

Not-For-Profit Health Care

The not-for-profit health care sector encompasses a variety of different types of health care entities seeking access to the capital markets. As a result, Standard & Poor's Ratings Services rating criteria covers a range of nonprofit health care providers in addition to single-site hospitals and multi-hospital systems. While each provider has unique areas of analytical focus, the framework for all of them is similar. Standard & Poor's continues to emphasize qualitative and quantitative factors in determining the rating of a health care entity. However, in today's more competitive and continually evolving health care environment, an examination of the provider's competitive position—including the nature of the market, market share, relationships with key market constituents, and cost structure—is essential to our evaluation.

Demand And Service Area Characteristics

Overall measures of business volume remain an important analytical tool, although the interpretation of volume data must be analyzed carefully. In markets with high managed care penetration, analysis of volume trends must include a review of payment terms and overall profitability of business lines. Although traditional inpatient and outpatient statistics are analyzed, Standard & Poor's also focuses on adjusted admissions and average daily census to gauge the revenue-producing capacity of an organization, along with the reimbursement rate environment.

To the extent that utilization is flat or declining, Standard & Poor's is interested in a provider's ability to control resource consumption and preserve cash flow. Population trends, unemployment rates, local wealth levels, the size of the region's uninsured population, and major employers are analyzed to determine their effect on health care utilization and payor profile. Additionally, the population profile is important in determining the type of services needed. Typically, an older population is likely to require more intense inpatient services than a younger population, which may be most effectively treated on an outpatient basis.

The types and levels of services provided are important analytical considerations affecting the institution's competitive and financial position. For example, major teaching hospitals, regional referral

centers, and large medical centers draw patients from broader regional bases, providing some insulation from local economic cycles. This information feeds into Standard & Poor's assessment of demand for the institution's services, its market position relative to the needs of the population and to the competition, and the evaluation of the institution's strategic plans. The reimbursement and planning environment also is an important service area characteristic, which frequently affects financial results. Some states have rate setting or planning regulations, such as certificates of need and Medicaid managed care initiatives, in an attempt to control health care costs and expenditures. Therefore, an understanding of the unique features of a state's reimbursement and health-planning environment is an important element in understanding a provider's fiscal well being.

Institutional Characteristics And Competitive Profile

The competitive environment—always an important element—has become even more so as third party contracting has contributed to overall heightened competition for patients on an inpatient and outpatient basis. An in-depth understanding of the provider's market share over time for key services, centers of excellence, and competitive position in its primary and secondary service areas is a critically important area of focus for Standard & Poor's as an indicator of credit strength. In addition, affiliations with other providers are a key issue, as consolidation remains a key factor in most markets. Standard & Poor's must be fully aware of the market dynamics of both the credit being rated as well as its competitors. Understanding current strategic alignments and payor relations for all market providers help Standard & Poor's better predict an individual hospital's future.

Standard & Poor's reviews the size of the provider's medical staff, the average age of the staff, and level of board certification and admission dispersion among the top admitters. The ability to attract and retain new doctors is another useful indicator. Additions and deletions to staff—traditionally an area of focus—include an emphasis on recruitment of primary-care physicians.

Given the role of primary-care physicians to influence patient flow and resource utilization, it is impor-

tant for Standard & Poor's to understand the relations that a provider has with primary-care physicians, as well as with the rest of the medical staff, including an understanding of practice patterns, and loyalty of the medical staff to the institution.

Standard & Poor's also factors the financial performance of physician practices into ratings where hospitals, systems, and managed care corporations employ and manage doctors. Whether these practices are inside or outside the obligated group, Standard & Poor's incorporates this business line into the rating through analysis of financial performance, strategic vision, and quality of management.

The successful operation of physician hospital organizations or similar structures is viewed positively if it enhances physician loyalty and establishes appropriate financial incentives. The ability of hospitals and physicians to negotiate third-party contracts, as a single unit remains helpful in many markets although this has become less prominent over the past few years as exclusive managed care contracts have been replaced by broader point of service networks. The role of information technology and electronic medical records is becoming increasingly important both as a means to improve quality of care, meet evolving standards of care, and pay-for-performance requirements, but also as a physician recruiting and retention tool. As relationships with physicians have evolved, Standard & Poor's also recognizes that relations between other providers and insurers have also changed. It is important to highlight these key relationships during the rating process, particularly since affiliation agreements and network formation are important to overall strategy.

Management And Administrative Factors

One of the best indicators of management's ability is the provider's track record. However, given the competitive operating and reimbursement environment, the past may not always be the best predictor of future results. Therefore, Standard & Poor's analysis of management seeks to determine whether the management team exhibits the depth and experience to provide leadership, deal effectively with the medical staff, budget effectively, monitor and control financial and personnel resources, define the hospital's role, and develop and implement a dynamic strategic plan, including an effective information technology program, to enhance the overall health of the organization.

Management's ability to assess its institution's strengths and weaknesses and to develop sound strategies to enhance the institution's competitive position is crucial to continued success. In meetings with Standard & Poor's, management teams should be prepared to discuss these topics in detail. The

provider's management, information technology, and capital budgeting systems should be appropriate for the size, type, and complexity of the institution. Standard & Poor's discusses with management the types and frequency of monitoring and reporting to the staff and to the board of trustees.

The role of the board and its interaction with the management team continue to be areas of analytical focus, and a meeting with the member of the board of trustees is desirable. The board's size, composition, structure, and activity are noted, with particular consideration given to its participation in setting strategic and financial policies. In addition many not-for-profit boards have adopted some or all of the rules articulated in the federal Sarbanes-Oxley legislation. It is helpful to understand the Board view of these rules and what, if any, have been adopted by the Board.

Another area of discussion is risk management and the hospital's malpractice coverage and history. The ability to get reasonably priced malpractice insurance is also examined, along with general property and casualty insurance. Overall levels of risk retention as well as diversification of insurance risk are examined to see if the provider is over reliant on their own balance sheet for first dollar coverage up to the retention limits or if there is an over reliance on any one insurance company. To the extent an organization relies on a captive insurance company additional information is likely to be requested regarding the captive's performance, funding levels at the captive as well as captive policies on reinsurance to make sure the captive itself has managed its risk appropriately.

Financial Factors

Financial position and performance are essential elements of Standard & Poor's analysis. However, if a provider's business fundamentals are not sound, currently sound financial performance and position may not be sufficient to offset longer-term business

Standard & Poor's Rated Health Care Providers

Standard & Poor's rates a broad spectrum of health care providers, including but not limited to:

- Single-site hospitals-including rehabilitation, children's, cancer centers and psychiatric institutions;
- Multi-hospital systems;
- Academic medical centers;
- Physician groups and faculty practice plans;
- Continuing care retirement communities and nursinghomes; and
- Human Service Providers

concerns. For example, a very competitive service area, a weak local economy, a weak medical staff profile or an over reliance on investment income might explain why a hospital is rated below what its financial profile might otherwise indicate. Conversely, the absence of competition and a growing economy and population base sometimes can compensate for lower cash levels or thinner margins. Standard & Poor's financial analysis highlights income statement, balance sheet, cash flow statement trends and future capital requirements. One bad year does not necessarily mean an immediate rating downgrade, unless the experience was very severe or is determined as being the beginning of a long-term shift in financial performance. When confronted by a weak year, Standard & Poor's carefully reviews management's corrective action plan to access the likelihood it will return the organization to financial health. The stronger and more detailed the correction plan, especially if combined with clear implementation schedules, are generally viewed more favorably than broad but undefined correction programs. Trend analysis is critical to all rating decisions.

