerry Doctrow of Legg Mason downgraded three of the four nursing facility stocks he covers saying, "…given the increased uncertainty over Medicare rates and the likelihood that any final resolution of 2003 rates may wait until the budget is approved in the summer or fall of 2002, we are not recommending these stocks to our clients at this time, despite what appear to be attractive valuations based on current 2002 estimates." Investor panic and the resulting sell-off on January 17th may have been an overly hasty reaction as A.J. Rice of Merrill Lynch notes, "…ultimately Congress has the authority to implement or disregard MedPAC's suggestions, i.e. MedPAC does not have the final say, Congress and CMS do." Rice, however, reminds investors that, "Some nursing home operators that have recently been able to swing marginally profitable could be pushed back into the red [by the uncertainty of funding policy]."

"MedPAC does not have the final say, Congress and CMS do."

With the January 17th sell-off, investors have been given further cause to be wary of the nursing facility sector at a time when the industry will begin to seek capital in order to expand to serve the aging United States population. Wall Street analysts do not believe this capital will be available without some clarity as to the future of government reimbursement for nursing home care. A.J. Rice states, "At a minimum, the uncertainty associated with the status of the Medicare give-backs will make it very hard for the nursing home industry, much of which remains financially troubled, to gain access to desperately needed capital….it could also thwart efforts by some to emerge from bankruptcy."

Access to equity capital is restricted by the uncertainty of Medicare funding.

The decision on how to fund this sector, indeed, is not MedPAC's, but Congress's and CMS'. The evidence is mixed and complex, and the goal of this report is to lay out the evidence that is publicly available.

Add-On Sunset

After the nursing facility industry came under financial pressure as a result of the PPS implementation and other BBA of 1997 provisions, Congress passed two acts to provide some relief—BBRA of 1999 and BIPA of 2000. These laws contained provisions to assist providers as they adjust to the PPS.

The major elements of the add-ons are:

Sec 101 BBRA 1999:

- 20% increase for 15 of the Resource Utilization Groups (RUGs). This was implemented in April of 2000 and will remain in effect until the implementation of refinements in the current RUG case-mix classification system. It is estimated that once the refinement is complete—and this 20% increase is thus "folded in to the base," or eliminated—Medicare payments to SNFs will be reduced by an estimated $1.0 billion annually.
- 4% across-the-board increase of the adjusted Federal per diem payment rate (the Federal part of the rate), exclusive of the 20% RUG increase. This is a temporary increase, for a duration of two-and-a-half years, from April of 2000 until the end of fiscal year 2002 and is valued at approximately $600 million annually.

Sec. 312 BIPA 2000:

- 16.66% increase in the nursing component of the case-mix adjusted Federal rate. This is a temporary increase, for a duration of eighteen months, from April of 2001 until the end of fiscal year 2002 and is valued at an estimated $1.1 billion annually.
- 6.7% increase in the 14 RUG payments for rehabilitation therapy services. This is an adjustment to the 20% increase granted in BBRA 1999 and spreads the funds directed at 3 of those 15 RUGs to an additional 11 rehabilitation RUGs. This was implemented in April of 2001 and will remain in effect until the implementation of refinements in the current RUG case-mix classification system. It is budget neutral to the total 20% increase in BBRA of 1999.
- Elimination of the BBA of 1997 Market Basket Index reduction of 1.0% for fiscal year 2001. This 1.0% increase provided for higher payments in fiscal year 2001 and was retained in the base rate when CMS applied the update for the fiscal year 2002 rates.

The industry is eager to have these "add-ons" extended beyond their expiration or, in the case of the refinement of 15 RUGs which will eliminate the 20% payment increase, the industry is hoping for a CMS delay.

Wall Street recognizes the concern but anticipates that a logical payment scheme will eventually emerge and that the publicly-traded nursing facility companies are trading at a discount due to the doubt regarding government payment. Credit Suisse First Boston states, "We consider the uncertainty surrounding the future of Medicare PPS reimbursement to be the most significant risk factor…for the nursing home industry." Credit Suisse First Boston believes that, "…the intent of Congress in signing BBRA-99 and BIPA-2000 was to provide permanent relief to the nursing home industry after the severe pain that was inflicted by BBA-97." It also states that, "While the BIPA/BBRA sunset is a concern, we believe that reasonable rates will eventually be sustained…we believe that the uncertainty is more than reflected in current stock prices, and that any clarity on this issue would likely result in a rally for the group."

Adam Feinstein of Lehman Brothers agrees, stating, "We do not know what will happen at this juncture, but there appears to be little motivation on behalf of Congress to cut nursing home reimbursement following the difficulty we have witnessed at providers in recent years. Thus, we believe that there will most likely be some compromise on this issue."

According to CMS estimates, the per diem effect of the BBRA and BIPA add-ons comes to an average of $56.25 per day. If the MedPAC recommendation to allow the nursing component and the across-the-board increase to sunset, the industry will lose an average per diem amount of $35.42. The remaining $20.83 is tied to the 20% increase and, under current law, will cease once the RUGs have been refined by CMS.

