El Camino Health

AGENDA

FINANCE COMMITTEE MEETING
OF THE EL CAMINO HOSPITAL BOARD

Monday, August 28, 2023 – 5:30 pm

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

Dial-In: 1-669-900-9128. Meeting Code: 994 3644 5623#. No participant code. Just press #.

MISSION: To provide oversight, information sharing, and financial reviews related to budgeting, capital budgeting, long-range financial planning and forecasting, and monthly financial reporting for the El Camino Hospital Board of Directors. In carrying out its review, advisory, and oversight responsibilities, the Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1. CALL TO ORDER / ROLL CALL	Don Watters, Chair	**information**	**5:30 pm - 5:31 pm**
2. CONSIDER APPROVAL OF AB 2449 REQUEST	Don Watters, Chair	**possible motion** *public comment*	**5:31 - 5:32**
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Don Watters, Chair	**information**	**5:32 - 5:33**
4. PUBLIC COMMUNICATION a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not covered by the agenda.* b. Written Correspondence	Don Watters, Chair	**information**	**5:33 - 5:36**
5. CONSENT CALENDAR *Any Committee Member may remove an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Finance Committee Meeting (05/31/2023) b. FY2023 Period 11 Financial Report ***Information*** c. FY2024 Pacing Plan d. Article(s) of Interest	Don Watters, Chair	**motion required** *public comment*	**5:36 - 5:41**
6. FY2023 PERIOD 12 FINANCIAL REPORT *(Pre-Audit Results)*	Carlos Bohorquez, CFO	**motion required** *public comment*	**5:41 - 5:51**
7. ADJOURN TO CLOSED SESSION	Don Watters, Chair	**motion required** *public comment*	**5:51 - 5:52**
8. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Don Watters, Chair	**information**	**5:52 - 5:53**

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at 650-988-8483 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
9. CONSENT CALENDAR *Any Committee Member may remove an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2*: a. Minutes of the Closed Session of the Finance Committee Meeting (05/31/2023) ***Information*** *Health and Safety Code Section 32106(b):* Physician Contracts b. ED & Inpatient Cardiothoracic Surgery Call Panel Renewal Agreement (MV) c. ED & Inpatient Interventional Cardiology (STEMI) Call Panel Renewal Agreement (MV) d. Enterprise Anesthesia Services Agreement	Don Watters, Chair	**motion required**	**5:53 - 5:54**
10. *Health and Safety Code Section 32106(b)* - for a report and discussion involving healthcare facility trade secrets: **FINANCIAL PERFORMANCE JVs & BUSINESS AFFILIATES**	Carlos Bohorquez, CFO	**information**	**5:54 - 6:09**
11. *Health and Safety Code Section 32106(b)* - for a report and discussion involving healthcare facility trade secrets: **FINANCIAL YEAR-END 2023 REVIEW OF OPERATING, FINANCIAL BALANCE SHEET PERFORMANCE & KPIs** (*Pre-Audit Year End Results)*	Carlos Bohorquez, CFO	**discussion**	**6:09 - 6:29**
12. ADJOURN TO OPEN SESSION	Don Watters, Chair	**motion required**	**6:29 - 6:30**
13. RECONVENE OPEN SESSION / REPORT OUT	Don Watters, Chair	**information**	**6:30 - 6:31**
To report any required disclosures regarding permissible actions taken during the Closed Session.			
14. CONTRACTS & AGREEMENTS ***Approval*** a. ED & Inpatient Cardiothoracic Surgery Call Panel Renewal Agreement (MV) b. ED & Inpatient Interventional Cardiology (STEMI) Call Panel Renewal Agreement (MV) ***Recommended for Board Approval*** c. Enterprise Anesthesia Services Agreement	Mark Adams, MD, CMO	**motion required** *public comment*	**6:31 - 6:34**
15. CLOSING COMMENTS	Don Watters, Chair	**information**	**information 6:34 - 6:39**
16. ADJOURNMENT	Don Watters, Chair	**motion required** *public comment*	**6:39 pm - 6:40 pm**

Upcoming Meetings:
Regular Meetings: September 25, 2023, November 27, 2023, February 26, 2023 (Joint IC-FC), March 25, 2023, May 27, 2023

Minutes of the Open Session of the
Finance Committee of the
El Camino Hospital Board of Directors
Wednesday, May 31, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Staff Present
Don Watters, Chair**		**Carlos Bohorquez**, Chief Financial Officer
Wayne Doiguchi		**Dan Woods**, Chief Executive Officer
Peter Fung, MD		**Mark Adams, MD,** Chief Medical Officer
Bill Hooper		**Ken King,** Chief Administrative Services Officer
Cynthia Stewart**	**via teleconference	**Omar Chughtai,** Chief Growth Officer
		Victor Cabrera, Dir, Decision Support & Business Analytics
		Jon Cowan, Sr. Dir. Government Relations & Community Partnerships
		Samreen Salehi, Executive Assistant II

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Finance Committee of El Camino Hospital (the "Committee") was called to order at 5:30 pm by Chair Don Watters. A verbal roll call was taken and all members were present at roll call and attended in person except for Chair Watters and Cynthia Stewart joined telephonically under the AB2449 guidelines. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020.	
2. CONSIDER APPROVAL OF AB 2449 REQUEST	Chair Watters and Cynthia Stewart participated in this session via Zoom under the "Just Cause" guidelines of the AB2449 request therefore a motion is not required.	
3. POTENTIAL CONFLICT OF INTEREST	Chair Watters asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts reported.	
4. CONSENT CALENDAR	**Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Finance Committee meeting (03/27/2023) (b) FY2024 Committee Planning: Goals, Pacing Plan and Meeting Dates (c) FY2023 Period 9 Financial Report and for information: (d) Progress Against FY2023 Pacing Plan (e) Article(s) of Interest. **Movant:** Fung **Second:** Doiguchi **Ayes:** Doiguchi, Fung, Hooper, Stewart, Watters **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Consent Calendar approved.***
5. REPORT ON BOARD ACTIONS	Chair Watters asked the Committee for any questions or feedback on the Report on Board Actions, as further detailed in the packet.	
6. FY2023 PERIOD 10 FINANCIAL REPORT	Carlos Bohorquez, Chief Financial Officer presented the FY2023 Period 10 Operational/ Financial results as of April 30th, 2023, and highlighted the following:	

	• Mr. Bohorquez began the discussion by stating that April is a unique month as it had only twenty working days, leading to lower activity across the organization as demonstrated by total discharges. • Adjusted discharges for April is 3,414 versus budget of 3,568 which were unfavorable to budget by 4.3%. **Overall Financial Performance** • Total operating revenue of $120.6 million. • Operating EBIDA of $19.4 million favorable to budget by $0.8 million • Days cash on hand (DCOH) is one area that we are below target which is attributed to the following indicators: 1) The slowdown of payments by the payors 2) We fully repaid the Medicare advanced payments made by the Federal Government at the onset of Covid. 3) We continue to invest in significant capital projects throughout the enterprise. 4) Last calendar year our investment portfolio decreased by more than 10%. • From an operations standpoint, net days in AR are higher than target which is attributed to ongoing challenges with private payors. • Total operating revenue of $1.191B is 2.2% better than budget and 6.6% better than last fiscal year. • Operating EBIDA is favorable to budget by $508,000. However, compared to the same period last fiscal year is lower by almost $24M. This is the result of funding of additional FTEs across the organization to support growth / quality and the impact of higher utilization of contract labor / premium pay. **Motion**: To approve the FY2023 Period 10 Financial Report **Movant:** Doiguchi **Second:** Fung **Ayes:** Doiguchi, Fung, Hooper, Stewart, Watters **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
7. FY2024 EL CAMINO HEALTH IMPLEMENTATION STRATEGY REPORT AND COMMUNITY BENEFIT PLAN	Jon Cowan, Senior Director of Government Relations & Community Partnerships presented the FY2024 El Camino Health Implementation Strategy Report and Community Benefits Plan and highlighted the following: Mr. Cowan stated the FY2024 El Camino Health Implementation Strategy Report and Community Benefits Plan reflects a total request of $6,342,431 and includes funding recommendations for grants, sponsorships, and placeholders. **Grant Proposals:** 44 recommended at $3,310,000 • Total Proposals: 71 (18% increase over prior year) • Total Requested: $6,342,431 (17% increase over prior year) • Total Funded: $3,310,000 (0% increase over prior year)	

	• Total Unfunded: $3,032,431 (43% increase over prior year) • Sponsorships: Recommended = $85,000 • Placeholder: Recommended = $15,000 • Placeholder process: Designated funds to be used in accordance with the ECH Community Benefit Grants Policy/Placeholder • FY2024 ECH Total Plan Request: $3,410,000 **Motion**: To approve the FY2024 ECH Implementation Strategy Report & Community Benefit Plan **Movant:** Fung **Second:** Doiguchi **Ayes:** Doiguchi, Fung, Hooper, Stewart, Watters **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
8. CAPITAL PROJECT APPROVAL (a) Cancer Center Expansion	Ken King, Chief Administrative Officer presented an overview of the Mountain View (MV) Cancer Center Minor Expansion Project and highlighted the following: • MV Outpatient Cancer Center continues to increase patient visits and infusion treatments. Patient visits are projected to grow by 27% over the next five years and another 20% in the following five years. • This minor expansion requires us to convert existing administrative space into clinical space by constructing three additional exam rooms, three additional scheduling stations, and support spaces for additional oncologists and support staff. • MV Cancer Center Minor Expansion Project, not to exceed $1,435,000. **Motion**: To approve the Cancer Center Expansion **Movant:** Hooper **Second:** Fung **Ayes:** Doiguchi, Fung, Hooper, Stewart, Watters **Noes:** None **Abstentions:** None **Absent:** None	
9. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:03 pm. **Movant:** Fung **Second:** Doiguchi **Ayes:** Doiguchi, Fung, Hooper, Stewart, Watters **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 6:03 pm***
10. AGENDA ITEM 18: RECONVENE OPEN SESSION/REPORT OUT	During the Closed Session, the Finance Committee approved the following items: Closed Session Minutes of the March 27th, 2023 Finance Committee Meeting, the FY2024 Operating and Capital Budget, the Ambulatory Surgery Center Acquisition, the Specialty Medical Group	

	PSA, the Medical Staff Development Plan, and the Anesthesia Services Agreement by a unanimous vote of all Committee Members present (Mr. Doiguchi, Dr. Fung, Mr. Hooper, Ms. Stewart, Mr. Watters).	
11. AGENDA ITEM 19: PHYSICIAN CONTRACTS & AGREEMENTS	**Motion:** To approve physician contracts. **Movant:** Fung **Second:** Doiguchi **Ayes:** Doiguchi, Fung, Hooper, Stewart, Watters **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	
12. AGENDA ITEM 20: CLOSING COMMENTS	None	
13. AGENDA ITEM 21: ADJOURNMENT	**Motion:** To adjourn at 7:49 pm. **Movant:** Fung **Second:** Doiguchi **Ayes:** Doiguchi, Fung, Hooper, Stewart, Watters **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:49 pm***

Attest as to the approval of the foregoing minutes by the Finance Committee of El Camino Hospital:

_____

Don Watters
Chair, Finance Committee

Prepared by: Samreen Salehi, Executive Assistant II, Administrative Services

El Camino Health

Summary of Financial Operations

Fiscal Year 2023 – Period 11

7/1/2022 to 05/31/2023

Executive Summary - Overall Commentary for Period 11

- **Challenging Financial Results for Period 11:**
  - Gross charges were favorable to budget by $36.9M / 7.8%.
    - Driven by Inpatient activity
      - Inpatient Charges $28.5M / 12.8% favorable to budget
      - Outpatient Charges $10.5M / 4.4% favorable to budget
      - Professional Charges: $2.1M / 17.7% unfavorable to budget
  - Cost Management
    - When adjusted for volume, overall operating expense unfavorable to budget by 2.5%
    - Labor: Improved Contract Labor levels and sustained improvement in overtime
- Net patient revenue was unfavorable to budget by $107K / 0.1% and $8.7M / 7.9% higher than the same period last year.
- Operating margin was unfavorable to budget by $1.7M / 11.8% and $5.8M / 32.1% lower than the same period last year. This was primarily driven by unfavorable payor mix, with commercial being 3.4% lower than budget.
- Operating EBIDA was unfavorable to budget by $897K / 4.2% and $5.2M / 20.5% lower than the same period last year.
- Net income was unfavorable to budget by $3.8M and $6.7M lower than the same period last year.