Income-statement analysis focuses on revenue growth, payor mix and profitability by payor, and operating and excess margins. Standard & Poor's looks at local state regulations and funding issues, as well as the level of competition among the insurers. Standard & Poor's will ask management about its managed care contracting strategy, current rate negotiations and role of pay-for-performance contracts, if any, in the local marketplace. Programs to control costs are also examined in detail, as is overall revenue cycle performance including management of bad debt.

Standard & Poor's is interested in measuring an institution's financial flexibility, or its ability to meet its debt-service requirements even under stressful conditions. Also important is an organization's ability to have sufficient cash flow and debt capacity to meet future capital needs. Low-cost providers with a favorable payor mix and market dominance will have a clear advantage. Competitive pressures may constrain high-cost providers from raising prices, although they may be suffering financially. Typically, Standard & Poor's will ask how the provider's costs compare with those of other providers, and is interested in any initiatives undertaken or under way to control or reduce costs of providing services. Low costs and demonstrated efficiencies are key to strong margins, along with negotiating clout with managed care payors. Key income statement indicators are operating and excess margins, historical pro forma debt-service coverage, and debt burden. Increasingly overall bad debt and charity care levels are impacting margins

negatively. In some cases community perceptions the sufficiency of the charity care that is being provided is an issue that can indirectly impact margins. Standard & Poor's also uses ratios such as full-time equivalent employees to adjusted admission, and salary and benefit expenses to net patient revenue to help analyze trends over time for a single credit and improve comparability between credits in similar markets with similar services. Institutions with favorable ratios have a greater degree of financial flexibility to meet the challenges of today's environment. Quality metrics are also reviewed in available and can provide some measure of flexibility if favorable. Pension funding levels are also reviewed, as they are increasingly an important use of cash that competes directly with an organization's ability to fund capital needs.

Although operating and excess margins are both important measures of profitability, Standard & Poor's believes that operating margin is the best measure of the ongoing ability to generate profits from the business. Excess margins include investment income (including realized gains and excluding unrealized gains), as well as unrestricted donations. However, weak operations combined with dependence on non-operating earnings can highlight underlying weakness in most cases. Some very well endowed institutions are exceptions to this especially if their fund raising ability is strong.

In addition to focusing on an organization's ability to produce profits, Standard & Poor's examines cash flow statements to measure a credit's cash-producing ability. Our ratios borrow heavily from corporate finance, and answer the question of whether an institution is generating sufficient cash flow to fund its strategic objectives while maintaining sufficient cushion consistent with its rating. Key cash flow ratios include cash flow to total liabilities and EBIDA (earnings before interest, depreciation, and amortization expenses). Standard and Poor's also excludes from excess income unrealized gains or losses from swap agreements.

Standard & Poor's analysis also focuses on the balance sheet, particularly leverage and liquidity. Balance-sheet strength is key in today's volatile operating environment. An institution with significant liquidity or light leverage can more easily survive the increasingly common scenarios of reduced reimbursement; poor managed care contracts, or volatile investment performance. Standard & Poor's uses traditional liquidity ratios such as days' cash on hand and cash to debt. Standard & Poor's also examines in detail a provider's investment allocation and investment policies, especially if nonoperating revenue is a significant source of funds for debt service. In addition, the liquidity of the investment portfolio is also examined closely especially if

the provider is using its own balance sheet to support potential variable rate debt tenders. Standard & Poor's uses capital structure and liquidity ratios such as debt to capital, to help evaluate more thoroughly debt repayment ability and debt capacity across the rating spectrum. Future capital needs and projected sources of capital to fund those needs, whether it is internal cash flow or external debt or a combination, remain an important element of Standard & Poor's analysis.

In addition, an organizations' overall mix of fixed versus variable rate debt is analyzed, both pre-and post-usage of swaps. Swaps are analyzed for termination risk, and the potential for large payments that may then be required. In general most health care credits entering into swaps have sufficient liquidity to handle unexpected termination events but this could be a problem if an organization's overall rating profiles deteriorate. Particular attention is paid to whether or not the swaps contain rating triggers that could force termination. Standard & Poor's has developed criteria (see related criteria) used in reviewing any organizations with swap exposure and assigns a debt derivative profile score as part of the review process.

Health Care Systems

Standard & Poor's definition of a health care system includes vertically or horizontally integrated systems that may have at least three hospitals with sufficient financial dispersion in a single region, as well as traditional multi-hospital/multi-state systems. The definition also includes systems that have multiple distinct business lines, even if geographic dispersion is more limited.

Over the past decade the number of systems, particularly those rated in the 'AA' category, has risen. System ratings generally are higher than ratings for single-site facilities because of the financial and nonfinancial synergies and the dispersion of risk that generally accrues to systems. This is amply demonstrated in Standard & Poor's not-for-profit medians published annually for systems and stand-alone facilities.

Standard & Poor's approach to rating health care systems is similar to that used for single-site facilities. In both cases, creditworthiness depends on certain qualitative, quantitative, and legal factors. However, a system's credit standing can be enhanced by geographic, financial, and business line dispersion. When rating systems, Standard & Poor's evaluates the extent to which these credit-enhancing qualities exist. Key rating considerations also include the system's structure, management's administrative philosophy, and overall system level financial track record—which naturally reflects any

economies of scale achieved through the consolidation of financial and management resources.

The first step in the rating process is to evaluate the system components that have covenanted to repay the debt issue. In the case of an obligated group legal structure, Standard & Poor's analyzes the obligated group and its relationship to the system as a whole. The entire financial profile of the system is analyzed in addition to the obligated group's profile. If the system employs a corporate-style unsecured GO pledge, Standard & Poor's focuses on the credit group, if applicable, as well as the entire system. Overall, Standard & Poor's seeks to understand the system's overall strategic plan, especially as it relates to growth, operations and financial policy including future capital and funding needs.

Obligated Group

The obligated group might not include all of the entities in the system. The initial obligated group often excludes leased and managed facilities, ventures not related to health care, and for-profit corporations. Similarly, the group often excludes businesses that might diminish the group's creditworthiness, such as money-losing physician businesses.

Standard & Poor's assesses any management plans that would change the obligated group's strength. Potential acquisition, divestiture, and diversification strategies are particularly important. Plans to divest an important revenue-producing entity or absorb a losing operation can affect the obligated group's financial strength. Many systems also guarantee the debt of weaker institutions, as a diversification strategy or to buoy an affiliated institution in distress. As a result, Standard & Poor's examines the downside risk of guarantees and in general fully factors those into the rating, although some credit is given in self-supporting situations. Standard & Poor's also evaluates potential transfers of cash or other assets out of the obligated group. Sheltering assets may be attractive for some purposes, but often weakens the balance sheet from a credit perspective. Standard & Poor's asks about any off-balance-sheet activity and will factor in any contingent liabilities that exist whether they are on the balance sheet or not. Major operating leases for employed physicians, research or administrative space are generally factored into the analysis.

Finally, Standard & Poor's reviews the system's activity outside the obligated group. Health care systems often have the opportunity to engage in health-related services and alternative delivery systems, as well as speculative nonhealth-related projects. Although these activities may take place in subsidiaries excluded from the obligated

group, Standard & Poor's evaluates the scope of such ventures and assesses their impact on the system's creditworthiness.

System Composition

The system's individual components also are important. Answers to the following questions are critical to system evaluation:

- In a system where members are geographically dispersed, are they located in markets with favorable economies and are they competitively positioned within these markets?
- How integrated is the system from an operations and finance perspective?
- What are the size, geographic location, and market position of the group's major acute-care players?
- Is the system constrained by any regulatory, competitive, reimbursement, or economic environments?
- Are the scope and types of services varied throughout the system?
- How effective is management at correcting problem subsidiaries?
- Has management demonstrated a willingness to divest non-profitable subsidiaries?