Investors expect that demographic trends will bring long-term stability and returns in the nursing facility sector

While the sector has failed to generate stable returns as of late, long-term investors see the future demand for nursing facilities as a long-term investment opportunity.

The nursing facility industry currently comprises the largest part of the long-term care business, with spending in 2000 of $92.2 billion, with further expected growth as the population ages. Nursing facility spending growth actually declined from 9.1% in 1995 to 0.2% in 1999 and then increased in 2000 to 3.3%.[3]

According to CMS data for January 2001, there were 16,944 certified nursing facilities in the United States with an average occupancy of 80.91%. There were 1,834,448 total beds in the U.S. Approximately 66% of the beds were owned by for-profit entities, while 34% were owned by not-for-profit organizations or government agencies. The industry is very fragmented, with no dominant providers. The largest provider, Beverly Enterprises, operates only 3.36% of the beds (see Figures 2 and 3).[4]

Figure 2: Total U.S. Nursing facility Ownership by Bed Count [4]

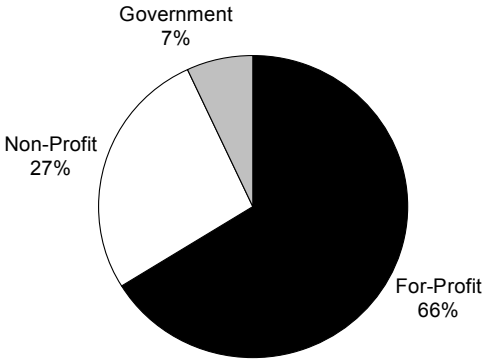
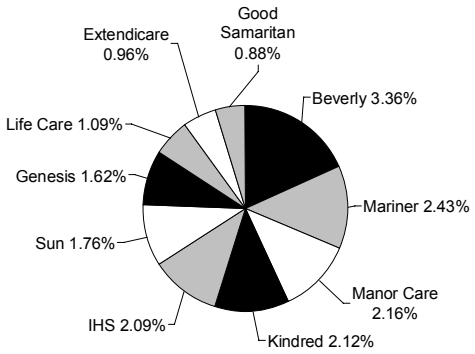


Figure 3: Top Ten Nursing facility Companies by Bed Count (18.46% of total) [4]



Another trend of which policy makers should be aware is the rising case complexity in nursing facility admissions. In an overview of the Long-Term Care Industry, Credit Suisse First Boston notes that the hospital diagnosis-related group (DRG) system incents hospitals to discharge patients, "quicker and sicker," and that as a result, "…acute-care hospital length of stay has steadily decreased to a median of 4.00 days in 1999 from 4.95 days in 1992, a drop of 19%." Many believe that this hospital trend results in relatively sicker average hospital discharges, increasing the number of patients requiring more complex care and lengthy stays in nursing facilities.

One would expect that the aging American population would present an opportunity for investors as the health care infrastructure for seniors will be required to expand (see Figure 4). While occupancy averages approximately 81%, demand is expected to increase the need for capacity, especially when the baby boomers start reaching retirement age in 2010-2015.

[3] CMS Office of the Actuary, National Health Statistics Group, freestanding facilities only
[4] Nursing Home Compare Provider File, January 2001, Center for Medicaid & State Operations

Figure 4: Projected U.S. Population Growth Rate 1992-2020

Age	Annual Growth Rate[1]
Under 65	0.7 %
Above 65	1.8 %
Above 85	2.6 %

Source: United States Bureau of the Census

(1) Compound Annualized Growth Rate (CAGR)

Industry Performance

MedPAC forecasts 9.4% Medicare margins for 2002.

At the January 2002 MedPAC meeting, the Commission's staff presented their analysis of the margins SNFs have achieved. MedPAC forecasts that freestanding SNFs will generate 2002 consolidated net income margins of –2.0% assuming that the two sunsetting provisions of BBRA and BIPA add-ons are not included. For their Medicare lines of business, MedPAC forecasts margins of 9.4% for freestanding facilities. While these data are extrapolated from 1999 cost reports, it is the most current and is consistent with CMS estimates using similar methodology. Companies in the industry have not made a practice of showing their operating costs broken out by payor in public filings. They contend that while their Medicare margins appear healthy, these earnings cross-subsidize Medicaid, which pays at much lower rates, depending on the state. The revenues reported tell part of the story. For example, Extendicare Health Services (TSE & NYSE: EXE.A) averaged $304 per Medicare patient per day while getting $112 per Medicaid patient per day. While Medicare patients are more costly to treat, the net result is that nursing facilities with any imbalance toward Medicaid exposure are struggling.

Publicly-held nursing facility companies are beginning to return to profitability.