Operational / Financial Results: Period 11 – May 2023 (as of 05/31/2023)

($ thousands)

		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	313	272	41	15.2%	293	19	6.6%	---	---	---
	Total Acute Discharges	1,851	1,820	31	1.7%	1,850	1	0.1%	---	---	---
	Adjusted Discharges	3,678	3,761	(83)	(2.2%)	3,571	107	3.0%	---	---	---
	Emergency Room Visits	7,225	5,614	1,611	28.7%	5,931	1,294	21.8%	---	---	---
	OP Procedural Cases	11,138	14,042	(2,904)	(20.7%)	12,681	(1,543)	(12.2%)	---	---	---
	Gross Charges ($)	508,380	471,466	36,915	7.8%	445,891	62,489	14.0%	---	---	---
Operations	Total FTEs	3,324	3,393	(69)	(2.0%)	3,236	87	2.7%	---	---	---
	Productive Hrs. / APD	27.3	29.0	(1.7)	(5.9%)	28.5	(1.2)	(4.3%)	---	---	---
	Cost Per CMI AD	18,482	18,036	446	2.5%	16,231	2,251	13.9%	---	---	---
	Net Days in A/R	56.5	54.0	2.5	4.6%	57.6	(1.1)	(2.0%)	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	118,737	118,844	(107)	(0.1%)	110,010	8,727	7.9%	138,547	82,105	
	Total Operating Revenue ($)	128,590	122,859	5,732	4.7%	113,307	15,283	13.5%	152,743	109,602	
	Operating Margin ($)	**12,324**	**13,977**	**(1,653)**	(11.8%)	**18,138**	**(5,814)**	(32.1%)	**1,915**	**3,836**	
	Operating EBIDA ($)	**20,387**	**21,284**	**(897)**	(4.2%)	**25,632**	**(5,245)**	(20.5%)	**11,188**	**10,741**	
	Net Income ($)	13,143	16,991	(3,848)	(22.6%)	19,834	(6,691)	(33.7%)	8,124	7,343	
	Operating Margin (%)	**9.6%**	**11.4%**	**(1.8%)**	(15.8%)	**16.0%**	**(6.4%)**	(40.1%)	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**15.9%**	**17.3%**	**(1.5%)**	(8.5%)	**22.6%**	**(6.8%)**	(29.9%)	**8.3%**	**9.8%**	
	DCOH (days)	256	325	(69)	(21.2%)	291	(35)	(11.9%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021. Dollar amounts have been adjusted to reflect monthly averages.
DCOH total includes cash, short-term and long-term investments.

El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Operational / Financial Results: YTD FY2023 (as of 05/31/2023)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	306	264	42	16.0%	275	31	11.2%	---	---	---
	Total Acute Discharges	20,161	19,308	853	4.4%	19,529	632	3.2%	---	---	---
	Adjusted Discharges	39,028	38,823	205	0.5%	38,151	877	2.3%	---	---	---
	Emergency Room Visits	70,574	60,704	9,870	16.3%	61,358	9,216	15.0%	---	---	---
	OP Procedural Cases	124,417	147,852	(23,435)	(15.9%)	140,423	(16,006)	(11.4%)	---	---	---
	Gross Charges ($)	5,264,555	4,903,243	361,313	7.4%	4,677,251	587,304	12.6%	---	---	---
Operations	Total FTEs	3,298	3,319	(21)	(0.6%)	3,091	207	6.7%	---	---	---
	Productive Hrs. / APD	27.9	30.3	(2.4)	(7.8%)	28.8	(0.9)	(3.0%)	---	---	---
	Cost Per CMI AD	18,020	18,036	(16)	(0.1%)	16,457	1,564	9.5%	---	---	---
	Net Days in A/R	56.5	54.0	2.5	4.6%	57.6	(1.1)	(2.0%)	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	1,263,682	1,243,145	20,537	1.7%	1,191,241	72,441	6.1%	1,524,020	903,150	
	Total Operating Revenue ($)	1,320,062	1,288,722	31,340	2.4%	1,231,179	88,883	7.2%	1,671,003	1,205,623	
	Operating Margin ($)	**125,104**	**130,799**	**(5,695)**	(4.4%)	**158,670**	**(33,566)**	(21.2%)	**21,063**	**42,197**	
	Operating EBIDA ($)	**212,550**	**212,940**	**(390)**	(0.2%)	**241,491**	**(28,941)**	(12.0%)	**123,072**	**118,151**	
	Net Income ($)	211,416	162,691	48,725	29.9%	56,207	155,209	276.1%	89,369	80,777	
	Operating Margin (%)	**9.5%**	**10.1%**	**(0.7%)**	(6.6%)	**12.9%**	**(3.4%)**	(26.5%)	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**16.1%**	**16.5%**	**(0.4%)**	(2.6%)	**19.6%**	**(3.5%)**	(17.9%)	**8.3%**	**9.8%**	
	DCOH (days)	256	325	(69)	(21.2%)	291	(35)	(11.9%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021
DCOH total includes cash, short-term and long-term investments.

El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Consolidated Balance Sheet (as of 05/31/2023)

($000s)

ASSETS		Audited
CURRENT ASSETS	**May 31, 2023**	**June 30, 2022**
Cash	251,448	196,067
Short Term Investments	111,857	125,816
Patient Accounts Receivable, net	218,785	209,668
Other Accounts and Notes Receivable	18,444	21,044
Intercompany Receivables	12,784	13,998
Inventories and Prepaids	37,608	36,476
Total Current Assets	**650,927**	**603,068**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	22,222	18,721
Plant & Equipment Fund	399,276	310,045
Women's Hospital Expansion	30,662	30,261
Operational Reserve Fund	207,898	182,907
Community Benefit Fund	17,730	18,299
Workers Compensation Reserve Fund	14,029	14,029
Postretirement Health/Life Reserve Fund	30,688	29,783
PTO Liability Fund	35,076	33,709
Malpractice Reserve Fund	1,906	1,906
Catastrophic Reserves Fund	26,208	24,668
Total Board Designated Assets	**785,696**	**664,329**
FUNDS HELD BY TRUSTEE	**-**	**0**
LONG TERM INVESTMENTS	**461,549**	**495,751**
CHARITABLE GIFT ANNUITY INVESTMENTS	**932**	**940**
INVESTMENTS IN AFFILIATES	**32,418**	**30,376**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,854,021	1,872,501
Less: Accumulated Depreciation	(784,575)	(778,427)
Construction in Progress	165,659	96,603
Property, Plant & Equipment - Net	**1,235,105**	**1,190,676**
DEFERRED OUTFLOWS	18,771	19,474
RESTRICTED ASSETS	37,119	31,200
OTHER ASSETS	205,103	216,842
TOTAL ASSETS	**3,427,619**	**3,252,657**

LIABILITIES AND FUND BALANCE		Audited
CURRENT LIABILITIES	**May 31, 2023**	**June 30, 2022**
Accounts Payable	41,949	51,286
Salaries and Related Liabilities	42,809	46,502
Accrued PTO	35,919	34,449
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	12,353	14,942
Intercompany Payables	9,246	13,489
Malpractice Reserves	2,096	2,096
Bonds Payable - Current	10,400	9,905
Bond Interest Payable	6,312	8,096
Other Liabilities	12,097	20,955
Total Current Liabilities	**175,481**	**204,021**
LONG TERM LIABILITIES		
Post Retirement Benefits	30,688	29,783
Worker's Comp Reserve	14,029	14,029
Other L/T Obligation (Asbestos)	34,208	37,944
Bond Payable	455,108	466,838
Total Long Term Liabilities	**534,034**	**548,593**
DEFERRED REVENUE-UNRESTRICTED	**6,568**	**12,312**
DEFERRED INFLOW OF RESOURCES	**111,050**	**104,367**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,346,995	2,136,565
Board Designated	208,939	210,197
Restricted	44,553	36,601
Total Fund Bal & Capital Accts	**2,600,486**	**2,383,363**
TOTAL LIABILITIES AND FUND BALANCE	**3,427,619**	**3,252,657**

El Camino Health

FY2024 Finance Committee Pacing Plan												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/28	9/25	OCT	11/27	DEC	JAN	2/26	3/25	APR	5/27	JUN
STANDING AGENDA ITEMS												
Standing Consent Agenda Items		✓	✓		✓			✓	✓		✓	
Minutes		✓	✓		✓			✓	✓		✓	
Period Financials Report (Approval)		✓	✓		✓			✓	✓		✓	
Board Actions		✓	✓		✓			✓	✓		✓	
APPROVAL ITEMS												
Candidate Interviews & Recommendation to Appoint (If required to add / replace committee member)												
Financial Report Year End Results			✓									
Next FY Committee Goals, Dates, Plan									✓		✓	
Next FY Org. Goals											✓	
Next FY Community Benefit Grant Program											✓	
Physician Contracts		✓	✓		✓			✓	✓		✓	
DISCUSSION ITEMS												
Financial Report (Pre-Audit Year End Results)		✓										
Financial Performance JVs/ Business Affiliates		✓										
Progress on Opportunities/ Risks					✓							
Medical Staff Development Plan (every 2 years)									✓			
Impact of Strategic Initiatives/Market Share Update								✓				
Progress Against Committee Goals & Pacing Plan (Quarterly)					✓			✓			✓	
Foundation Strategic Update					✓							

FY2024 Finance Committee Pacing Plan												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/23	9/25	OCT	11/27	DEC	JAN	2/26	3/25	APR	5/27	JUN
ECHMN Update					✓				✓			
Community Benefit Grant Application Process					✓				✓			
Progress Against 2027 Strategic Plan					✓				✓		✓	
Key Service Lines Performance/ Growth Plans											✓	
Managed Care Update								✓				
Long-Range Financial Forecast								✓				
Next FY Budget and Preliminary Assumptions Review									✓			
Review FY Operational / Capital Budget for Recommendation to Board									✓		✓	
Summary Physician Financial Arrangements									✓			
Post Implementation (as needed)												
Other Updates[1] (as needed)												

1: Includes updates on special projects/joint ventures/real estate, ad-hoc updates

KaufmanHall

JUNE 2023

National Hospital Flash Report

Real Data. Real Insight. Real Time.

Based on May Data from More Than 1,300 Hospitals

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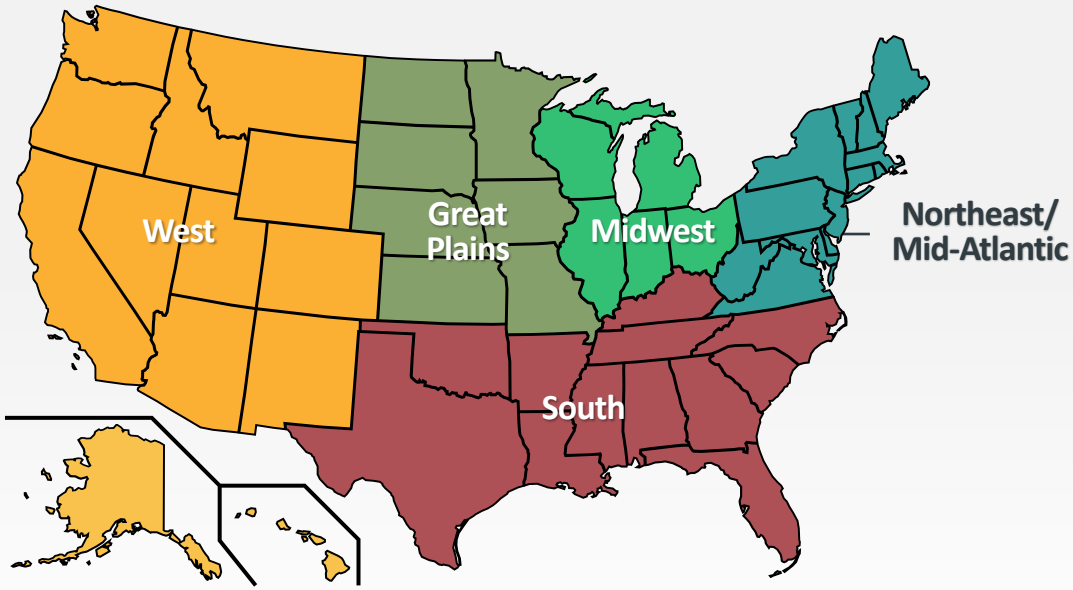
About the Data

The *National Hospital Flash Report* uses both actual and budget data over the last three years, sampled from more than 1,300 hospitals on a recurring monthly basis from Syntellis Performance Solutions.