In addition, Standard & Poor's evaluates each entity's percentage contribution to net revenues, assets, and profits, financial and admission trends, payor mix, and overall profitability. These factors demonstrate the degree of financial, geographic, and risk dispersion in the system. Positive rating factors associated with systems include management expertise, access to capital, economies of scale, pricing flexibility, and the use of corporate personnel, centralized cash management, development of centralized information technology expertise, and insurance and pension trusts. In addition to these traditional strengths, the newly added systems demonstrate regional dominance through vertical integration and the ability to adapt to local managed-care penetration. Also, in most cases, systems have larger, more diverse revenue bases, making them less vulnerable to reimbursement and market pressures.

Board and management

The organizational structures of health care systems vary considerably, based on board philosophy, as well as more practical factors, such as the system's size, services, and geographic scope. These factors translate directly into the level of corporate control and the degree to which centralized services are available to subsidiaries.

Regardless of a system's organizational structure, management must be able to control the dynamics associated with a large corporation. Typically, a health care system has greater financial resources

than a single hospital and, consequently, greater financial flexibility. Rating benefits derived from this flexibility depend directly on the system's ability to manage these resources. If growth is being pursued aggressively, what is the size of the overall capital plan, how much debt is being used to finance new projects versus internal cash flow, and are the plans prudent? Conversely, if the system is over bedded or operating unprofitable ventures, is the flexibility being used as a cushion to delay decisions? Is management willing to make hard decisions to divest unprofitable or non-strategic subsidiaries? These issues highlight management's ability, as well as the financial planning capabilities of the system.

Successful health care systems include regional providers offering a continuum of services, as well as the more traditionally defined multi-hospital systems.

The role of the board and its interaction with the management team continue to be areas of analytical focus, and a meeting with a member of the board of trustees is desirable. The board's size, composition, structure, and activity are noted, with particular consideration given to its participation in setting strategic and financial policies. In addition many not-for-profit boards have adopted some or all of the rules articulated in the federal Sarbanes-Oxley legislation. It is helpful to understand the Board view of these rules and what, if any, have been adopted by the Board.

Major distinguishing factors

In assessing the credit strength of various types of systems, Standard & Poor's draws three major distinctions. First, distinctions can be drawn between systems formed by natural market synergies over time and those formed more recently because of market pressures. Whether they are regional or national, the more mature systems formed over time generally are better positioned to take advantage of the incentives in the current health care market, while recently formed systems face the challenge of internal system integration, in addition to a multitude of external pressures. While there still are benefits to multi-state providers, including economic and regulatory diversification, national systems must create or participate in local mini-systems to compete with strong regional systems and alliances.

Second, distinctions can be made between systems that have a salaried, hospital-based medical group and those with a traditional medical staff. As revenues continue to be limited, systems that control physician resources will be best positioned to contain expenses and maximize margins.

For health systems that own their own managed care plan, Standard & Poor's evaluates the strategic and financial contribution of the plan. Critical areas of analysis include:

- The plan's position within the overall managed care market, including products offered, price competitiveness, market share, and composition of the provider network;
- Impact of the plan on relationships with other insurance companies that the provider contracts with;
- Strategic purpose of owning the plan, such as increasing market share, improving negotiating leverage with existing market managed care players, better care management, or capturing a larger portion of premium dollars; and
- Financial results, including the stand-alone performance of the plan and its impact on financial results of the rest of the health system.

If the plan loses money, or is subsidized by the larger system (these are often hidden subsidies) management will be expected to articulate a clear strategic benefit for plan ownership, a detailed performance improvement plan, or a well-conceived exit strategy.

Finally, distinctions can be made between systems' managed care strategies. Many systems that have owned managed care products through the past decade have extensive experience with underwriting, claims administration, physician integration, and resource control that can only be gained over time.

As always, the presence of a single credit-enhancing feature will not necessarily improve a rating. On the other hand, a system need not exhibit all the characteristics discussed above to obtain a solid rating.

Legal Criteria Summary

Part A: Structural provisions

Security

- Unsecured GO pledge.
- Revenue pledge, GO of the obligated group with or without a mortgage of the facility.
- A joint and several obligation of the obligated group.
- Negative lien covenant with senior lien debt limited.

Permitted investments

- Investments rated by Standard & Poor's in the investment-grade category.
- Obligations of, or obligations guaranteed as to principal and interest by the U.S. government or any agency or instrumentality whose obligations are backed by the full faith and credit of the U.S. government.
- FHA debentures.
- Obligations of government sponsored agencies that are not backed by the full faith and credit of the U.S. government (examples include: FHLMC, FHL banks, FNMA, SLMA).
- Federal funds, unsecured certificates of deposit, time deposits, and bankers' acceptances from any bank whose short-term obligations are rated by Standard & Poor's and mature in less than 365 days.
- Deposits, not rated by Standard & Poor's, but fully insured by the FDIC.
- Commercial paper rated by Standard & Poor's in top two categories.
- Investments in money market funds rated by Standard & Poor's in top two categories.
- Repurchase agreements with any transferor whose debt or commercial paper is rated by Standard & Poor's.
- U.S. Treasury STRIPS, REFCORP STRIPS, and FICO STRIPS, or any stripped securities rated by Standard & Poor's.

Events of default

- Failure to pay principal, interest and premium when due.
- Failure to observe or perform any other covenant for 30 days (technical default).
- Default in the payment of any material indebtedness for borrowed monies.
- Obligor becomes bankrupt or insolvent.
- Cross-default provisions in legal documents.

Remedies

- Acceleration by trustee permitted.
- Bondholders can force acceleration or waive certain events of default.

Legal Review

Standard & Poor's evaluates the legal provisions of a health care bond issue based, in part, on the credit strengths and weaknesses of the health care obligor. Legal provisions alone cannot prevent operating and financial performance declines, interruptions of debt-service payments, events of default, and the risk of overall credit deterioration. Consequently, while weak or liberal provisions can cause a lower rating to be assigned, strong legal covenants generally will not lead to a rating higher than that of the obligor. Credit quality determines the degree of influence that legal provisions bear on a bond's rating.

Legal covenants should provide protection to bondholders, while allowing hospital management sufficient operating flexibility to respond to changing business conditions. However, Standard &

Poor's will assess any future hospital action that affects the hospital's credit quality, even if such action is addressed in the legal documents, and will adjust the rating accordingly. In general not-for-profit healthcare providers will provide a gross revenue pledge with clear limits on senior debt. In addition, a rate covenant is expected along with reasonable transfer of assets tests including departures from the obligated group.

Unsecured health care pledges

A number of health care credits have chosen to issue bonds with an unsecured GO pledge, which is essentially a promise to pay by a corporate parent with no underlying revenue pledge or mortgage from the hospitals or other operating units. There may be a revenue pledge from the parent itself. While the

Legal Criteria Summary (continued)

Part B: Covenants

Rate covenant

- An event of technical default shall exist if, at any time, the net available falls below 100% of MADS on all long-term debt.
- The obligor shall employ an independent, nationally recognized consultant and immediately follow the consulting firm's recommendations if the obligor's net available falls below 110% of MADS on all long-term debt.

Insurance

- The obligor must maintain adequate levels of coverage, including malpractice, business interruptions, and natural hazards with insurance consultants reports discussing adequacy of insurance levels annually for any self-insurance programs.

Notification

- The obligor agrees to notify:
 - Bondholders and Standard & Poor's immediately upon an event of default;
 - Standard & Poor's upon a change in the obligated group structure;
 - Standard & Poor's upon a change to legal structure;
 - Standard & Poor's upon the incurrence of additional debt;
 - Standard & Poor's upon entering into any SWAP transaction and
 - Standard & Poor's on any mode change.