Despite the difficulties in the late 1990s, the publicly-held nursing facility companies are beginning to return to profitability. Kindred Healthcare Inc. (NASDAQ: KIND), which emerged from bankruptcy proceedings in April of 2001, reported a 14.2% margin on its earnings before interest, taxes, depreciation, amortization, and rent (EBITDAR) for the quarter ending September 30, 2001. Kindred also reported a positive net income. Genesis Health Ventures, Inc. (NASDAQ: GHVE), which also recently emerged from bankruptcy de-leveraged, is generating positive EBITDAR and is expected to go net income positive in the next quarter. Figure 5 shows income statement summaries for both of these companies and also Beverly Enterprises Inc. (NYSE: BEV) and Manor Care, Inc. (NYSE: HCR), two companies that managed to avoid bankruptcy.

Figure 5: Publicly-Held Nursing Facility Company Income Statement Summaries

Largest For-Profit Skilled Nursing Facility Chains
Results of Operations and Margins
Third Quarter 2001

($000's)	Beverly (BEV)		Genesis (GHVE)	
Revenue	$ 690,875	-	$ 660,095	-
EBITDAR	91,338	13.22 %	62,037	9.40 %
EBITDA	63,929	9.25 %	49,410	7.49 %
EBIT	40,560	5.87 %	22,203	3.36 %
EBT	21,950	3.18 %	1,868	0.28 %
Net Income before Preferred Dividends	12,073	1.75 %	1,868	0.28 %
Net Income to Common	$ 12,073	1.75 %	$(9,631)	(1.46)%

	Kindred (KIND)		Manor Care (HCR)	
Revenue	$ 768,680	-	$ 687,639	-
EBITDAR	109,476	14.24 %	99,268	14.44 %
EBITDA	47,162	6.14 %	94,718	13.77 %
EBIT	30,394	3.95 %	61,621	8.96 %
EBT	26,081	3.39 %	50,556	7.35 %
Net Income before Preferred Dividends	14,799	1.93 %	31,218	4.54 %
Net Income to Common	$ 14,799	1.93 %	$ 31,218	4.54 %

Source: Public filings, company information, and Wall Street estimates
Note: Income statement data presented on a consolidated basis and includes non-nursing facility lines of business

State of the Industry—Debt Market Perspective

Bond analysts are concerned that reimbursement reduction could restrict access to capital.

If the nursing component and the across-the-board add-ons sunset, the industry reduction of the temporary add-ons would be an average per diem amount of $35.42 (on a base averaging approximately $338). Wall Street high-yield bond analysts, who look at nursing facility credit worthiness, are concerned that this reduction in reimbursement could have a very negative impact on nursing facility company credit profiles and their ability to access capital.

Figure 6 demonstrates the impact of a slightly lower average rate reduction of $30.00 per day on three statistics that bond analysts and investors look at when evaluating a company's ability to pay its debt service and other obligations. The statistics are:

- EBITDAR - earnings before interest, taxes, rent, and non-cash charges (depreciation and amortization). EBITDAR shows cash flow available to pay interest, rent, and taxes after paying operational costs. EBITDAR is used to make apples-to-apples comparisons between companies because most companies finance their businesses differently and it represents earnings before financing costs.[5]
- Rent Adjusted Leverage - measures how much the company has borrowed or obligated through leases as a multiple of the cash flow available to pay such debt service and lease payments. The rule of thumb is that at a rent adjusted leverage multiple of 5x it is very difficult to raise new capital—at 6x it is nearly impossible.
- Fixed Charge Coverage - indicates the company's ability to pay rent and interest based on the amount of cash flow remaining after capital expenditures. Analysts consider a 2x fixed charge coverage to be the minimum required to raise capital.

Figure 6: Impact of a $30.00 Average Per Diem Reduction

Third Quarter 2001 (Annualized)	Current Statistics			Statistics Assuming $30.00 Average Per Diem Reduction		
Company	Adjusted EBITDAR (1) Margin	Net Rent Adjusted Leverage (2)	Fixed Charge Coverage (3)	Adjusted EBITDAR (1) Margin	Net Rent Adjusted Leverage (2)	Fixed Charge Coverage (3)
Beverly Enterprises	13.2 %	4.2 x	1.5 x	11.6 %	4.9 x	1.2 x
Extendicare Health Services	11.9	5.2	1.5	10.1	6.1	1.2
Genesis Health Ventures	9.4	3.5	2.3	8.2	4.1	1.9
HCR Manor Care	14.4	2.4	3.7	12.4	2.9	2.9
Mariner Post Acute Network	10.8	3.7	1.6	8.9	5.9	1.3
Kindred Healthcare	14.2	5.4	1.1	13.9	5.9	1.1
Average	12.3 %	4.1 x	2.0 x	10.8 %	5.0 x	1.6 x

Source: Company reports and Wall Street estimates

(1) EBITDAR is Earnings Before Interest, Tax, Depreciation, Amortization, Rent, and unusual or extraordinary items

(2) Net Rent Adjusted Leverage = (Net Long Term Debt + 8x Rent Expense) / EBITDAR

(3) Fixed Charge Coverage = (EBITDAR - Capex) / (Rent Expense + Net Interest)

A per diem rate drop of $30 would make access to debt financing difficult for most of the industry.