The sample of hospitals for this report is representative of all hospitals in the United States both geographically and by bed size. Additionally, hospitals of all types are represented, from large academic to small critical access. Advanced statistical techniques are used to standardize data, identify and handle outliers, and ensure statistical soundness prior to inclusion in the report.

While this report presents data in the aggregate, Syntellis Performance Solutions also has real-time data down to individual department, jobcode, paytype, and account levels, which can be customized into peer groups for unparalleled comparisons to drive operational decisions and performance improvement initiatives.

Map of Regions



About the Data *(continued)*

About Kaufman Hall

KaufmanHall

Kaufman Hall provides management consulting solutions to help society's foundational institutions realize sustained success amid changing market conditions. Since 1985, Kaufman Hall has been a trusted advisor to boards and executive management teams, helping them incorporate proven methods, rigorous analytics, and industry-leading solutions into their strategic planning and financial management processes, with a focus on achieving their most challenging goals.

Kaufman Hall services use a rigorous, disciplined, and structured approach that is based on the principles of corporate finance. The breadth and integration of Kaufman Hall advisory services are unparalleled, encompassing strategy; financial and capital planning; performance improvement; treasury and capital markets management; mergers, acquisitions, partnerships, and joint ventures; and real estate.

About Syntellis Performance Solutions

SYNTELLIS

Syntellis Performance Solutions provides innovative enterprise performance management software, data and intelligence solutions for healthcare organizations. Its solutions include enterprise planning, cost and decision support, and financial and clinical analytics tools to elevate organizational performance and transform vision into reality. With over 2,800 organizations and 450,000 users relying on its Axiom, Connected Analytics and Stratasan software, combined with No. 1 rankings from Black Book Research and an HFMA Peer Review designation for six consecutive years, Syntellis helps healthcare providers acquire insights, accelerate decisions and advance their business plans. For more information, please visit syntellis.com.

Key Takeaways

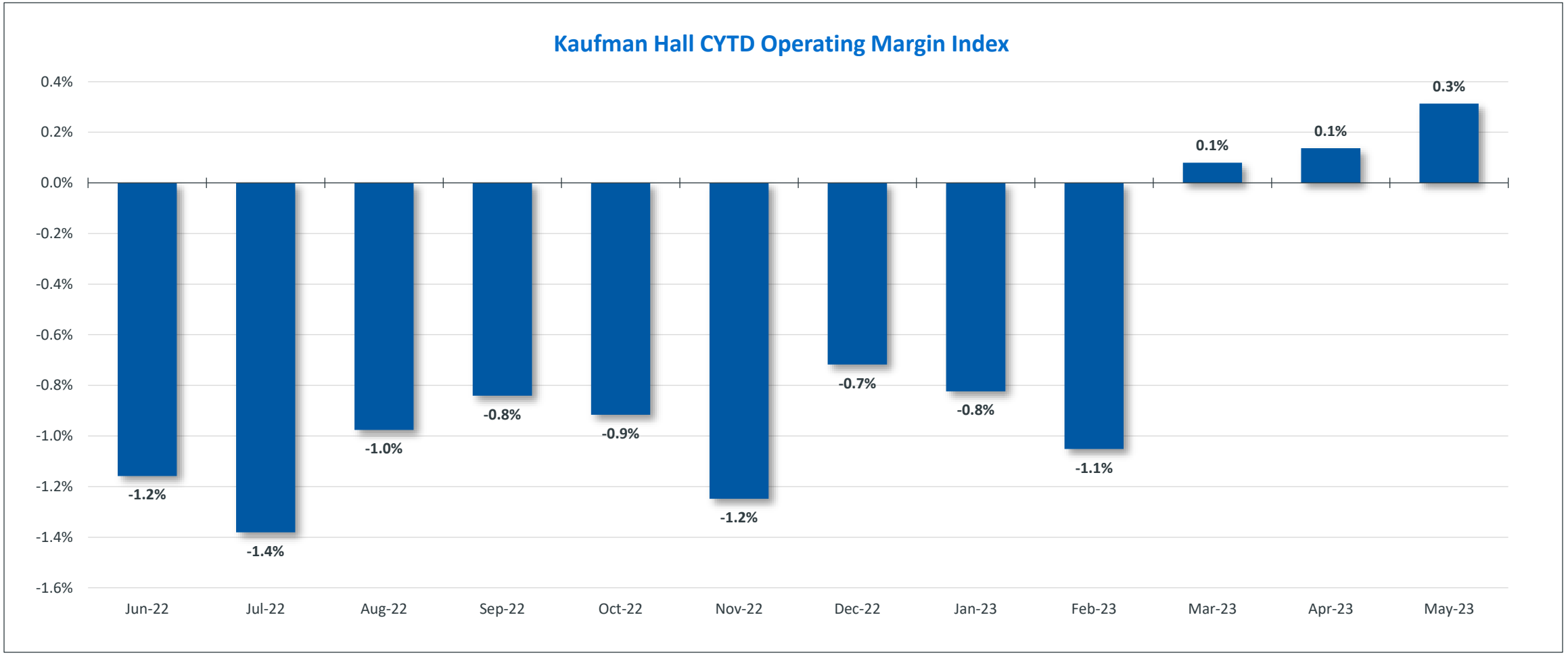
1. **Hospitals' operating margins moved back into positive territory in May.**
   However, operating margins continue to stand well below historical norms.

2. **People are becoming more comfortable with inpatient care.**
   Discharges, emergency department visits and operating room minutes all climbed, although very modestly on a year-to-date basis.

3. **There is a sizeable and growing gap between primary hospital revenue sources.**
   Revenue from outpatient care is increasing at a much greater rate than revenue from inpatient care.

4. **Labor expenses are beginning to decline.**
   While labor costs remain significant, expenses in May were well below comparable levels from May 2022.

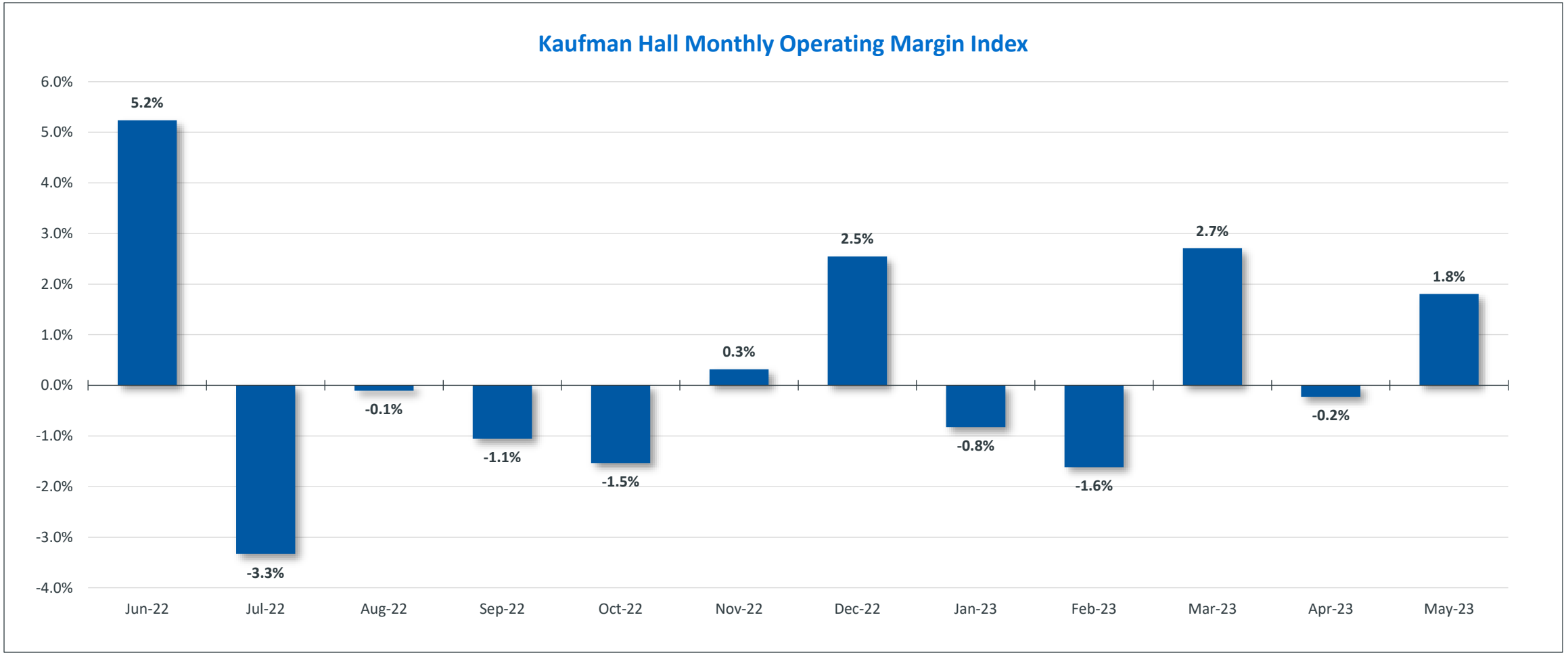
Operating Margin



Kaufman Hall, *National Hospital Flash Report* (June 2023)

** Note: The Kaufman Hall Hospital Operating Margin and Operating EBITDA Margin Indices are comprised of the national median of our dataset adjusted for allocations to hospitals from corporate, physician, and other entities.*

Operating Margin *(continued)*



Kaufman Hall, *National Hospital Flash Report* (June 2023)

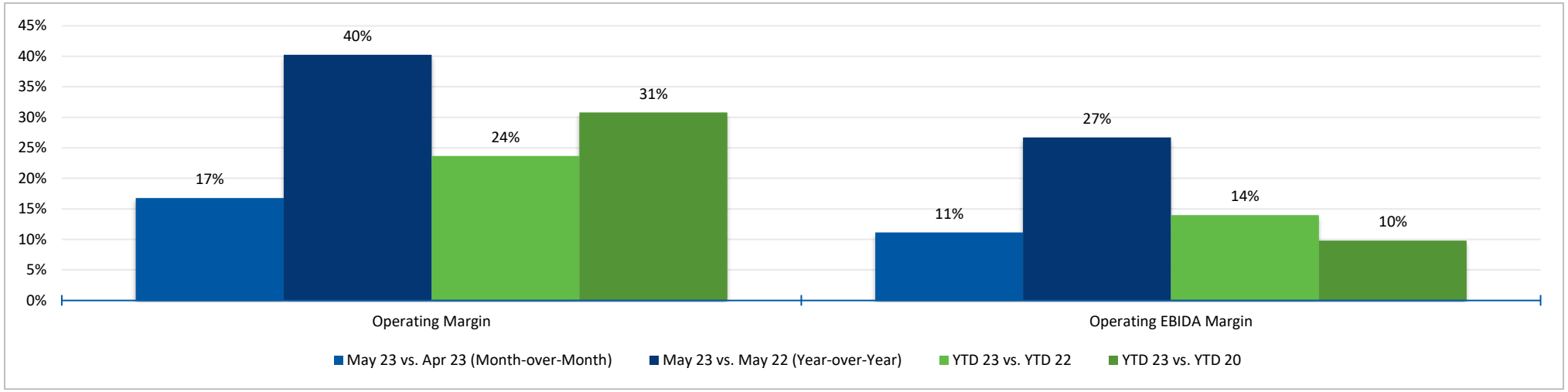
** Note: The Kaufman Hall Hospital Operating Margin and Operating EBITDA Margin Indices are comprised of the national median of our dataset adjusted for allocations to hospitals from corporate, physician, and other entities.*