Part C: Legal Tests

Disposition of assets

- Transfers of assets outside the obligated group must be limited.

Mergers/consolidations divestitures/change in system composition

- Surviving organization assumes all concurrent obligations at time of merger or consolidation;
- No event of default immediately post transaction (including covenant defaults).

Substitution

- Limitation on ability to substitute new security without bondholder approval.
1. For a more complete listing of permitted investments see criteria for Qualified Investments for Municipal Transactions.
 2. In calculating debt service, Standard & Poor's treats interim debt, balloon debt (which is expected to be refinanced) and variable-rate debt as if it were long-term debt with level debt service payments at the current market rate. Standard & Poor's also includes guarantees in its "worst-case" debt service calculation.
 3. The sum of excess income, depreciation expense, amortization expense, and interest expense.

corporate model has fallen into disfavor in recent years, a number of the largest systems have this legacy structure. While the corporate parent may or may not have significant resources of its own, the bulk of the value-producing assets are not directly pledged to the debt. However, various internal arrangements allow the parent to collect money from constituent members to pay debt service. While this type of legal structure gained popularity in the mid-to-late 1990s for larger not-for-profit health care providers, and is currently in disfavor, it has been successfully time-tested in many other parts of the U.S. corporate debt market.

Standard & Poor's ratings incorporate analysis of the legal documents; however, these security agreements play a secondary role in gauging and rating an obligor's ability and willingness to repay debt. Standard & Poor's credit analysis always begins by looking through obligated group structures to the position of the organization as a whole regardless of the specific pledge being provided. In some cases minor rating adjustments can be made for non-obligated entities that are appropriately 'ring-fenced' from the main obligated entity. This is discussed in more detail within our senior living criteria.

Standard & Poor's expects that some credits will continue to use the unsecured GO structure or one of its many variations, especially if its legal structure is already established in the market. The flexibility of these documents must be matched by wise governance and sound management as fundamental changes in corporate assets can, and often do, have a profound impact on credit quality. Standard & Poor's active and ongoing surveillance of these credits monitors the impact of additions, and more significantly, deletions of affiliates.

Required covenants

In general, Standard & Poor's is comfortable analyzing the concept of an unsecured GO pledge. However, to provide effective bond security, several features, outlined below, strengthen the obligor's credit rating and legal and security arrangements.

Credit rating: Credits issuing under an unsecured GO pledge typically are rated 'A+' or better. Although Standard & Poor's stated earlier that this structure by itself would not negatively affect a rating, lower-rated credits often do not have the credit characteristics necessary to prove to Standard & Poor's that they can effectively manage under a looser legal structure.

Senior debt: The unsecured GO debt typically remains the senior debt security for the entire health care system. To preserve the senior position of this debt, Standard & Poor's expects clearly defined limits on senior liens outside this structure. As a benchmark, senior liens up to 25% of long-term debt; unrestricted fund balance; or net proper-

ty, plant, and equipment will be allowed in the documents. **Access to cash:** Senior corporate officers should be able to quickly upstream cash and liquid investments without limit from constituent members. **Rate covenant:** The system as a whole, including any contractual affiliates, should maintain a rate covenant of at least 1x principal and interest coverage of maximum annual debt service. Failure to meet this test should generate an independent consultant's report to the system's governing body and senior management.

Designated affiliate model

The unsecured GO pledge also includes the concept of designated or restricted affiliates. This model is more like traditional legal structures, as it seeks to marry the freedom of the unsecured GO pledge with some of the characteristics of the more traditional obligated group structure. Under this variation of the unsecured GO model, the parent, which remains the only entity promising to pay, seeks to move the credit analysis and the key legal covenants from the system as a whole to a narrower subset of the system, namely restricted or designated affiliates. These affiliates are bound to the parent either through ownership or contract. In either case, however, the parent has a clearly established mechanism to upstream funds for debt-service payments if necessary.

A key difference between this structure and traditional obligated groups is enforceability. As a result, although the designated affiliate model appears to be structured like a more traditional joint and several obligation, and within the system it essentially is a joint and several pledge, it actually cannot be directly enforced as such by bondholders. Rather, bondholders must rely on the parent's obligation to enforce its internal documents. As a result, Standard & Poor's legal analysis of the designated affiliate model will mirror that performed for pure unsecured GO pledges.

One potentially troubling aspect of the designated affiliate model is the ability of the parent to designate and undesignate affiliates almost at will. In theory, the parent could undesignate enough affiliates so that the credit is fundamentally changed. While generally considered highly unlikely, this has the potential to threaten management's ability to repay debt. In these cases, some simple additions to the previously stated requirements should be in place.

Typically Standard & Poor's sees at least 1x rate covenant calculated on the entire system audit, not just the credit group. In addition, the results of contractually designated affiliates should be included within the rate covenant calculation. If violated, this test will provide the board of directors and bondholders with a valuable independent assessment of management and current operations. As always,

Standard & Poor's also expects that the unsecured GO pledge remains the senior debt of the credit group. The permitted lien test and its 25% limit on lien debt that can run to the parent and designated or restricted affiliates as opposed to the system as whole, should remain in force at all times. Compliance should exist at all times, not just at the time of a new debt transaction. A common mistake is to treat this as a transaction test instead of a default test. If applied only at the time of a transaction, subsequent undesignations could leave the remaining members of the credit group in violation of this principle. When properly structured, this test will safeguard against the parent undesignating affiliates in such a way as to leave the system with too much senior lien debt. By making this an on-going requirement, it precludes a violation of the test and, as a result, the rated unsecured debt cannot fall to a junior lien position when measured against the 25% allowed limit.

Off-Balance Sheet Debt

Nonprofit health care organizations are increasingly using off-balance sheet debt to finance certain assets. How this usage is viewed from a credit perspective varies for a number of reasons. Some of the questions Standard & Poor's asks to determine the credit impact include:

- What are the assets being financed?
- Are they critical to the ongoing welfare and mission of the organization?
- What is the legal structure of the deal?
- Is there a moral or legal obligation involved?
- Are there true contingent liabilities being undertaken by the organization?

The answers to these questions, combined with an obligor's fundamental credit strength, are used to gauge the potential rating impact of any off-balance-sheet transaction. In certain cases the impact is significant; in others slight. In either case, Standard & Poor's needs to be informed of all off-balance-sheet transactions because there may be financing risks that could have credit consequences. Issuers and obligors often perceive off-balance-sheet financing as a means to preserve debt capacity and enhance operating flexibility, with no impact on their senior debt rating—a free lunch, if you will. However, this is clearly not always the case.

Broadly speaking, off-balance sheet debt refers to a host of different financing structures. These include:

- Sale/leaseback transactions;
- REIT financings;
- Various types of operating leases or guarantees;

- Contribution agreements between unrelated parties to finance jointly owned assets; and
- Public/private joint ventures or partnerships, many with a real estate developer.

The common element is that the repayment obligation does not appear as a liability on the rated organization's balance sheet and, in some cases, may appear as an operating lease.

Standard & Poor's ascertains the risks of off-balance sheet transactions—regardless of the legal structure—when a rated non-profit organization is involved and the transaction is deemed important to the organization's ongoing welfare or mission. Once the potential off-balance-sheet risk is identified, Standard & Poor's review of a rated organization factors in the relevant risks, which include additional debt-service costs or operating lease payments related to the financing. The potential of having to “step up” to a guarantee is also assessed. The impact on a rated obligor's debt could range from minimal to high, in which case it is treated as the equivalent of an obligation on parity with the obligor's own debt. This range reflects the legal structure as well as the degree to which an organization, as a whole, is legally or equally as important, morally obligated on the transaction. The importance of the asset being financed via the off-balance sheet to the overall mission and strategy of the organization is also central in determining the extent of the rating impact.