Figure 6 illustrates that applying a rate drop of $30.00 to the Medicare patient per diem for several of the large providers creates a one point average increase in rent adjusted leverage. Extendicare, Mariner, and Kindred would move into 6x rent adjusted leverage territory, making further debt financing very doubtful. Fixed Charge coverage, currently averaging 2x for the sector, would drop below that level for all companies but Manor Care.

[5] Note: The EBITDAR margin is *not* the same as a net income margin. A net income margin is earnings (profits) after all other obligations have been met, divided by net revenues. MedPAC has estimated that the net income margin for all freestanding SNFs is a *loss* of –2%.

For-profit, publicly-held companies

The major publicly-traded companies in the nursing facility sector are Manor Care, Inc., Beverly Enterprises Inc., Extendicare Health Services, Inc., Kindred Healthcare Inc., and Genesis Health Ventures, Inc. Kindred and Genesis both emerged from bankruptcy in 2001. Integrated Health Services, Mariner Post-Acute Network, and Sun Healthcare were publicly-traded nursing facility chains that are currently undergoing Chapter 11 bankruptcy restructuring.

Troubled companies were often over-leveraged or aggressively pursuing highly reimbursed ancillary services, or both

Adam Feinstein of Lehman Brothers recounted the recent history of the industry in a recent report:

Nursing facility spending grew at a 34% CAGR from 1988 to 1994.

> "Nursing home spending grew rapidly throughout the late 1980s and into the mid-1990s, representing $85 billion in annual expenditures in 1997, versus only $45 billion in 1989 (34% CAGR [(Compound Annualized Growth Rate)] from 1988 to 1994). **The key catalyst for this growth was a change in Medicare reimbursement guidelines through OBRA-87 with the federal government:** (1) expanding the availability of the nursing home benefit, leading to increased beneficiary utilization, and (2) creating a cost-based reimbursement system, including ancillary services provided at a nursing home. **Nursing home operators expanded ancillary service offerings to take advantage of this new system, leading to a dramatic increase in physical, occupational, and speech therapy costs. As a result, the industry prospered during that period and was deemed the most attractive and fastest-growth health care segment.** However, BBA-97 changed the rules of the game with the implementation of a prospective payment system. As a result, [the rate of growth in] government spending slowed down dramatically, causing many nursing home operators to file for bankruptcy. Nonetheless, providers received some major relief from the government with Medicare give-backs enacted through BBRA-99 and BIPA-00, implying that government reimbursement cuts had been too severe in 1997. Thus, we have just entered the early stages of the next big upcycle in Medicare spending."

This is the open policy question: should Medicare enter a big upcycle?

Following irrational pre-BBA Medicare policy incentives led to the downfall of many chains

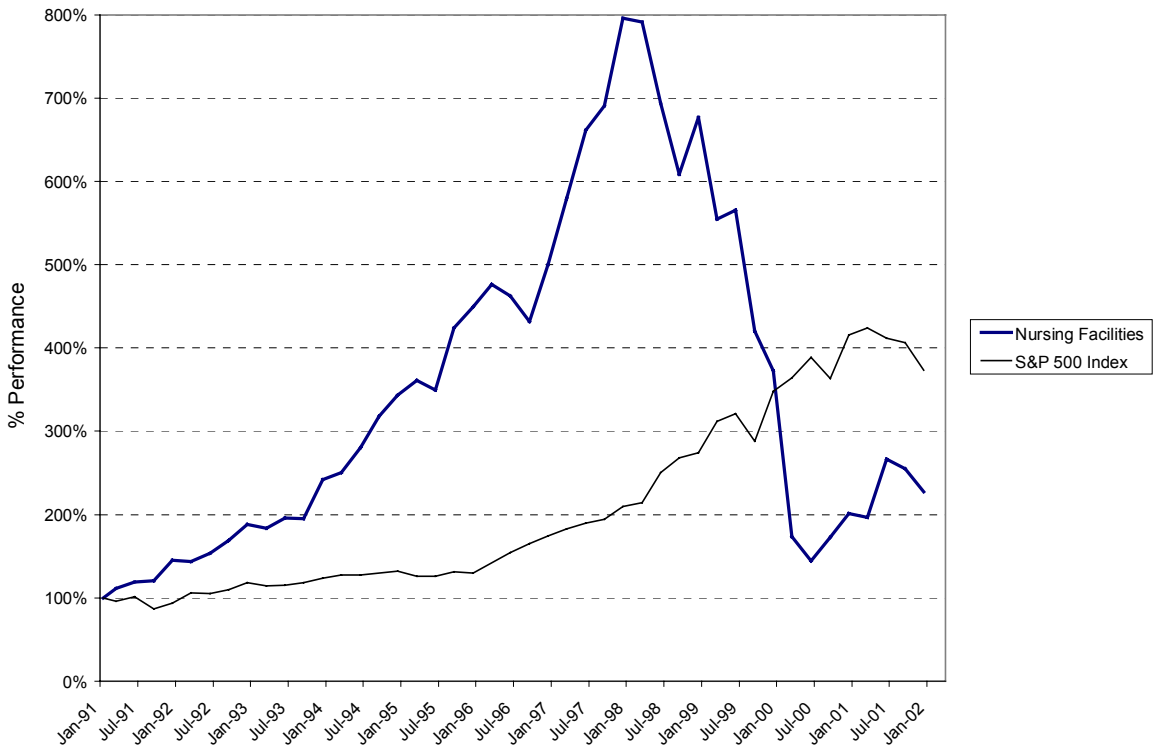
Adam Feinstein, in his report on Kindred (a company with a large SNF business that is emerging from bankruptcy) explains the problems it faced with its ancillary services business:

> "We note that BBA-97 greatly reduced the profitability of offering ancillary services, decreasing the industry's demand for these services. This hurt SNFs in general, but it especially hurt companies that were capitalizing on the growing and until then profitable market offering these services (such as Vencor [(now Kindred)], which had set up its Vencare division specifically to offer them—in 1997, before the Medicare cuts had been put into effect, Vencare generated $642 million or approximately 20% of Vencor's revenue). The decreased profitability of the segment led the company to integrate its rehabilitation therapy business into the health services division and its institutional pharmacy business into the hospital division, resulting in a $56.3 million charge [loss] in 4Q99."

During the course of the downfall of a number of nursing facility chains, a considerable amount of capital was lost by debt and equity investors. Figure 7 shows the total Firm Value (equity market capitalization + net debt) of the sector relative to its value ten years ago compared to the performance of the S&P 500 Index over the same period.

Figure 7: Nursing Facility Firm Value Performance vs. S&P 500, 1991-2001

The nursing facility sector greatly outperformed the market in the early and mid-1990s.



Source: Factset Research
Nursing Facilities: Beverly, Centennial, Extendicare, Genesis, Integrated, Kindred & Ventas, Manor Care, Mariner, National, & Sun

Companies emerging from bankruptcy with clean balance sheets have a competitive advantage over those that do not

Wall Street analysts are more optimistic about the companies that emerge from bankruptcy with clean balance sheets and are, in some cases, better positioned to succeed than companies which limped through the PPS implementation. Adam Feinstein of Lehman Brothers states:

> "Kindred has increased financial flexibility following its emergence from bankruptcy. The restructuring of the company's debt and the proceeds from its recent offering have left the company with a healthy balance sheet, with little leverage and a debt-to-capital ratio of only 28.9%….With its balance sheet strength, Kindred should be well positioned to make acquisitions and to invest in its existing facilities….Lastly, as part of the reorganization plan, Kindred entered into a government settlement that absolved the company from any government liability prior to the reorganization."

Case Study: Manor Care

Despite tough recent years, at least one company stuck to basics and survived

In a recent report on Manor Care (NYSE: HCR), Credit Suisse First Boston explained how the company has weathered the implementation of SNF PPS relatively unscathed compared to its peers:

"Manor Care remained an investment-grade credit throughout the PPS transition period, an impressive accomplishment in an environment where most of its publicly-traded peers entered bankruptcy. We believe a sound balance sheet and experienced management are the two most important success factors in a business that is as inherently government-dependent…as the nursing home business."

Before and After PPS
"The old HCR's business had been focused on high-acuity Medicare patients, while the old Manor Care's strength had been catering to lower-acuity private-pay patients in affluent markets. Since many of these patients were vulnerable to competition from the rapidly-expanding assisted living industry, the new Manor Care underwent a transition, converting low-acuity facilities to a more high-acuity, Medicare-oriented focus. The company has expanded the number of subacute and rehabilitation units that specialize in providing higher-acuity, higher-margin services.

"Today, over 90% of the company's admissions are Medicare patients, up significantly from the pre-PPS era. Higher Medicare admissions mean more high-acuity patients in HCR's facilities; over 80% of the Medicare admissions are rehabilitation-therapy patients. Since HCR operates quality facilities in upscale markets, it has a high rate of patient conversion to private-pay classification (rather than Medicaid) when Medicare eligibility expires.

"Among the companies that operate skilled nursing facilities, Manor Care generates the largest share of its revenues (about 39%) from private pay sources. This is in part a result of its focus on upscale markets, where patients whose Medicare eligibility has expired have the highest likelihood of transitioning to private-pay status. HCR's payor mix is also due in part to its assisted living operations and outpatient rehabilitation clinics, which are both virtually all private pay. About 33% of HCR's revenues come from Medicaid, with 28% from Medicare. HCR's 67% "quality mix" [(private pay + Medicare)] is the highest of the major nursing home companies."