National and Regional Data

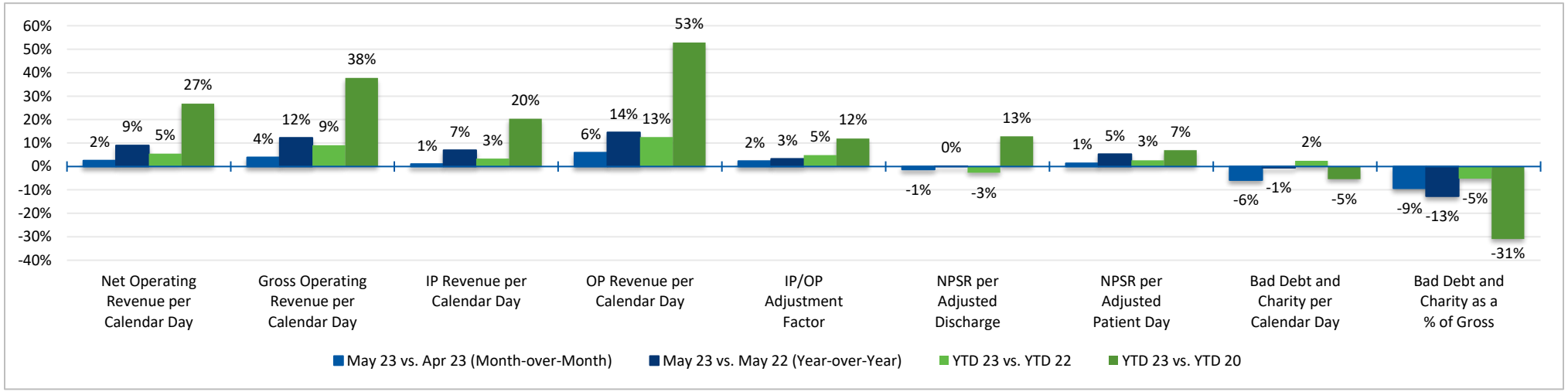
Profitability, Revenue, Expense, and Volume