The potential risks of off-balance-sheet financings include:

- The potential dilutive effects on the rated obligor's bondholder security;
- Risks associated with the ownership and control of the asset being financed;
- Potential liability and poor public relations if the off-balance sheet financing encounters financial problems;
- Strained managerial resources resulting from administration of an off-balance-sheet project and related financing program; and
- Potential jeopardy of the rated issuer's tax-exempt status.

Fueling the rise in off-balance-sheet financing are the following one or more goals:

- Preserve debt capacity by only financing the most mission-critical assets or programs with the obligor's strongest security;
- Enhance financial flexibility by proceeding on a speedier time table than that required for a more traditional bond financing;
- Increase risk sharing through joint ownership or other collaborative relationships;

- Financing terms that can be more flexible and more suitable to the specific asset being financed; and
- Legal covenant flexibility.

In addition, some entities, especially in senior living, are attempting to fund non-recourse projects with limited support from an obligated entity. While Standard & Poor's always begins its analysis of the organization as a whole, there are limited circumstances where obligated group performance can be 'ring-fenced' from the impact of non-

recourse debt that in most cases is dilutive to the obligated group. In these cases Standard & Poor's will review the strategic importance of the non-obligated entity, the financial relationship between the parties, the scope and depth of management resources and legal issues. In some case the debt of the obligated group can be up to three notches higher than the consolidated rating of the organization. This is discussed in more detail in the senior living criteria. ■

Senior Living

The majority of rated credits in Standard & Poor's Ratings Services not-for-profit senior living sector are either single-site continuing care retirement communities (CCRCs), or multi-facility organizations where CCRCs comprise the majority of the organization. CCRCs typically offer independent living, assisted living, nursing care, and additional services to senior citizens pursuant to a long-term resident contract. These contracts may include payment of an entrance, or advance fee as well as a monthly maintenance fee. CCRCs appeal to many elderly people because of the variety of living and service arrangements available, and the security of convenient access to nursing care and other support services if, and, as they become needed.

The majority of Standard & Poor's CCRC credit ratings are in the 'BBB' or 'A' categories. Ratings tend to cluster in the lower end of the investment-grade spectrum because of industry-risk factors, including the competitive and fragmented nature of the business, the small size of many CCRCs, the discretionary nature of the services provided, and the significant demand for capital to update facilities in order to attract an increasingly sophisticated and demanding resident population, resulting in generally high leverage and debt burden. Historically, the industry has generally been reliant on investment income to offset operating losses and keep annual price increases to a minimum. In the past several years, however, the industry as a whole has focused greater efforts on generating positive income from operations, since market volatility can lead to unstable earnings and coverage trends. This shift is one of the drivers behind the recent stabilization of long term care credit ratings.

Standard & Poor's analysts evaluate a CCRC's creditworthiness based on the organizational struc-

ture (including whether it is a standalone facility or a multi-site organization), the strength of the organization's governance and management, demonstrated demand for existing and planned facilities, and the adequacy and predictability of key revenue sources. The mix of private versus governmental revenue sources is also relevant to the analysis, as Medicaid and Medicare reimbursement can be unpredictable. Additionally, because of the service-oriented nature of this business, the ability to keep revenue increases in line with labor and other costs is key to Standard & Poor's analysis. A strong emphasis is placed on adequate liquidity, to meet operating and debt-service costs, as well as future capital needs and future service liabilities if the organization offers life care contracts. In addition, the service offerings, location, and the condition and attractiveness of the physical facilities are compared with those offered by other competitors in the service area, as well as the merits of the proposed project and financing. Financial performance is evaluated, including the use of ratio analysis, to determine the ability of the organization to meet operating costs and existing and planned fixed-capital costs. The annual ratio report for CCRCs explains our ratios in detail. Future capital plans, as well as potential projects at affiliated organizations, are also considered.

Organizational Structure

System ratings generally are higher than ratings for single-site facilities because of the financial and nonfinancial synergies and the dispersion of risk that generally accrues to systems. Standard & Poor's approach to rating senior living systems is similar to that used for single-site facilities. In both cases, creditworthiness depends on certain qualitative, quantitative, and legal factors. However, a

system's credit standing can be enhanced by geographic, financial, and product line dispersion. When rating systems, Standard & Poor's evaluates the extent to which these credit-enhancing qualities exist. Key rating considerations also include the system's structure, management's fiscal and administrative philosophy, and overall system level financial track record—which naturally reflects any economies achieved through the consolidation of financial and management resources.

Management

Standard & Poor's analysis of the organization and management of a CCRC is extensive. While the management strength and expertise of board members in the industry has grown significantly, this area was at one time a significant weakness. A site visit and tour of the facility and service area are usually required for all proposed financings. Standard & Poor's representatives typically meet with key members of the administration and board, and management company (if under independent management contract). It is also desirable for representatives of the sponsoring organization to attend this meeting to discern their role in, and commitment to, the continuation of the enterprise.

An organization's track record is one strong indicator of management's ability and the board's role in oversight. However, similar to the acute care sector, senior living has been impacted by outside pressures such as economic forces, rising insurance costs, reimbursement pressure and staffing challenges in skilled nursing, to name a few.

Standard & Poor's analysis of management seeks to determine whether the management team exhibits the depth and experience to identify and react to upcoming challenges, to budget effectively, monitor and control financial and personnel resources, and develop and implement a dynamic strategic plan to enhance the overall health of the organization.

Management's ability to assess its institution's strengths and weaknesses and to develop sound strategies to enhance the institution's competitive position is crucial to continued success. In meetings with Standard & Poor's, management teams should be prepared to discuss these topics in detail. The provider's management, information, and capital budgeting systems should be appropriate for the size, type, and complexity of the institution. Standard & Poor's discusses with management the types and frequency of monitoring and reporting to the staff and to the board of trustees. Credit considerations include the organization's:

- Mission;
- Governance structure and financial goals;
- Compliance procedures with regulatory authorities;

- Accreditation;
- Financial planning and budget preparation; and
- Role of the Board in reviewing and providing input into the issues noted above.

Demand, Market Position And Demographics

Demand is a key indicator of the financial health of a CCRC, and demand is driven by both competitive characteristics of a facility (the attractiveness of the product, the service offerings and amenities, as well as pricing), and the demographics and economic characteristics of the service area. In this regard, Standard & Poor's evaluates the appropriateness of the CCRC's marketing program, product offerings and pricing relative to service area characteristics. Management and/or its financial representatives will be expected to prepare a competitive market profile of existing and proposed CCRCs and other organizations that could be viewed as competitors in the service area, including stand-alone assisted living, skilled nursing facilities, or other senior residential communities. The analysis should include census by contract and/or unit type and should indicate the fees in effect for each major type of contract or service offered. Area population trends, per capita wealth and income levels, as well as median home prices are also part of the analysis. Additionally, the relation of a project's entry fees to area median home prices, as well as trends in the real estate market, are explored.

In addition to service area and competitive information, Standard & Poor's reviews a range of operating statistics, including occupancy by level of service, unit turnover rates (due to move-outs and deaths), and fill-up rates of any new units, as these measures are also indicators of a facility's demand and desirability.