Efficiency
"[Manor Care] has a track record for efficiency. Despite its focus on high-acuity patients, its Medicare per diem rate was among the lowest in the industry prior to the PPS switch at the beginning of 1999. (Why so low under a cost-based environment? HCR had to be competitive in competing for private-pay patients). As a consequence, it has been more successful at operating profitably under PPS than most nursing home companies."

Not-for-profit companies still struggle to access capital

Nonprofit nursing facilities, which are unable to access the equity markets, look toward the debt markets to raise capital and, in some cases, manage to attract philanthropic donations.

Moody's Investors Services expects that for the bonds of the nonprofit hospital and health care systems sector at large, "…rating activity will stabilize over the next six to twelve months, replacing a prolonged period of great credit volatility…." Moody's forecast is based on a number of factors, including sector players, "…re-evaluating or exiting non-core businesses that have proven financially unsuccessful…and a declining adverse financial impact from the cuts imposed by the Balanced Budget Act of 1997…." These elements in the larger nonprofit sector are in keeping with what is occurring with the nonprofit nursing facility companies.

In discussing the not-for-profit healthcare sector as a whole, Moody's warns that, "At the same time, however, we caution that we do not expect a significant improvement in financial position….Not-for-profit hospitals are currently facing a national nursing shortage; escalating drug and utility costs; an economic and stock market downturn that could negatively affect financial profiles; increased stress on debt levels to finance new capital needs; high management turnover that could disturb continuity of operations; and competition from specialty hospitals, entrepreneurial physicians, and expanding for-profit systems."[6]

Nursing facilities issue a small portion of the debt issued by not-for-profit health care providers. According to Thomson Financial, a market data research firm, of the $41.7 billion in debt issued in 2000 and 2001 together by not-for-profit health care providers, only $1.3 billion (3.1%) was issued by nursing facilities. This is down from the $1.3 billion in nursing facility bonds issued in 1999 alone.

The market makes a distinction between the for-profit and the not-for-profit sectors of the nursing facility industry. According to Jeannette Price, a public finance investment banker with Salomon Smith Barney:

> "In general, nonprofits were not as tarnished by the period of significant financial troubles in the nursing home industry in the late nineties. After all the bankruptcies, long-term care was not a popular investment sector. **However, investors preferred the lower risk profile of the nonprofit facilities. This is in part because the nonprofits didn't emphasize the Medicare optimizing strategy of the for-profits in the early and mid-1990's. They maintained smaller Medicare populations, had lower amounts of debt, and never owned the Medicare-reliant ancillary business; all factors that contributed to much of the for-profit default."**

Investors preferred the lower risk profile of the nonprofit facilities.

Many not-for-profit nursing facilities have difficulty accessing the bond market because of thin profit margins and the uncertainty of cash flow from government reimbursement. According to Price, nursing facilities that are part of continuing care retirement communities (CCRCs) are better able to access capital than those that are freestanding. A nursing facility in a CCRC has a bigger balance sheet, is more able to

[6] Moody's Investors Service, Not-For-Profit Healthcare, Outlook and Medians, September 2001

build reserves, has more diverse services, and is less reliant on the government. Often CCRCs can leverage cash flows from their independent living unit entrance fees to secure letters of credit from private banks and are thus able to access lower interest rates than the bonds which are financing the nursing facility operations.

Bonds that finance nursing facility operations are typically unrated and may not be priced as attractively to the issuer. Skilled nursing facilities rarely have the credit strength on their own to achieve investment grade ratings, and have difficulty in securing credit enhancement in the form of private bond insurance or letters of credit. Price, however, notes, that there is generally a market for unrated nursing facility bonds that have a solid credit profile:

> "Some key credit factors necessary for a nursing home to access the unrated market include a decent balance sheet (a minimum of 60 days cash on hand), adequate debt service coverage (1.25 times or more), a credible sponsor, either existing occupancy or an under-bedded market, a decent Medicaid state (depending on payer mix) a strong competitive position or a Certificate-of-Need (CON) state—these are some critical aspects bond holders review. Some of the bond issues for skilled nursing facilities however are very small—and are able to secure sufficient investors without meeting the higher credit standards of a broader pool of investors."

The form of credit enhancement that is most accessible to not-for-profit nursing facilities has traditionally been the government mortgage insurance programs, most typically FHA or Ginnie Mae. If a nursing facility meets the criteria for these programs, and can progress through their somewhat lengthy approval process, these programs can provide access to highly rated debt which can be sold at low interest rates, attractive to the issuer.

The largest nonprofit nursing facility chain, the 215 facility Good Samaritan Society, has managed to maintain investment-grade bond ratings (A3/A-). Moody's, however, changed the outlook on February 3, 2002 on this A3 paper from "stable" to "negative" due to diminishing balance sheet strength despite relatively better operating performance. Most of Samaritan's nonprofit peers are not positioned as well and are in the unrated sector or pay a premium in order to insure their bonds.