National Data

Profitability

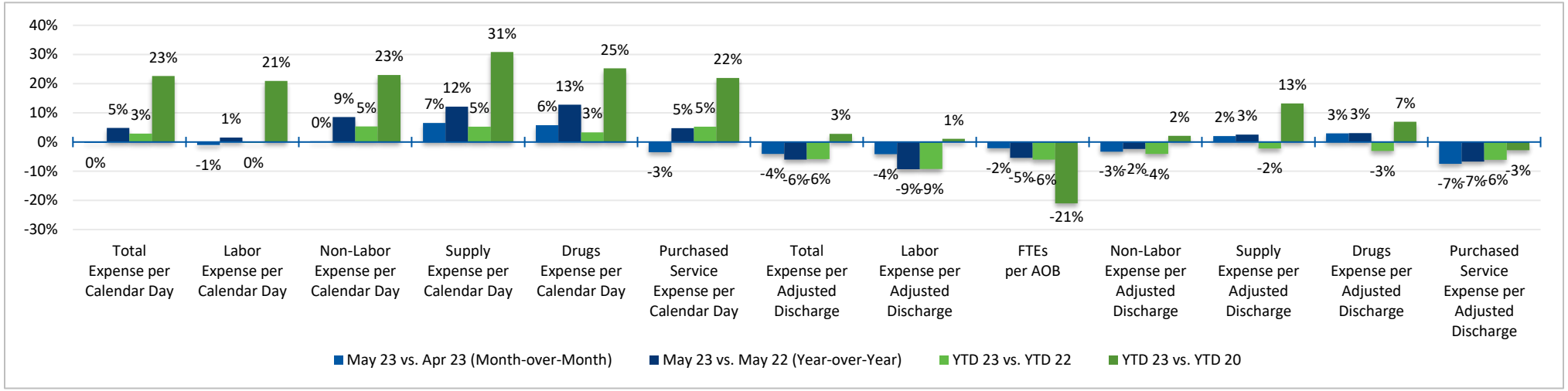


Revenue

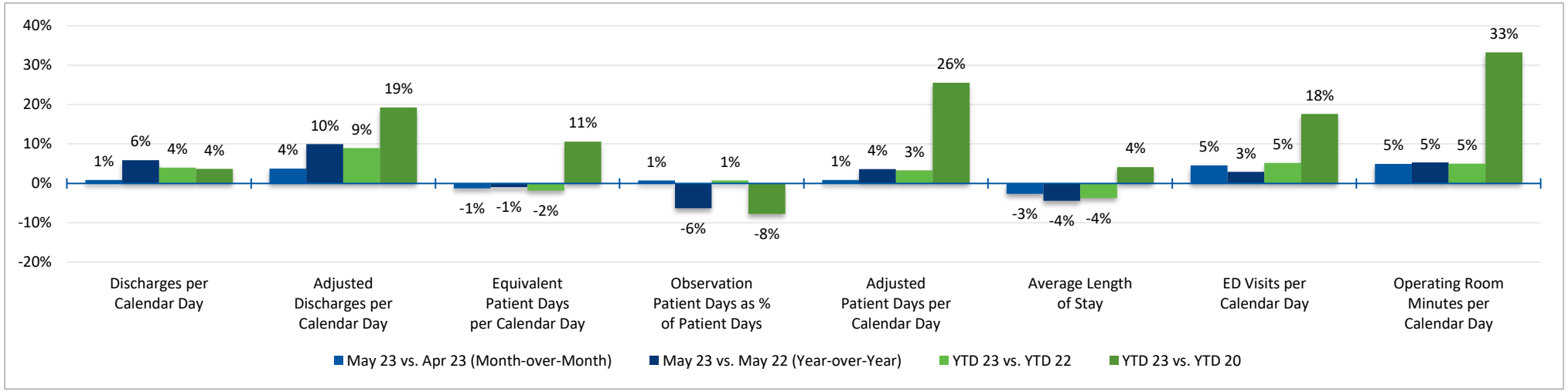


National Data *(continued)*

Expense

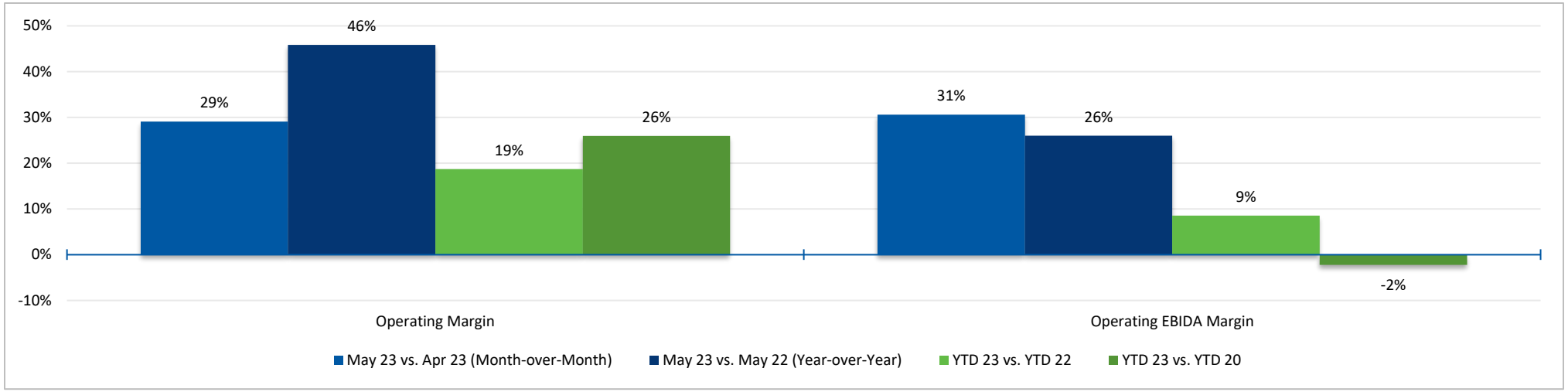


Volume

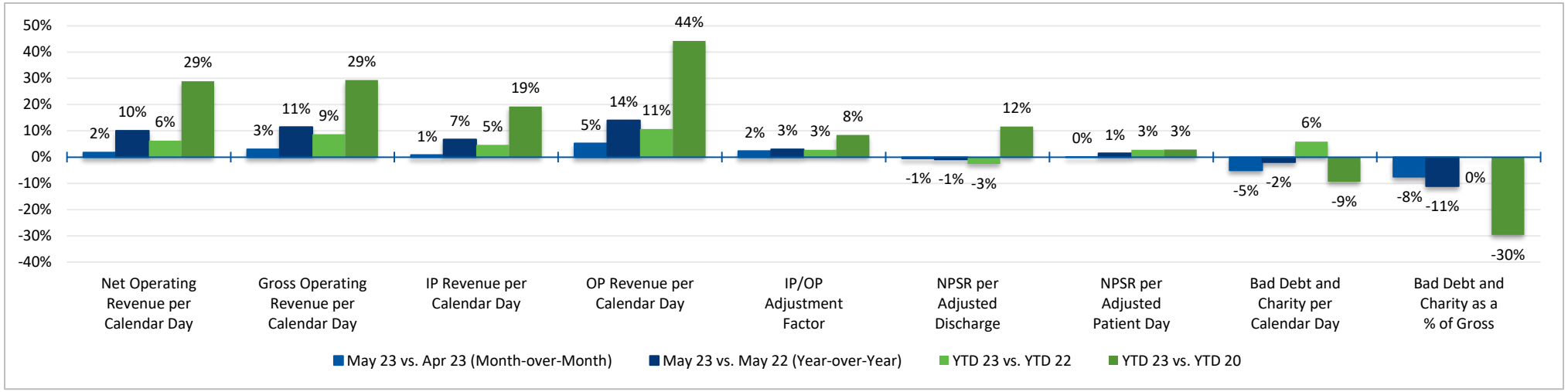


Regional Data: West

Profitability

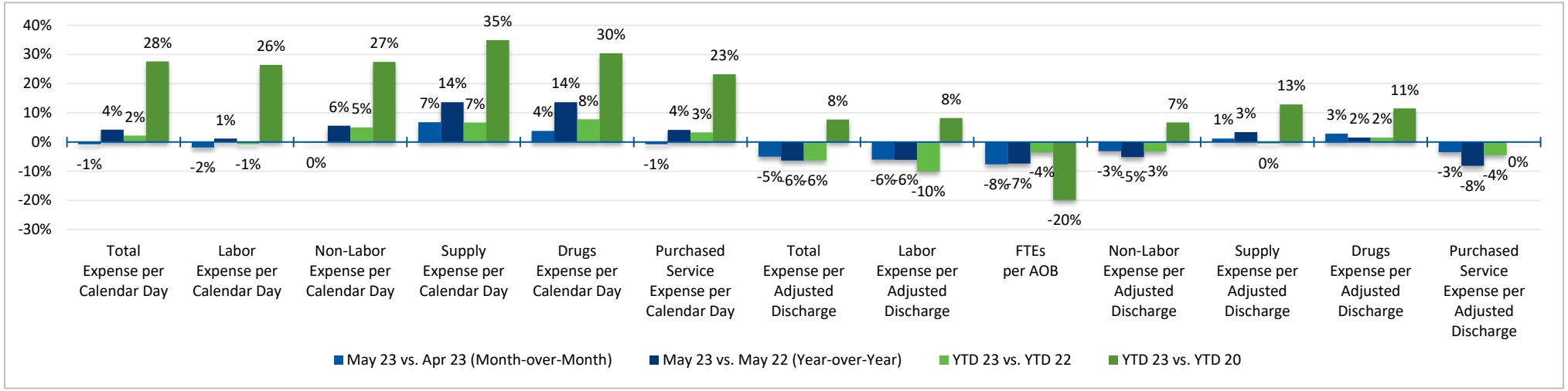


Revenue

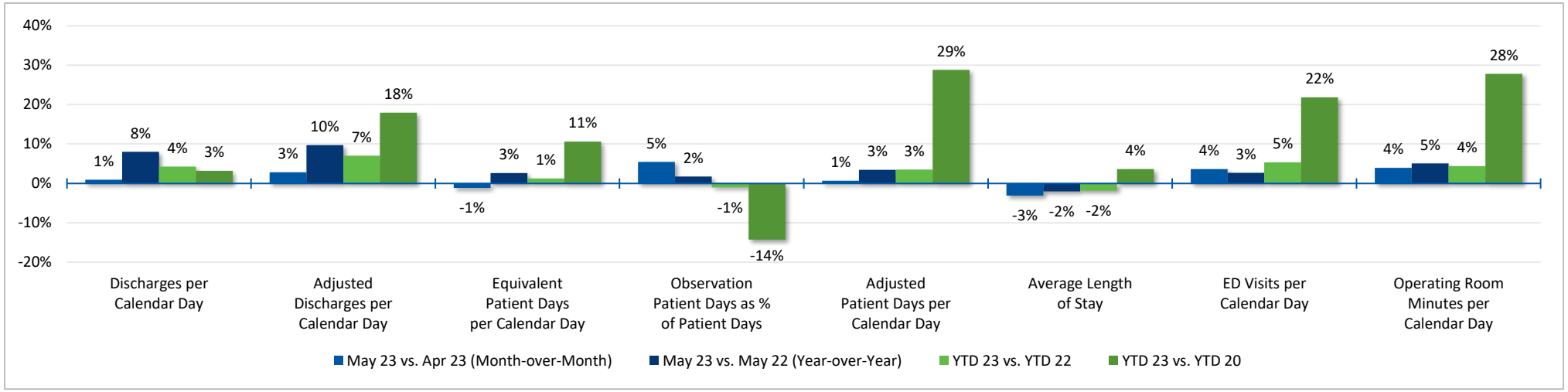


Regional Data: West *(continued)*

Expense

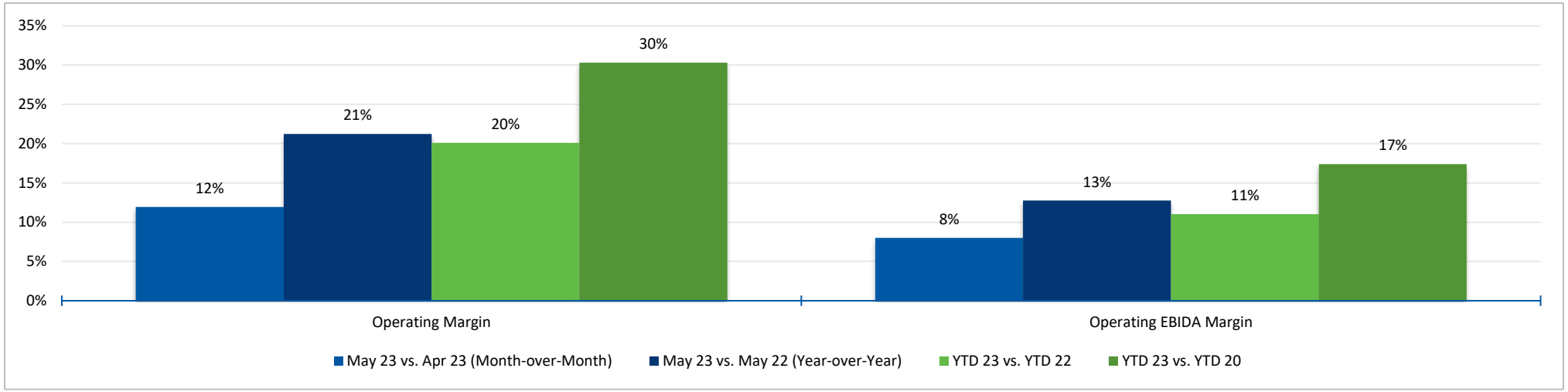


Volume

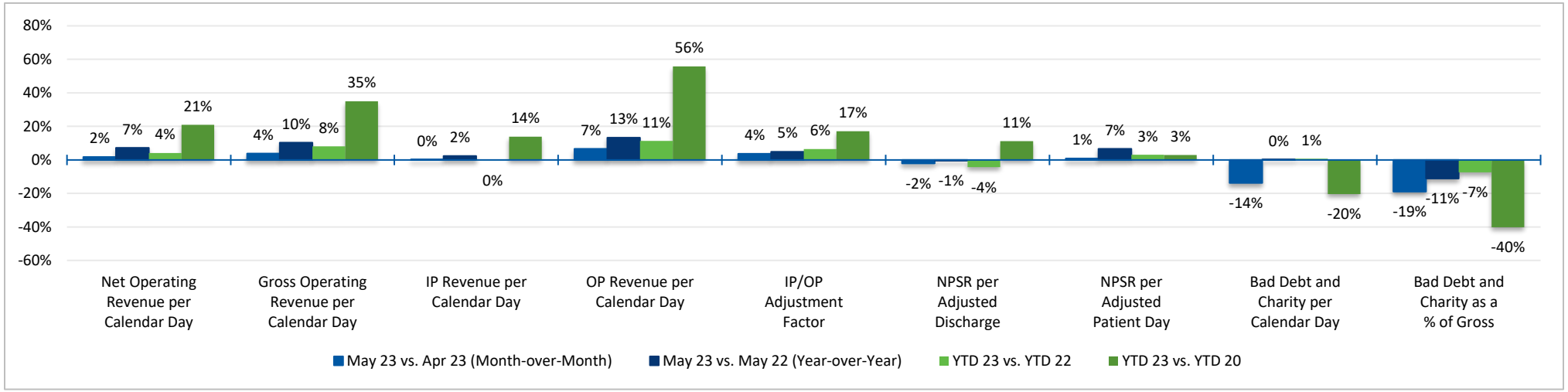


Regional Data: Midwest

Profitability

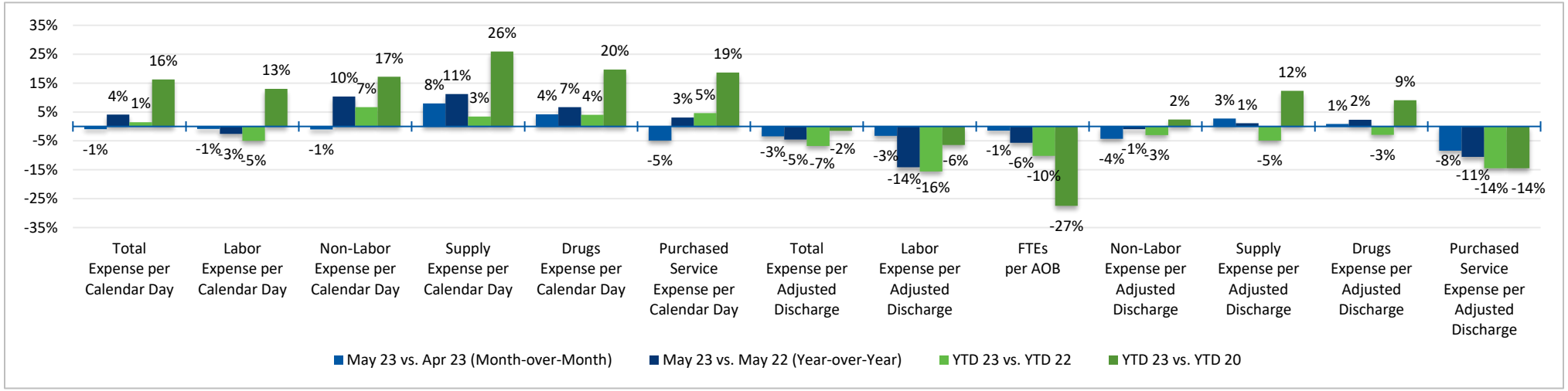


Revenue

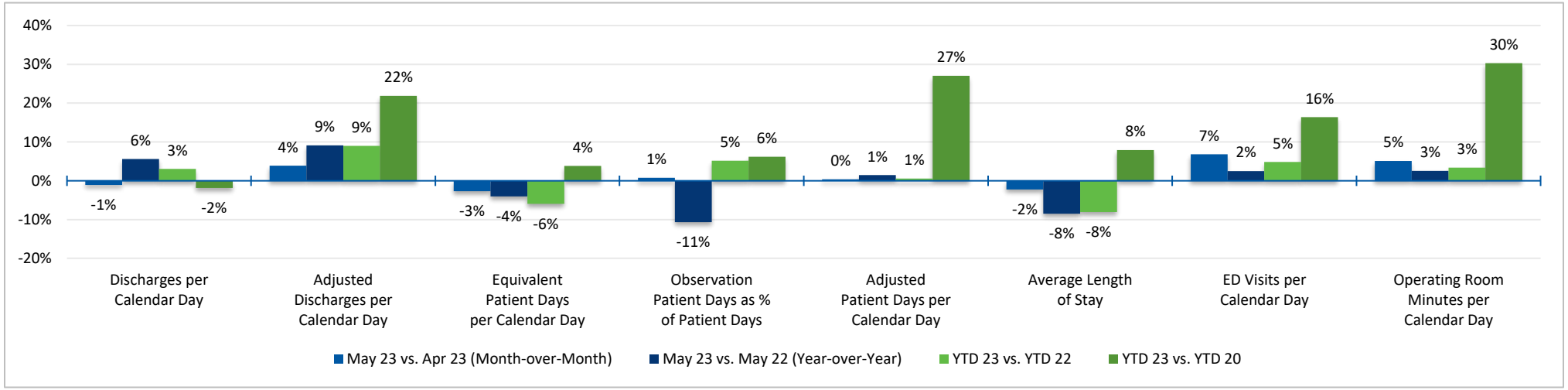


Regional Data: Midwest *(continued)*

Expense

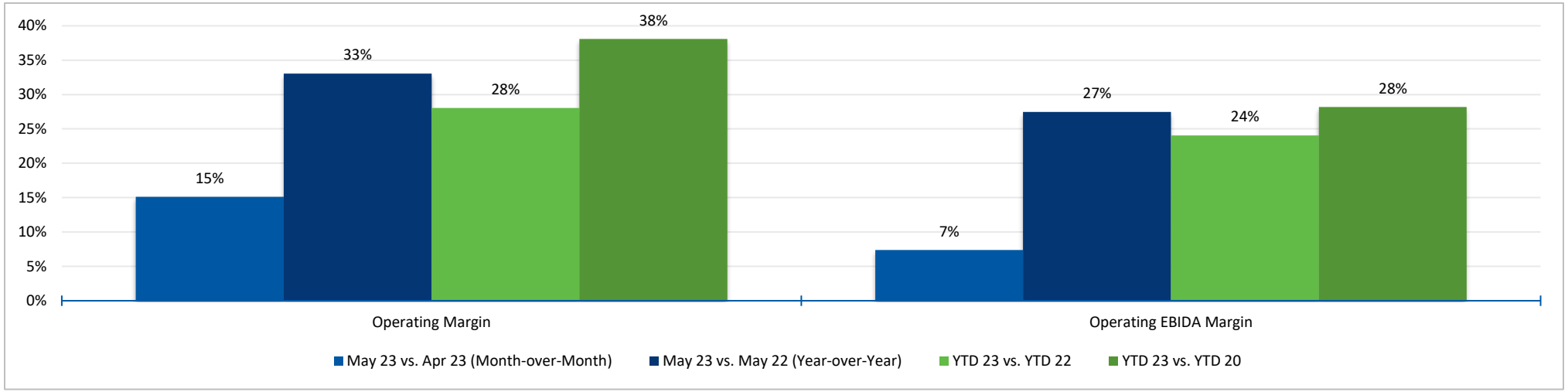


Volume

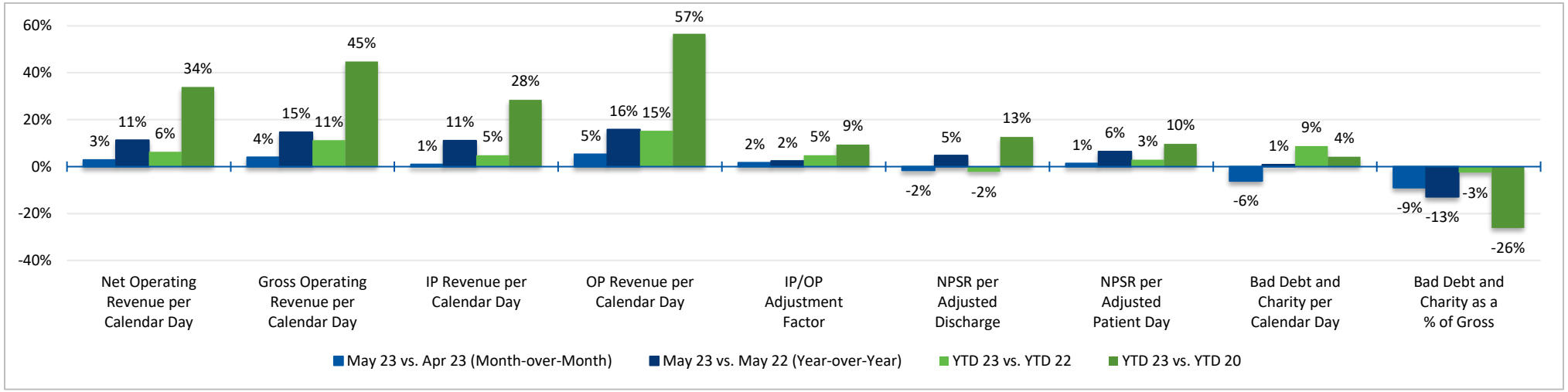


Regional Data: South

Profitability

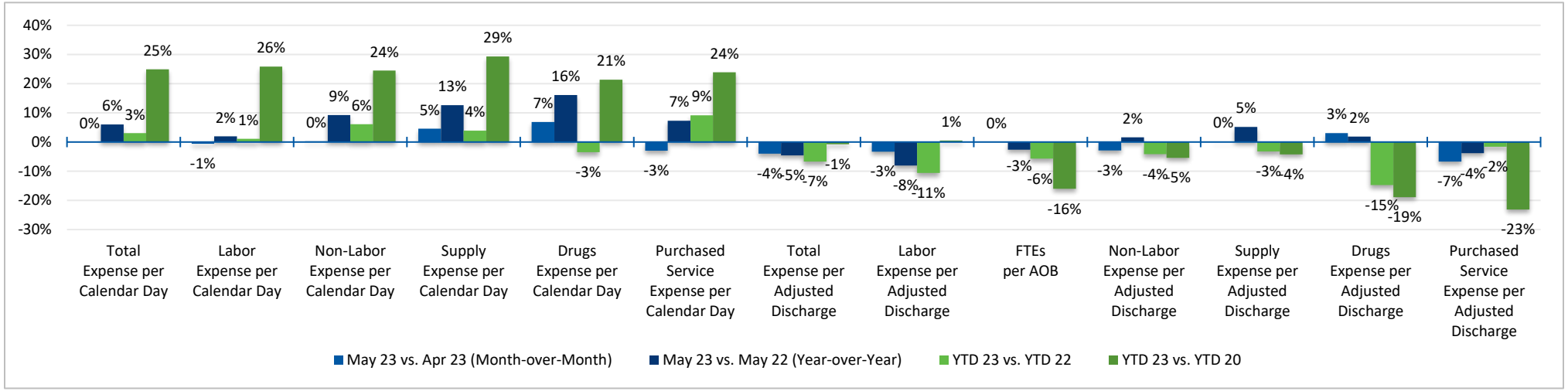


Revenue

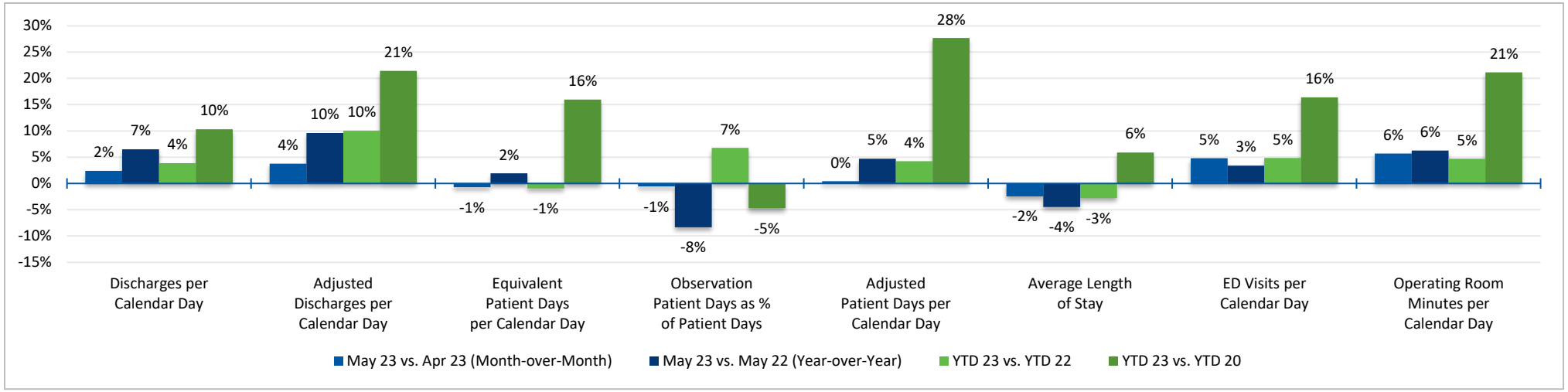


Regional Data: South *(continued)*

Expense

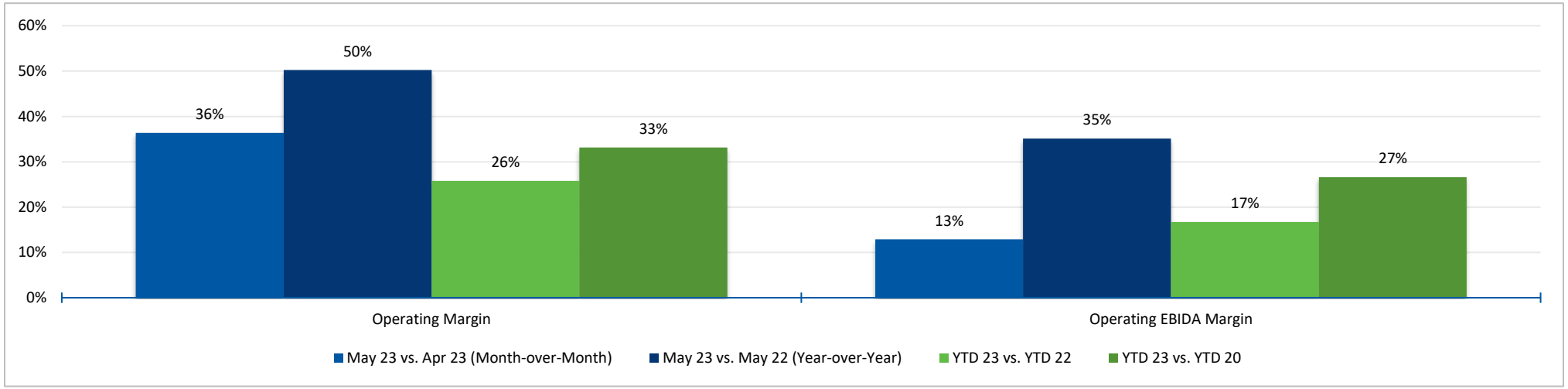


Volume

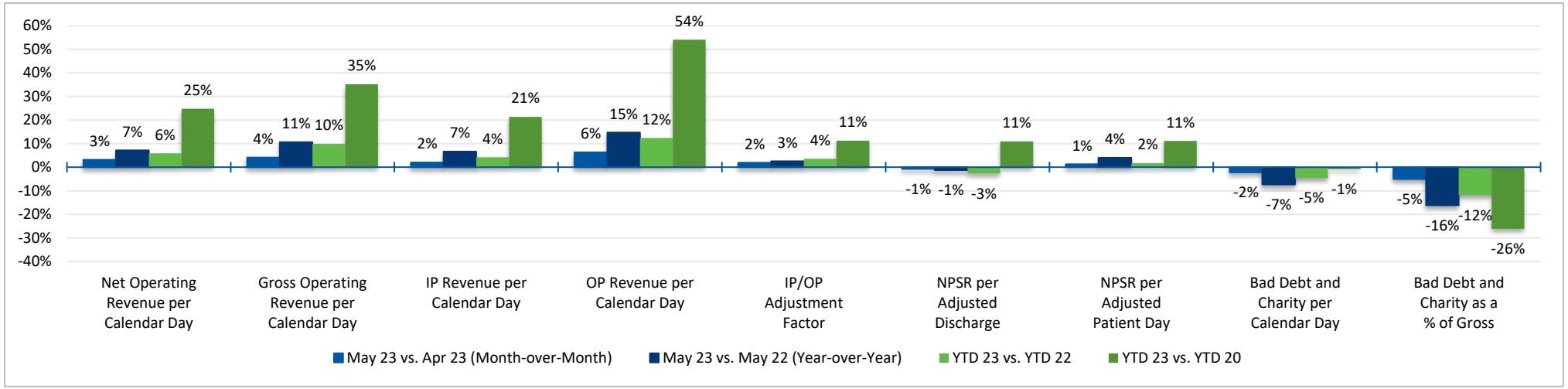


Regional Data: Northeast/Mid-Atlantic

Profitability

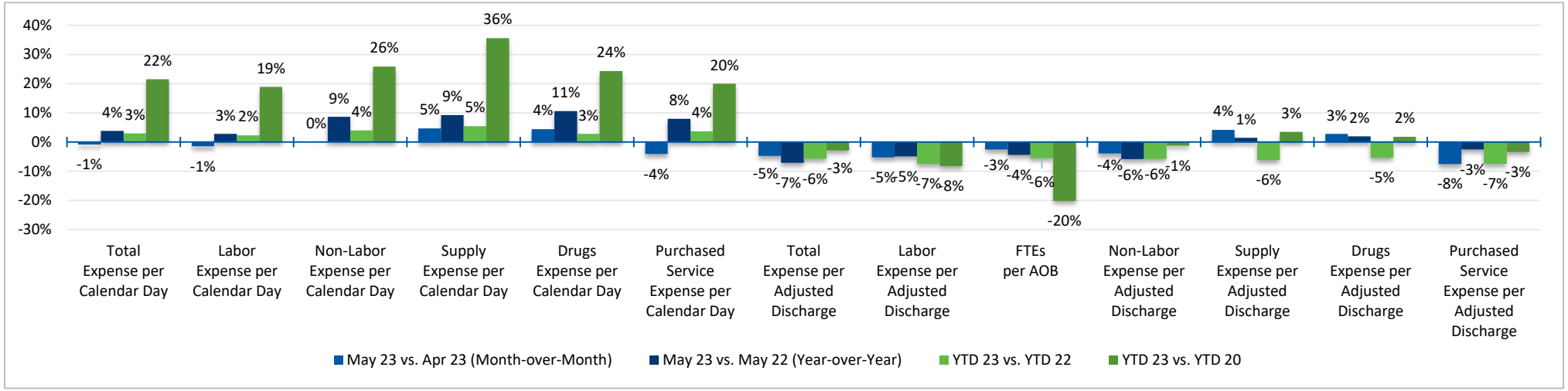


Revenue

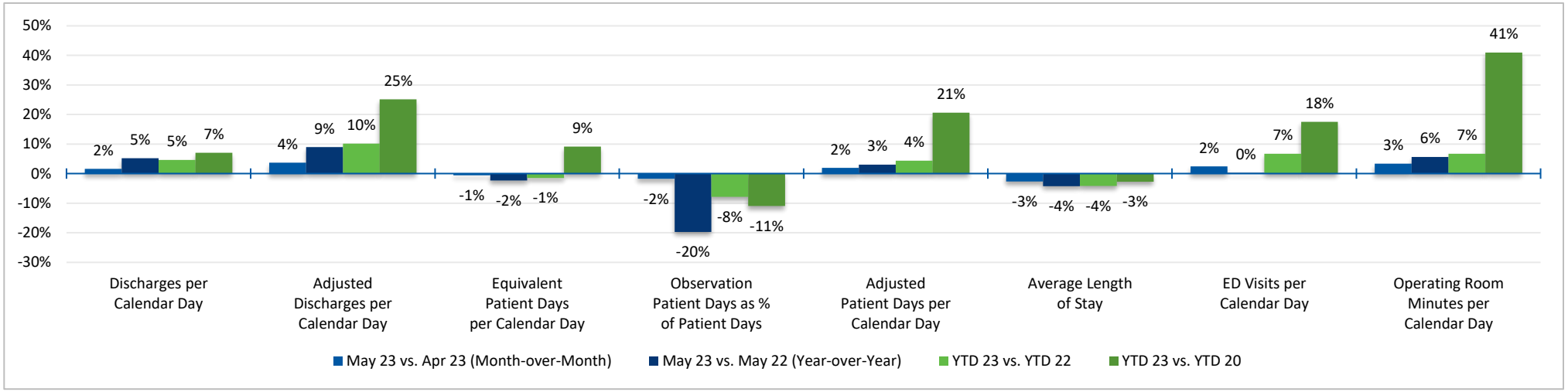