Contract Types

There are a variety of important financial factors that Standard & Poor's examines in addition to an organization's audited financial statements and ratios. These factors can influence how financially strong the institution must be to offset certain risks. For example, three main contract types are used by CCRCs, either singularly or, more recently, in combination. However, certain contract types are riskier than others. The first type is known as a Type A, or life-care contracts. The distinguishing feature of this contract type is that the resident pays one monthly fee regardless of the level of service received (i.e., whether the patient is in independent or assisted living or skilled nursing). Type A contracts pose the highest level of risk, as the organization must manage the cost of resident care effectively with more limited ability to recoup costs through higher fees. For all providers, entrance requirements and screen-

ing procedures (financial and health-oriented) are analyzed, but this may be most critical to life-care organizations, which are essentially offering long-term care insurance to residents.

The Type B, or modified, contract typically offers the same range of service levels and amenities as a life-care contract, except that the contract typically provides only a fixed number of skilled nursing days at no charge, with any excess utilization subject to a full or discounted per diem charge. The total number of fixed days can vary depending on the organizations specific contract details. When a resident moves permanently to a higher level of care, he/she pays higher rates for that service level. Typically, entrance fees and monthly maintenance fees are lower for CCRCs offering Type B contracts, reflecting the substantial reduction of the potential health care liability.

The third contract type is the Type C, or fee-for-service contract. Facilities employing this contract type charge different rates for each level of care, and may also offer more services and amenities on a fee-for-service basis. Residents are guaranteed access to nursing care, but pay full per diem rates.

Other features now offered by CCRCs are refundable advance or entrance fees; with these contracts, the refund amount is negotiated in advance, and usually tied to length of occupancy and/or resale of the unit. At this time, a 90% refund model is becoming more common; entry fees under this type of contract are typically significantly higher than non-refundable entry fees, but the organization has limited ability to significantly build reserves after initial fill-up as subsequent resident turnover only generates limited cash flow. Refund policies, while fulfilling a market demand, add an element of risk. Strong actuarially determined reserves help offset these risks. Because CCRC providers frequently offer refundable advance fees as an option, more scrutiny is devoted to how monthly fees are determined and subsequently adjusted, as well as the conditions for the entry fee refund (primarily whether it is dependent on unit reoccupancy). Even the refundable contracts that are dependent on reoccupancy usually have language that sets a fixed time frame for resale before the refund must be returned, typically up to one year. However, this concern is somewhat mitigated if an organization has a history of strong demand and typically refills a unit in a much shorter time frame.

Financial Performance

One of the basic factors that determine financial stability is an organization's ability to match its revenues to its cost structure. In the senior living industry, one basic factor influencing this is the contract type, as noted above. Additionally, a histo-

ry of monthly and entry fee rate increases as well as pricing philosophy are central to the analysis. Additionally, Standard & Poor's examines the organization's contracts and pricing methodology vis-à-vis its ability to recoup the cost of providing services. On the cost side, Standard & Poor's evaluates trends, particularly with regard to more recent pressures such as liability and workers compensation insurance, and nurse staffing and other labor costs. Finally, Standard & Poor's will review the CCRC's overall financial performance and projections. Key financial indicators include operating and excess margins, revenue and expense growth rates, coverage of pro forma maximum annual debt service, debt burden, and days' cash on hand. The sources and reliability of nonoperating income—including contributions, and endowment earnings—are also evaluated.

Balance Sheet And Capital Program

Cash reserves and overall leverage measures play a key role in evaluating a senior living organization's creditworthiness. A solid balance sheet can offset the risk of the health care liability of a life-care facility, for example, or earnings volatility related to cost spikes or occupancy pressures. Key debt ratios include debt service as a percentage of revenues, the debt-to-capital ratio, debt-service coverage, and the cash-to-debt level. A review of investment policies, asset allocation and endowment spending policies are also examined. To determine whether the cash flows of the CCRCs are sufficient to meet the future health needs of the resident population, Standard & Poor's will also review the most recent actuary's report, with related assumptions.

As in all revenue-bond analysis, Standard & Poor's focuses on the structure of a proposed debt issue from an economic and legal standpoint to ensure that the proposed structure is feasible in light of the obligor's existing financial performance, commitments, and debt capacity. Project-related financings are generally supported by an independent feasibility study prepared by a consultant with extensive experience in the CCRC industry. In addition to the project that is the subject of the bond issue being rated, Standard & Poor's evaluates an organization's strategic and financial plans over a three-to-five year period, including annual capital spending as well as any significant upcoming development projects or future debt plans. Standard & Poor's incorporates to some degree any expected debt or spending that is planned to occur within a one-to-two year time frame, but also seeks to understand the longer-term strategic direction and planned financial goals of the organization.

Legal Criteria

Standard & Poor's legal criteria for CCRC financings are similar to those for health care revenue bond financings. They include:

- A revenue pledge of the CCRC. A mortgage may also be offered.
- A fully funded debt service reserve fund at bond closing.

Residents' and other creditors' claims to entrance fees should be subordinate to debt-service payments.

-Documentation Requirements for CCRCs

Factoring Non-Recourse Debt In Senior Living

Growth strategies in the senior living sector, including development of new communities or expansions and/or redevelopment of existing campuses, represent both an opportunity, and potential added credit stress for rated organizations. Opportunities include increased risk dispersion, the ability to capitalize on demographic growth, leverage management strength, create revenue diversity and expense economies of scale, and allocate overhead expenses over a larger revenue base. Campus redevelopment projects allow organizations to maintain marketability through offering bigger units, more

amenities, such as fitness centers, or a wider range of services including Alzheimer's care. Additionally, there are a significant number of senior living organizations that were built thirty or more years ago, which require major reconstruction in order to meet expectations of today's seniors. Typically, such projects are funded primarily with debt, so management must balance the potential long-term benefit of the projects with the near-term construction and financial risk and potential rating impact of the additional debt.

The capital-intensive structure of most developments typically requires the issuance of a relatively large amount of debt, potentially creating financial stress. Long-term debt increases the financial risk of the organization in the near-term by straining the income statement with increased debt service, and increasing leverage on the balance sheet. Standard & Poor's looks at existing "in-ground coverage" as one important measure of financial impact—whether the existing organization can pay the full amount of the new total maximum annual debt service (as well as its existing debt service) without the benefit of new project revenues, in case the project experiences significant delays in construction or fill-up, prolonged start-up losses, or in rare cases, project failure. With projects that produce new units, the cash and revenue payoff is usually anticipated three-to-five years out, so Standard & Poor's views this as a period of crucial risk. Once the facility achieves stabilized occupancy (typically 90%), the organization has a significant increase in liquidity from the entry fees received upon fill-up, and may use some of this cash to pay down a large portion of the project-related debt—in many cases, this is a scheduled pay down that is part of the original plan of finance.

When developing or acquiring a new facility, an organization can leverage the credit strength of the rated entity by issuing new project debt as part of the existing obligated group. However, many senior living organizations do not believe that 'start-up risk' of a new project should be borne by residents of existing facilities. Additionally, as a practical matter, many credits are not strong enough to successfully handle the costs and risks of a major development project without negatively impacting their current rating. In order to protect residents of existing facilities, as well as protecting their credit strength, some organizations segregate new projects from the rated entity (typically an existing obligated group), by issuing debt through non-obligated subsidiaries, or through non-recourse ventures. In addition, a number of senior living organizations are adopting a range of covenants and organizational structures aimed at protecting, or "ring-fencing" the rated entity.

Documentation Requirements for CCRCs

The following documentation is required to complete any credit analysis:

- Three to five years' audited financial statements, with current and prior-year unaudited interim statements;
- A sources and uses statement for the bond financing;
- A debt service amortization schedule;
- A description of the obligor, including members of the board of directors and management team, and affiliated organizations;
- A description of the service area, including demographic and economic supporting data;
- Utilization and payor mix data for major business segments for the past five years and current year budget;
- Current-year financial budget with supporting assumptions;
- Resident contract types and refund policies in effect for CCRCs; and
- History of advance fees and maintenance fees for CCRCs and/or room rates for nursing home services.