While some not-for-profit nursing facilities have additional sources of income such as philanthropic donations and endowment income, it is often only supplemental income and may only cover facility maintenance. Jeannette Price of Salomon Smith Barney notes:

> "One of the greatest credit challenges for long-term care facilities is developing adequate endowments. It is very challenging for them to build significant reserves because, in general, the business does not have high margins and subsequently does not throw off much cash flow. Unless the nursing home has a strong sponsor with an identifiable constituency, fund raising can be a challenge as well—a nursing home is not a glamorous cause. Certain organizations including some Masonic Homes have been able to tap broadly into their membership for annual giving and estates, and build large endowments over time (which they use in part to provide services to Masons without resources). Not many organizations have the ability to do this. In general, a nursing facility may successfully do a fund drive for a specific project or program, but are usually not able to build an endowment. Some well-endowed organizations developed initially out of an estate, and are able to build on that over time."

Robert Wetzler, a public finance research analyst with Fitch IBCA, writes in a report on ratings guidelines for nonprofit nursing homes that, "The financial health of nursing homes generally depends on reducing exposure to Medicaid reimbursement to the extent possible while expanding private-pay revenue, and controlling Medicare costs to maximize returns under PPS." (This statement can be applied to the for-profit nursing homes as well.) Wetzler also points out that, "Profitability has declined significantly across the industry, indicated most clearly by recent bankruptcy filings by some of the industry's largest providers. Medicare's Prospective Payment System (PPS) receives most of the blame for industry woes, although other factors, such as ill-advised acquisitions and over leveraged balance sheets have contributed most substantially to poor performance."

Revenue streams vs. costs

Skilled nursing facility companies have struggled over the last few years with varying revenue streams and ever-increasing costs. The implementation of the SNF PPS occurred as medical costs continued to rise each year—driven by a labor market for nurses and other staff that remains tight, and ever-increasing expenditures on liability insurance.

"Spending-down"
Medicare—Private Pay—Medicaid

Medicare beneficiaries who are discharged after a qualifying hospital stay are covered by Medicare for skilled nursing care for up to 100 days provided they continue to require skilled services. If beneficiaries continue to require care in a skilled nursing facility once Medicare coverage lapses, they can pay out-of-pocket as long as they have assets (private pay). Once their assets are "spent-down," they become Medicaid eligible. The per diem rate to the provider typically decreases as patients move along each step from Medicare to private pay to Medicaid.

Revenue

Medicare comprises approximately one-quarter of publicly-held nursing facility company revenue.

Medicare
Among the large for-profit nursing facility companies, Medicare typically comprises 10-15% of the resident census and approximately 25% of revenue. This revenue has dropped from prior years as a result of the Balanced Budged Act of 1997 and the implementation of SNF PPS in 1999. As noted above, Medicare margins greatly exceed those of Medicaid. While many of the large for-profit nursing facilities were building up their ancillary services businesses prior to the implementation of the SNF PPS, Medicare revenues allowed the industry to expand despite losses on other lines of business. Now, under the constraints of PPS, the Medicare bulge is gone.

Medicaid
Among the large for-profit nursing facility companies, Medicaid typically comprises 65-70% of the resident census and typically generates 45% of revenue for nursing facilities. Because Medicaid is a program that is administered by state governments and only partially funded by the federal government, it is difficult for Wall Street to forecast Medicaid trends on a nationwide basis. As a result of the recession, shrinking state budgets are a concern to the industry and investors alike. Credit Suisse First Boston points out that, "…most states' rates for nursing home care are pegged to a 'market basket' inflation update, which is dominated by increases in wage rates. If labor rates are going up (which they almost always are in health care), so are the Medicaid rates. On average, Medicaid per diems tend to increase about 4-6% per year; last year was higher due to the extraordinary increases in labor costs."

According to industry sources, SNF Medicare business segments continue to generate healthy margins which allow them to survive with negative Medicaid margins. **The profitable Medicare and private-pay segments cross-subsidize Medicaid.** Medicaid rates are set by individual states and concerns regarding state budget declines are being voiced on Wall Street. Adam Feinstein of Lehman Brothers states, "…with respect to Medicaid, state tax receipts are declining with the slowdown in the wider economy,

leading to more discussion of cutting Medicaid funds. It is difficult to make a broad conclusion, since Medicaid is managed at the individual state level. Nonetheless, the potential exists for some disruption at individual states." On the other hand, A.J. Rice of Merrill Lynch is more optimistic that Medicaid will not suffer the state budget axe and states that, "To the extent that people are concerned about an economic downturn impacting State Medicaid budgets, we would point out that an economic downturn should also have a beneficial impact on the company's wage rate trends, particularly in the area of unskilled workers." Rice also reminds investors that, "To our knowledge, there has not been a year-over-year decline in Medicaid rates in any state in the last 15 years. In the event that a state faces financial pressure, the rate of increase may slow, but it does not typically decline on an absolute basis. We note that in the early 1990's, the industry was in an uproar when California held Medicaid rates constant for two years, at the time an unprecedented event."