Regional Data: Northeast/Mid-Atlantic *(continued)*

Expense

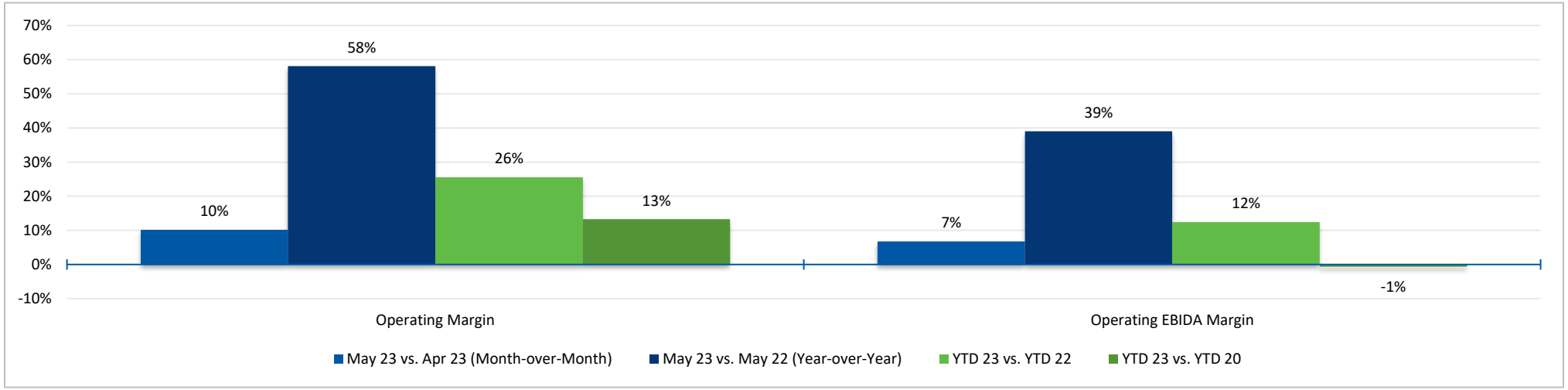


Volume

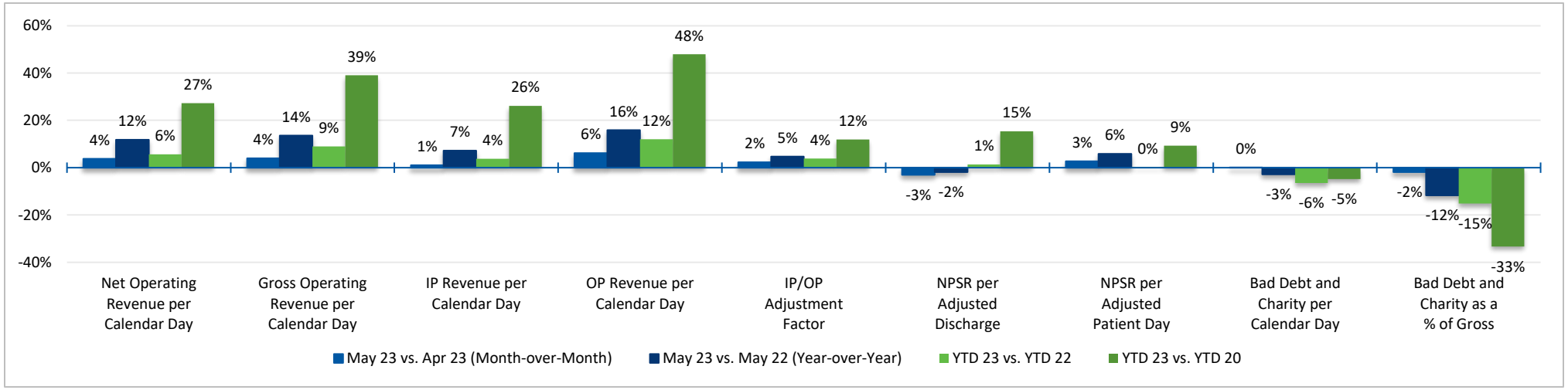


Regional Data: Great Plains

Profitability

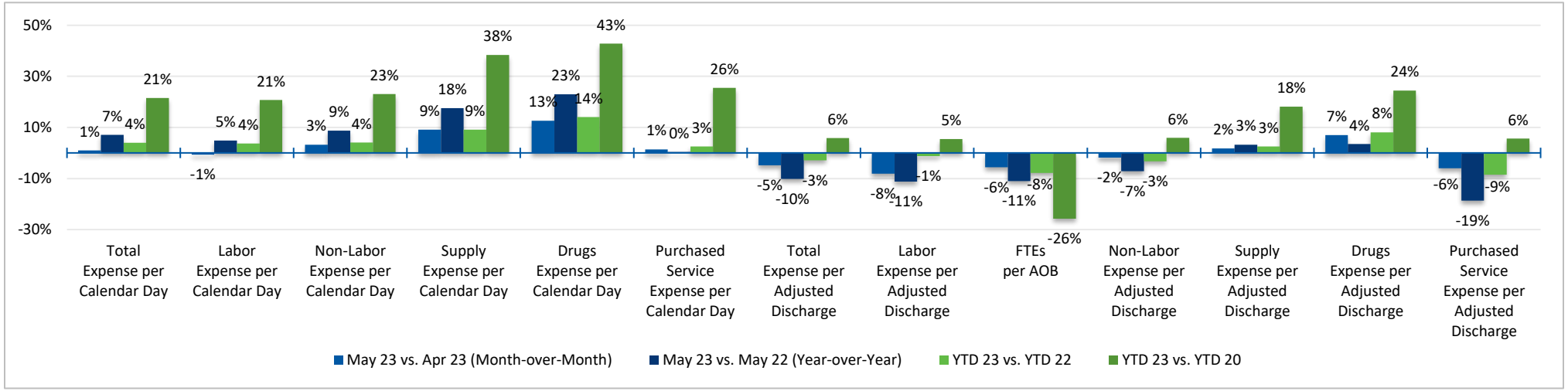


Revenue

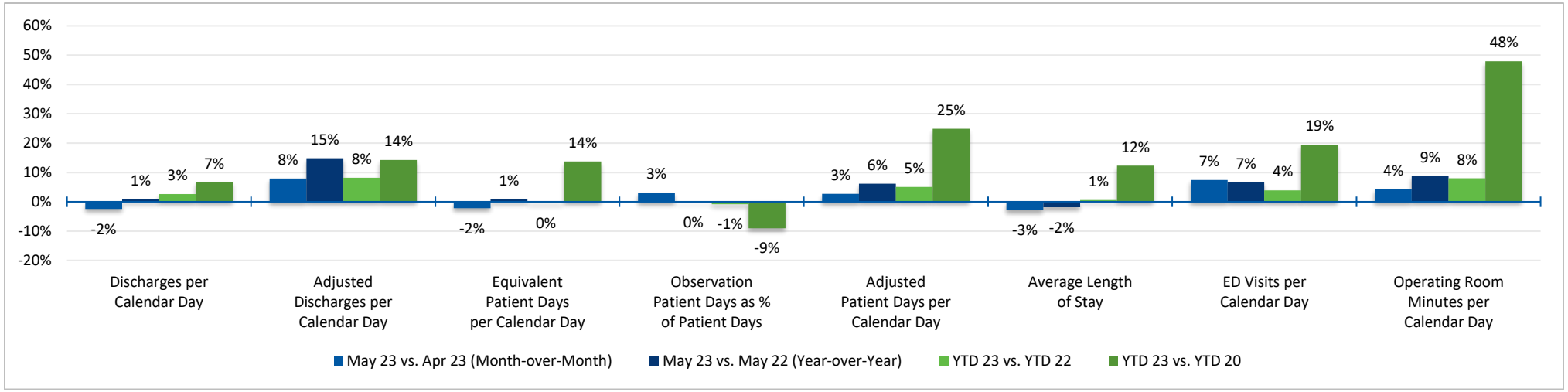


Regional Data: Great Plains *(continued)*

Expense



Volume



Data by Hospital Bed Size

Profitability, Revenue, Expense, and Volume

0-25 Beds

		May 23 vs. Apr 23 (Month-over-Month)	May 23 vs. May 22 (Year-over-Year)	YTD 23 vs. YTD 22	YTD 23 vs. YTD 20
Margin	Operating Margin	19.5%	28.9%	13.9%	45.5%
	Operating EBIDA Margin	20.3%	25.7%	4.1%	20.1%
Volume	Discharges per Calendar Day	-6.4%	2.0%	2.4%	0.5%
	Adjusted Discharges per Calendar Day	5.9%	15.0%	9.6%	31.3%
	Equivalent Patient Days per Calendar Day	-2.8%	1.3%	-4.5%	7.3%
	Observation Patient Days as % of Patient Days	9.9%	-16.2%	-0.3%	-12.7%
	Adjusted Patient Days per Calendar Day	3.4%	9.6%	6.9%	34.5%
	Average Length of Stay	0.8%	-7.4%	-6.4%	7.5%
	ED Visits per Calendar Day	6.2%	4.3%	5.1%	19.4%
	Operating Room Minutes per Calendar Day	4.0%	5.0%	4.3%	38.8%
Revenue	Net Operating Revenue per Calendar Day	3.4%	9.0%	4.3%	26.7%