The following additional documents are needed to complete a public rating:

- A preliminary official statement;
- A three-year financial forecast with related assumptions for project financing;
- Legal documents;
- The latest actuary's report;
- The past two years' auditor's management letter comments, with management's response; and
- For new credits, a site visit, including a management meeting and tour.

However, Standard & Poor's seldom views these new entities as totally "off-credit" from the existing organization. Instead, we perform an extensive analysis designed to determine whether the existing organization can be separated, to some degree, from the consolidated credit, and if so by how much. The analysis hinges on how closely the non-obligated entities are tied to the existing obligated group, both legally and strategically. Non-obligated communities that further the mission and strategic intent of the rated organization, that are located near existing obligated communities, and that have the same or a similar name will likely be viewed as very closely connected to the rated organization. We also seek to understand what the financial commitments are between the rated organization and affiliated project, what support has historically been provided, if any, and whether the management team of the rated organization has the ability and willingness to let the non-obligated community fail in a worst-case scenario.

Analytical Treatment Of Non-Recourse Debt

It is Standard & Poor's long-standing practice to factor "off-balance sheet" debt related to a rated organization into the assessment of that organization's financial profile and creditworthiness, regardless of the accounting treatment surrounding the obligation. This includes "non-recourse" debt issued by non-obligated affiliates related to a rated entity. In the not-for-profit health care and senior living sectors, the historical approach was to base the rating on a review of the consolidated entity (including both obligated and non-obligated entities, often under a parent organization) rather than only the obligated group, in keeping with Standard & Poor's criteria in other sectors. Under this approach, non-recourse debt and the risks associated with the non-obligated ventures (in this case, typically start-up CCRCs) were fully incorporated into the rated organization. The basis for this position was that the parent entity (which may or may not be part of the obligated group) may have the ability and incentive to divert resources from the financially healthy obligated entity in support of troubled non-obligated affiliates. Efforts to segregate risk, as well as the organization's legal ability and a willingness to divest of troubled entities, were not typically considered. This criteria has evolved in recent years, however, to incorporate the efforts by not-for-profit providers in this sector to segregate risk and to allow for some separation, in many cases, of the rated entity from non-recourse project risk.

In all cases, the rating of a financially healthy obligated group is still constrained by the creditworthiness of the consolidated organization. The central criteria issue is whether a rated entity can be suffi-

ciently insulated (or "ring-fenced") from the credit risks of new communities such that an obligated group can be rated higher than the consolidated entity. Standard & Poor's believes "ring-fencing" is possible in some cases, and has adapted existing criteria such that it is appropriate for not-for-profit organizations. Most importantly, there are both legal and strategic considerations, which focus on both the organization's ability and willingness to allow non-recourse debt to be supported only by its specifically pledged revenue, with no additional support from the rated entity, if the non-obligated venture is not able to meet its financial commitments. The legal criteria include the use of a set of structural features, covenants and collateral similar to those used in corporate sector (see "Ring-Fencing Criteria" below). Qualitative criteria that analysts will examine range from basic operating issues such as co-branding practices and location of the facilities, the strategic importance of the non-obligated facility or facilities, to the financial relationships among the various parties and any history of support for, or divestiture of, non-obligated entities.

If an obligated group is successfully "ring-fenced", the rated credit can have its rating up to a full rating category higher than the fully consolidated analysis would suggest. However, in many cases, a development project is linked to the strategic goals of an organization and therefore the parent or even an obligated group may extend limited support for start-up projects or offers some assistance to a troubled facility before deciding to abandon the venture. Therefore, assumptions regarding the likelihood of any future support are factored in, even if the full amount of debt is not consolidated. The rating decision to 'float' a rating one, two or three notches higher than the rating that an analysis of the consolidated entity would suggest, remains a judgment of the rating committee, but this judgment will be based on four main factors:

- Strategic importance;
- Financial relationships among parties;
- Scope and management resources; and
- Legal issues

As a starting point, Standard & Poor's analyzes the creditworthiness of the consolidated organization, assuming the full debt burden and operational risk of both obligated and non-obligated affiliates. The creditworthiness of the obligated group is also analyzed on a standalone basis, without taking into consideration any risk of non-obligated entities. The ultimate rating is determined by analyzing the strategic value and risk of non-obligated affiliates, as well as the financial relationships among the entities. In addition, the legal structure and security features of the obligated group are analyzed, to determine whether Standard & Poor's "ring-fenc-

ing” criteria may apply. In some cases, even if the obligated group is adequately “ring-fenced” from credit risk of non-obligated affiliates, other factors contribute to a closer linkage than the legal structure alone may suggest.

In general, the rating model looks like this:

Strategic Importance: The Probability Of Support

The single most important judgment that Standard & Poor’s rating analysts will make is whether the management team of the rated organization would let the non-obligated community fail in a worst-case scenario. To understand this, it is important to understand the strategic importance of non-obligated facilities. Non-obligated communities that further the mission and strategic intent of the rated organization, that are located near existing obligated communities, and that have the same or a similar name will likely be viewed as closely connected to the rated organization. An organization is likely to provide at least some assistance to a troubled community, or be hesitant to divest of a project that has strategic importance. Another related concept is that the obligated entity may have a “moral obligation” to support a community, particularly if it is co-branded and located in a contiguous or market with existing communities or shares a common sponsor—often a religious entity. This concept is based on the supposition that a rated entity may, from a practical standpoint, be forced to support a non-obligated facility, if not doing so could potentially cause damage to an organization’s reputation or standing within a community. For example, if a “John Doe House”, a (fictional) CCRC, adds a second campus in close geographic proximity and calls it “John Doe House South”, and the campuses are associated with each other from a marketing perspective, the parent or even John Doe House management would likely support a troubled John Doe House South rather than abandon it to bankruptcy or closure.

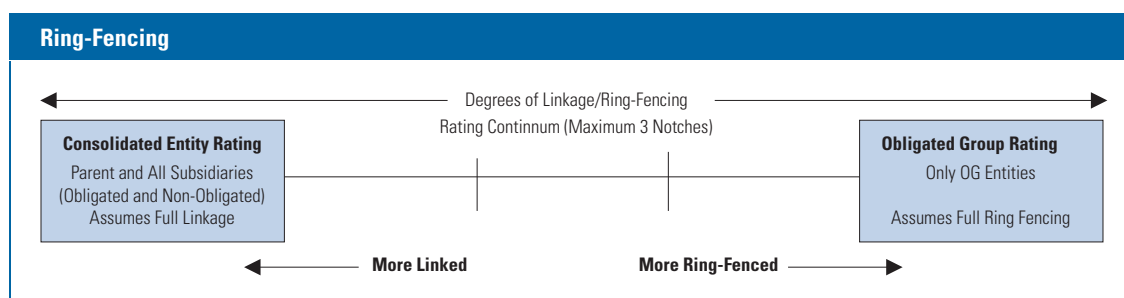
Financial Relationships Among Parties

Other evidence of linkage or separation can be detected from an analysis of the financial commit-

ments among the obligated and non-obligated entities, as well as the obligated group’s track record in dealing with affiliated projects. Most obvious areas to examine include inter-company loans, cash transfers or other movement of funds or undertaking of liabilities among obligated and non-obligated entities. Another important, but more subtle financial relationship that exists between obligated and non-obligated entities (or between a parent and its obligated and non-obligated affiliates) is related to management services. Management relationships and fees charged for management services should be clearly formulated and documented in the form of a contract. Waiving or subordinating management fees for projects that are experiencing financial difficulty is one means of providing support for an entity that falls short of explicit cash transfers, loans or subsidies. Similarly, an undefined fee methodology (or charging of higher or lower fees to communities based on financial health) can be a way to assist an ailing community. An organization’s track record in this regard is germane to assessing the degree of linkage or separation of an obligated group. A history of divesting of under-performing organizations is also helpful in this area.