Private Pay

Among the large for-profit nursing facility companies, private pay and other sources typically comprise 20% of the resident census and typically generate 30% of revenue for nursing facilities. Nursing home residents who pay themselves tend to do it for a relatively short period of time before they spend down their assets and become Medicaid eligible. Some nursing facilities (such as some of those in the Manor Care chain) have historically catered to more well-to-do customers and still benefit from higher private-pay margins. They do, however, face increasing competition from assisted-living alternatives and expect slowing revenue growth from their private pay business.

Long-Term Care Insurance

Very few aging Americans buy private long-term care health insurance.

A revenue source in its infancy, long-term care insurance generates a very small portion of nursing facility revenue. Very few aging Americans buy private long-term care health insurance and when they do it is often initiated at an advanced age—defeating the purpose of the insurance design. Inevitably, unless this trend is reversed, likely through changes in tax policy, the growing financing burden will remain on the taxpayer base and present rapidly increasing fiscal pressures on the public programs—Medicare and Medicaid.

Figure 8: Revenue by Payor, Large For-Profit Nursing Facility Companies

	Company							
Payor	Beverly (1)	Extendicare	Genesis	Kindred	Manor Care	Mariner	Sun	Average
Medicare	17 %	24 %	18 %	28 %	24 %	30 %	24 %	24 %
Medicaid	62	51	43	49	33	49	47	48
Total Government	79 %	75 %	61 %	77 %	57 %	80 %	70 %	71 %
Private and Other	21	25	39	23	43	21	30	29
Total	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %

Source: Company filings

(1) Beverly includes room and board revenues. Does not include ancillary and other revenue.

Costs

In addition to increased medical spending, which continues industry wide, nursing facilities face other cost increases, notably labor rates and liability insurance premiums.

Labor

The most significant cost for nursing facilities is labor. According to a Credit Suisse First Boston analysis, about 55-60% of most nursing facility companies' revenues go to pay for labor costs. It notes that the wage rate increases over the last two years have been significant, increasing 6-8% on a weighted average basis. Thus, the industry remains at the mercy of the labor market which, despite the recession, remains tight because of what it calls a, "…severe nationwide nursing shortage." Because of the labor shortage, many nursing facility companies rely on staffing agencies which are viewed by Wall Street as expensive. Credit Suisse First Boston praises Manor Care which has increased efficiency by reducing its (expensive) agency staffing from 50% to 25% over the last year by hiring more employees.

Most of nursing facility labor is relatively low-skilled.

For most nursing facilities, the majority of staff are relatively low-skilled certified nursing assistants (CNAs). The nursing facility industry competes for CNAs against other low-skilled or unskilled service industry sector jobs (fast food for example). The recent tight labor market has driven wages up and caused strain on company budgets as a result.

The labor problem also presents itself among highly-skilled registered nurses. According to Deborah Lawson of Salomon Smith Barney, an existing nationwide shortage of registered nurses is being exacerbated by several factors: fewer nurses are in training programs and those who are, are more likely to be in non-baccalaureate degree programs (meaning they are less skilled), the existing nursing population is aging (the average age in 2000 was 45), and vacancy and turnover rates are also on the rise.

Liability

Liability insurance continues to be an increasing cost for nursing facilities. Several companies report anecdotally that they spend more on insurance than they do on raw food. Adam Feinstein of Lehman Brothers notes that nursing facility operators have faced a rapidly growing number of patient liability lawsuits and settlement amounts whose costs have depressed earnings. He states, "…some states have either passed or proposed tort reform. Florida passed a bill, implemented on October 1, 2001, that will limit liability in the future. Thus, liability costs may moderate in the future, but remain a major source of risk." It is worth noting that several major chains have sold their operations in Florida, which has been an especially costly state in terms of lawsuits.

Summary

- The incentives for SNFs are more appropriate than they were pre-BBA, and as a result, SNF reimbursement behavior reflects these improved incentives.

- Pre-BBA, many firms were going for the brass ring of Medicare SNF reimbursement—ancillaries—or with unsustainable business practices: expanding very rapidly, taking on huge amounts of debt, buying ancillary services businesses, and gobbling up capital in a feeding frenzy. That strategy backfired on many of the industry's biggest companies. Many have new leadership and often more conservative management and growth objectives.

- As a result of the post-BBA struggle, and faced with uncertain revenues, this industry was forced to become more streamlined.

- The sector is highly reliant, for now, on the high Medicare margins it received from the BBRA 1999 and BIPA 2000 add-ons. How, and when, the industry is weaned from these add-ons is the primary variable to its short-term survival and long-term stability. Clearly these payments cannot be permanently justified, but for now they are the jacks that are holding up a somewhat shaky house.