	Gross Operating Revenue per Calendar Day	5.1%	13.7%	9.5%	40.0%
	IP Revenue per Calendar Day	-3.9%	0.8%	-3.5%	13.0%
	OP Revenue per Calendar Day	5.8%	15.1%	12.0%	53.0%
	IP/OP Adjustment Factor	7.7%	8.9%	12.4%	28.1%
	NPSR per Adjusted Discharge	-3.7%	-6.9%	-10.4%	6.4%
	NPSR per Adjusted Patient Day	-0.7%	-4.6%	-4.4%	-1.0%
	Bad Debt and Charity per Calendar Day	-9.6%	-2.8%	1.2%	-2.2%
	Bad Debt and Charity as a % of Gross	-11.3%	-12.9%	-5.6%	-32.7%
Expense	Total Expense per Calendar Day	-0.4%	5.1%	2.1%	19.6%
	Labor Expense per Calendar Day	-1.3%	2.3%	0.0%	19.5%
	Non-Labor Expense per Calendar Day	-1.2%	9.3%	4.4%	20.3%
	Supply Expense per Calendar Day	5.6%	13.3%	4.0%	30.6%
	Drugs Expense per Calendar Day	7.7%	13.5%	6.4%	34.6%
	Purchased Service Expense per Calendar Day	-5.0%	4.5%	3.4%	24.7%
	Total Expense per Adjusted Discharge	-5.0%	-11.1%	-8.6%	-10.6%
	Labor Expense per Adjusted Discharge	-5.4%	-14.0%	-12.7%	-9.7%
	FTEs per AOB	-11.7%	-15.3%	-10.3%	-27.8%
	Non-Labor Expense per Adjusted Discharge	-5.7%	-8.0%	-7.5%	-8.1%
	Supply Expense per Adjusted Discharge	3.2%	-0.3%	-3.9%	8.8%
	Drugs Expense per Adjusted Discharge	1.1%	-0.4%	-2.5%	16.6%
	Purchased Service Expense per Adjusted Discharge	-4.6%	-15.3%	-13.3%	-11.3%