Scope And Management Resources

One of the most qualitative and least tangible areas of analysis is the question of the commitment of management resources toward non-obligated ventures, and the magnitude of the non-obligated projects relative to the obligated group. Even if the obligated group is legally “ring-fenced” and has no history of financial support for non-obligated projects, significant growth activities can pose credit risk, by potentially stretching the resources of the obligated group’s management team or causing management to lose focus on core operations. Related to this, the sheer scope of non-recourse debt relative to the obligated group may be a credit concern, for example if non-recourse debt is orders of magnitude larger than the obligated group debt and financial resources.



Legal Issues Related To Non-Recourse Debt

Standard & Poor's analysis hinges upon assessing both the willingness to support non-obligated entities (demonstrated by the issues above), and the ability of an organization to do so. Across Standard & Poor's, the ability to rate an obligated group or subsidiary higher than the consolidated entity hinges first on whether the entity meets a rigorous set of legal criteria (see 'Ring-Fencing' section below). The security features are designed to limit a parent entity's ability to drive the subsidiary (in this case, an obligated group) into bankruptcy, or to transfer assets or liabilities in support of non-obligated affiliates. If the legal criteria for "ring-fencing" are met, then the other factors affecting linkage are then considered.

In addition to security features and other legal issues, the regulatory environment in which a CCRC operates also plays a role in the analysis. States with strong regulatory oversight may limit or prohibit a CCRC from transferring funds outside the community to troubled affiliates. A strong regulatory environment could have positive credit implications in this regard.

'Ring-Fencing' In The Not-For-Profit Hospital Sector

Historically, the analysis of other health care credits (i.e. acute care hospitals and health care systems) has been based on fully consolidated results including obligated and non-obligated parent companies and subsidiaries. At times this has benefited entities especially when closely aligned, for example when non-obligated foundations with large endowments are factored into overall ratings. However, in the acute care sector, the most common non-obligated subsidiaries have been physician enterprises. Typically these entities dilute the performance of the obligated group. However, the physician enterprise are generally essential to the on-going operations of the organization as a whole, so no matter

how legally segregated they are, Standard & Poor's considers them to be very closely linked to the rated entity and therefore a consolidated approach is used. Other types of subsidiaries can range from pharmacy operations, to nursing homes to medical equipment companies as well as to a broad range of horizontal expansion into control of other hospitals. While we expect to continue to review these arrangements in light of the "ring-fencing" criteria, these types of subsidiaries usually support the overall mission of the organization, are direct subsidized by the obligated group directly or indirectly, and thus would continue to be reviewed as a single organization for credit rating purposes.

'Ring-Fencing' Criteria

In general, the rating of a weaker parent constrains the rating of an otherwise financially healthy, wholly owned subsidiary. A weak parent has the ability and may have the incentive to siphon assets out of its financially healthy subsidiary and to burden it with liabilities during times of financial stress, although this scenario is less likely within a not-for-profit context. The weak parent might also have an economic incentive to file the subsidiary into bankruptcy if the parent itself were forced into bankruptcy, regardless of the subsidiary's stand-alone strength.

Ring-fencing may allow for an exception to this rule. In appropriate circumstances, a package of enhancements, including legal and structural inhibitors to a filing of the subsidiary by the parent and provision of so-called "nonpetition" language by the parent, along with other considerations such as regulatory insulation, may allow a subsidiary's rating to be elevated over the credit quality of the consolidated entity (assuming the stand-alone rating of the subsidiary merits the same). Typically, Standard & Poor's will not rate even ring-fenced subsidiaries more than three "notches" above the credit quality of the consolidated entity.

Additional Documentation Requirements For 'Ring-Fencing'

- Audited financial statements of obligated group and consolidated audited financial statements of parent and all affiliates (three years)
- Obligated group trust indenture and other legal documents, including any that evidence limitations on transfers of cash outside the obligated group
- List of board members of parent, obligated group facilities, and non-obligated facilities, including identification of independent directors
- Number and composition of board members required to transfer assets outside a community, make loans to affiliates, or file bankruptcy.
- Reserve powers of the parent and/or obligated group board of directors, particularly with regard to nomination and replacement of directors
- Copy of management services agreement and information on management fee methodology
- Any limited support agreements from parent or obligated group to non-obligated affiliates, including plans to replenish resources at the parent level if support agreements are drawn upon;
- Legal opinions (non-consolidation)
- Information on the role of the state regulatory agencies governing CCRCs.

Structural features

Structural features are focused on addressing two main concerns: (1) whether a healthy obligated group's assets may be subject to substantive consolidation in bankruptcy in the event of insolvency of the parent or non-obligated entities; and (2) whether the parent may have the ability to cause the subsidiary to file itself into bankruptcy. Moreover, the structure of a "ring-fenced" subsidiary should have mechanisms in place restricting the ability of the parent to siphon off assets or burden the subsidiary with liabilities. In structured finance, these concerns are partially addressed through the use of a special purpose entity (SPE) subsidiary. It is conceivable that some of these features can be applied to senior living 501©(3) organizations, including:

- The incorporation of each obligated group facility into a separate 501©(3), special purpose operating entity (SPOE). A special purpose operating entity is not a bankruptcy remote entity, as that term is traditionally used in structured finance transactions, although it does share some characteristics);
- The creation of a duty of the board of directors of the special purpose operating entity towards the residents of the senior living facility in question (this should be consistent with the charitable purposes for which the 501©(3) was established);
- Provision of a non-consolidation opinion between the parent and the special purpose operating entity, where appropriate;
- "Independent director" on each SPOE board, unrelated to or affiliated with the parent whose

vote is required to file the facility into bankruptcy and to approve contracts, notes or other obligations with the parent.

Covenants

Covenants are often offered as a means to justify ratings separation, particularly protective covenants (designed to limit transfers of assets) and the nonpetition covenant (in which the parent undertakes not to file the subsidiary into bankruptcy). Standard & Poor's view is that in and of themselves, covenants do not sufficiently insulate a subsidiary from its parent, but a tightly drafted covenant package is desired, including but not limited to:

- Negative pledges.
- Nonpetition covenant.
- Restrictions on asset transfer and inter-company advances.

Collateral

If debt issued by the senior living obligated group debt is fully secured by a pledge of all or substantially all of the assets of the obligated group facilities, such pledge should reduce the parent's incentive to attempt to cause the obligated group to voluntarily file itself into bankruptcy. Such a security pledge could include:

- A gross revenue pledge and a general pledge of assets, including mortgages;
- The parent's pledge of any interest in the subsidiary;
- All pledges must be perfected; and
- In addition, all non-recourse debt must be similarly secured.

For a complete description of Standard & Poor's 'ring-fencing' criteria, please see, "Ring-Fencing A Subsidiary", RatingsDirect, Oct. 19, 1999. ■

Physician Groups And Faculty Practice Plans

Health care industry changes, including reimbursement reforms at the state and national levels during the past 15 years, have helped develop and expand more cost-effective outpatient treatments. At the same time, limitations on physicians' income and the emergence of large hospital-based outpatient departments have increased physician group competition with hospitals by bringing business into physician-owned outpatient settings that

traditionally have been performed at hospitals. Ambulatory surgery and radiology procedures are two good examples that are often offered by well-organized, well-capitalized multi-specialty group practices, and typically at a lower price than hospitals. These physician groups occasionally need access to capital to build facilities and purchase equipment that will allow them to provide cost-effective health care services.