26-99 Beds

		May 23 vs. Apr 23 (Month-over-Month)	May 23 vs. May 22 (Year-over-Year)	YTD 23 vs. YTD 22	YTD 23 vs. YTD 20
Margin	Operating Margin	19.2%	45.6%	22.1%	28.3%
	Operating EBIDA Margin	11.9%	27.0%	13.0%	5.8%
Volume	Discharges per Calendar Day	0.2%	4.1%	2.9%	5.4%
	Adjusted Discharges per Calendar Day	2.5%	11.6%	10.1%	23.7%
	Equivalent Patient Days per Calendar Day	-1.8%	-1.1%	-1.9%	11.9%
	Observation Patient Days as % of Patient Days	0.3%	-1.1%	12.9%	-13.1%
	Adjusted Patient Days per Calendar Day	1.9%	3.6%	3.7%	31.4%
	Average Length of Stay	-3.5%	-6.4%	-6.6%	0.5%
	ED Visits per Calendar Day	5.4%	4.0%	6.0%	21.9%
	Operating Room Minutes per Calendar Day	5.2%	-0.1%	4.7%	31.0%
Revenue	Net Operating Revenue per Calendar Day	4.2%	7.9%	4.4%	26.9%
	Gross Operating Revenue per Calendar Day	3.9%	10.4%	8.7%	42.0%
	IP Revenue per Calendar Day	0.3%	7.2%	1.1%	20.8%
	OP Revenue per Calendar Day	5.7%	12.9%	12.1%	53.1%
	IP/OP Adjustment Factor	3.5%	2.4%	6.5%	16.5%
	NPSR per Adjusted Discharge	0.2%	0.1%	-3.7%	12.8%
	NPSR per Adjusted Patient Day	0.1%	2.2%	1.7%	4.0%
	Bad Debt and Charity per Calendar Day	-7.2%	1.6%	1.1%	-6.0%
	Bad Debt and Charity as a % of Gross	-12.9%	-9.5%	-6.8%	-32.4%
Expense	Total Expense per Calendar Day	-0.3%	3.3%	1.3%	22.4%
	Labor Expense per Calendar Day	-0.6%	-0.4%	-1.0%	16.6%
	Non-Labor Expense per Calendar Day	0.3%	8.0%	4.6%	23.5%
	Supply Expense per Calendar Day	6.7%	7.7%	3.4%	31.4%
	Drugs Expense per Calendar Day	1.9%	9.4%	1.1%	22.7%
	Purchased Service Expense per Calendar Day	-2.9%	1.8%	3.3%	20.6%
	Total Expense per Adjusted Discharge	-3.5%	-7.6%	-7.3%	-1.0%
	Labor Expense per Adjusted Discharge	-4.1%	-11.5%	-11.6%	-5.8%
	FTEs per AOB	-3.7%	-8.8%	-7.6%	-29.4%
	Non-Labor Expense per Adjusted Discharge	-1.7%	-3.8%	-4.3%	0.8%
	Supply Expense per Adjusted Discharge	0.2%	0.9%	-6.1%	4.9%
	Drugs Expense per Adjusted Discharge	2.8%	-1.2%	-8.7%	-7.8%
	Purchased Service Expense per Adjusted Discharge	-7.4%	-4.6%	-8.4%	-8.2%

100-199 Beds

		May 23 vs. Apr 23 (Month-over-Month)	May 23 vs. May 22 (Year-over-Year)	YTD 23 vs. YTD 22	YTD 23 vs. YTD 20
Margin	Operating Margin	19.3%	53.0%	24.2%	54.0%
	Operating EBIDA Margin	12.2%	28.2%	14.7%	24.7%
Volume	Discharges per Calendar Day	2.6%	8.9%	5.6%	6.7%
	Adjusted Discharges per Calendar Day	4.0%	11.4%	11.5%	13.4%
	Equivalent Patient Days per Calendar Day	-1.6%	-0.2%	-2.3%	10.3%
	Observation Patient Days as % of Patient Days	-1.7%	-14.9%	-2.3%	-5.2%
	Adjusted Patient Days per Calendar Day	1.1%	4.5%	3.4%	28.1%
	Average Length of Stay	-2.2%	-5.1%	-3.4%	3.6%
	ED Visits per Calendar Day	5.0%	1.4%	5.2%	13.5%
	Operating Room Minutes per Calendar Day	5.1%	13.6%	4.4%	33.1%
Revenue	Net Operating Revenue per Calendar Day	3.3%	11.0%	5.8%	27.1%
	Gross Operating Revenue per Calendar Day	4.6%	12.1%	9.6%	35.3%
	IP Revenue per Calendar Day	1.4%	7.8%	3.0%	20.1%
	OP Revenue per Calendar Day	5.9%	15.3%	12.9%	52.1%
	IP/OP Adjustment Factor	2.5%	3.4%	5.7%	11.9%
	NPSR per Adjusted Discharge	-0.7%	-0.8%	-3.3%	14.6%
	NPSR per Adjusted Patient Day	2.8%	5.4%	2.4%	6.5%
	Bad Debt and Charity per Calendar Day	-3.4%	-4.3%	0.7%	-15.9%
	Bad Debt and Charity as a % of Gross	-7.2%	-16.4%	-6.3%	-35.4%
Expense	Total Expense per Calendar Day	-0.1%	4.6%	3.0%	21.5%
	Labor Expense per Calendar Day	-1.2%	1.8%	-0.7%	21.6%
	Non-Labor Expense per Calendar Day	0.9%	8.1%	5.0%	20.9%
	Supply Expense per Calendar Day	8.0%	12.1%	4.4%	25.6%
	Drugs Expense per Calendar Day	10.0%	11.6%	0.3%	20.4%
	Purchased Service Expense per Calendar Day	-3.1%	5.7%	5.9%	15.7%
	Total Expense per Adjusted Discharge	-5.2%	-8.0%	-6.8%	7.7%
	Labor Expense per Adjusted Discharge	-4.9%	-10.1%	-11.1%	8.5%
	FTEs per AOB	-1.4%	-4.6%	-7.1%	-21.8%
	Non-Labor Expense per Adjusted Discharge	-5.7%	-4.0%	-5.4%	6.1%
	Supply Expense per Adjusted Discharge	2.4%	-0.4%	-4.3%	14.6%
	Drugs Expense per Adjusted Discharge	2.0%	0.3%	-6.7%	-2.1%
	Purchased Service Expense per Adjusted Discharge	-9.7%	-11.9%	-9.3%	-10.2%

200-299 Beds

		May 23 vs. Apr 23 (Month-over-Month)	May 23 vs. May 22 (Year-over-Year)	YTD 23 vs. YTD 22	YTD 23 vs. YTD 20
Margin	Operating Margin	5.1%	19.6%	26.9%	13.7%
	Operating EBIDA Margin	3.0%	29.2%	20.7%	8.3%
Volume	Discharges per Calendar Day	1.5%	4.3%	5.4%	0.6%
	Adjusted Discharges per Calendar Day	3.1%	7.2%	8.9%	16.4%
	Equivalent Patient Days per Calendar Day	-1.3%	-1.5%	-1.1%	11.2%
	Observation Patient Days as % of Patient Days	4.1%	-0.7%	-3.0%	-2.0%
	Adjusted Patient Days per Calendar Day	0.7%	0.4%	1.3%	20.2%
	Average Length of Stay	-2.4%	-2.9%	-5.3%	1.4%
	ED Visits per Calendar Day	4.7%	2.4%	4.4%	11.8%
	Operating Room Minutes per Calendar Day	3.6%	4.1%	4.4%	31.0%
Revenue	Net Operating Revenue per Calendar Day	1.3%	6.7%	5.9%	27.2%
	Gross Operating Revenue per Calendar Day	2.9%	10.9%	7.8%	35.9%
	IP Revenue per Calendar Day	0.6%	7.5%	5.2%	24.9%
	OP Revenue per Calendar Day	5.3%	13.9%	12.3%	51.0%
	IP/OP Adjustment Factor	1.3%	3.4%	3.5%	10.2%
	NPSR per Adjusted Discharge	-1.1%	2.0%	-2.6%	10.5%
	NPSR per Adjusted Patient Day	1.0%	6.6%	3.6%	8.7%
	Bad Debt and Charity per Calendar Day	-2.2%	-9.0%	2.4%	-3.8%
	Bad Debt and Charity as a % of Gross	-6.6%	-19.4%	-6.2%	-29.7%
Expense	Total Expense per Calendar Day	0.2%	5.2%	2.2%	23.9%
	Labor Expense per Calendar Day	-1.1%	-0.2%	-0.7%	22.6%
	Non-Labor Expense per Calendar Day	1.4%	7.4%	6.3%	26.4%
	Supply Expense per Calendar Day	7.8%	10.0%	5.8%	34.5%
	Drugs Expense per Calendar Day	11.5%	9.8%	-0.3%	16.3%
	Purchased Service Expense per Calendar Day	-2.8%	10.2%	9.3%	24.5%
	Total Expense per Adjusted Discharge	-3.5%	-2.7%	-5.3%	2.5%
	Labor Expense per Adjusted Discharge	-3.9%	-7.3%	-10.9%	3.2%
	FTEs per AOB	-1.2%	-2.7%	-2.1%	-16.5%
	Non-Labor Expense per Adjusted Discharge	-0.3%	-1.4%	-2.0%	2.1%
	Supply Expense per Adjusted Discharge	3.6%	5.5%	-2.0%	11.0%
	Drugs Expense per Adjusted Discharge	8.5%	3.3%	-5.3%	-7.9%
	Purchased Service Expense per Adjusted Discharge	-5.7%	0.3%	-1.4%	1.1%

300-499 Beds

		May 23 vs. Apr 23 (Month-over-Month)	May 23 vs. May 22 (Year-over-Year)	YTD 23 vs. YTD 22	YTD 23 vs. YTD 20
Margin	Operating Margin	25.4%	26.5%	33.1%	-10.7%
	Operating EBIDA Margin	15.8%	10.4%	22.5%	-10.6%
Volume	Discharges per Calendar Day	1.9%	5.9%	1.3%	3.7%
	Adjusted Discharges per Calendar Day	4.3%	7.8%	5.6%	14.3%
	Equivalent Patient Days per Calendar Day	-1.3%	-2.9%	-2.1%	7.5%
	Observation Patient Days as % of Patient Days	4.4%	-0.2%	3.3%	-5.2%
	Adjusted Patient Days per Calendar Day	1.1%	1.0%	2.1%	19.8%
	Average Length of Stay	-3.5%	-3.4%	-3.3%	1.3%
	ED Visits per Calendar Day	3.6%	0.6%	4.3%	12.9%
	Operating Room Minutes per Calendar Day	3.9%	5.8%	6.5%	32.4%
Revenue	Net Operating Revenue per Calendar Day	1.3%	9.0%	5.8%	25.5%
	Gross Operating Revenue per Calendar Day	3.7%	9.7%	8.5%	34.1%
	IP Revenue per Calendar Day	1.2%	5.1%	4.1%	23.6%
	OP Revenue per Calendar Day	6.3%	14.2%	13.6%	53.1%
	IP/OP Adjustment Factor	2.6%	3.7%	3.9%	10.9%
	NPSR per Adjusted Discharge	-2.2%	1.5%	0.9%	12.5%
	NPSR per Adjusted Patient Day	1.4%	6.0%	3.5%	10.6%
	Bad Debt and Charity per Calendar Day	-9.1%	-0.5%	1.7%	-11.3%
	Bad Debt and Charity as a % of Gross	-10.9%	-11.4%	-6.4%	-31.1%
Expense	Total Expense per Calendar Day	-0.5%	6.1%	2.7%	23.8%
	Labor Expense per Calendar Day	-0.5%	1.1%	-0.3%	22.6%
	Non-Labor Expense per Calendar Day	0.2%	8.9%	6.6%	24.0%
	Supply Expense per Calendar Day	4.5%	12.7%	7.7%	33.3%
	Drugs Expense per Calendar Day	3.5%	13.0%	4.9%	26.2%
	Purchased Service Expense per Calendar Day	-3.2%	5.9%	7.8%	18.8%
	Total Expense per Adjusted Discharge	-6.3%	-1.3%	-3.7%	8.3%
	Labor Expense per Adjusted Discharge	-3.5%	-5.3%	-6.2%	8.2%
	FTEs per AOB	-1.0%	-1.9%	-3.6%	-15.7%
	Non-Labor Expense per Adjusted Discharge	-4.8%	1.4%	1.2%	12.8%
	Supply Expense per Adjusted Discharge	-0.7%	4.7%	2.1%	14.8%
	Drugs Expense per Adjusted Discharge	-1.8%	6.6%	0.5%	11.6%
	Purchased Service Expense per Adjusted Discharge	-7.5%	1.0%	1.8%	2.4%

500+ Beds

		May 23 vs. Apr 23 (Month-over-Month)	May 23 vs. May 22 (Year-over-Year)	YTD 23 vs. YTD 22	YTD 23 vs. YTD 20
Margin	Operating Margin	23.2%	46.8%	47.0%	32.9%
	Operating EBIDA Margin	13.0%	33.7%	40.8%	1.3%
Volume	Discharges per Calendar Day	0.9%	5.5%	6.6%	10.3%
	Adjusted Discharges per Calendar Day	2.9%	8.3%	7.9%	18.6%
	Equivalent Patient Days per Calendar Day	-1.1%	4.4%	3.4%	15.1%
	Observation Patient Days as % of Patient Days	-0.7%	-6.5%	-4.9%	-4.1%
	Adjusted Patient Days per Calendar Day	-0.2%	6.3%	5.3%	23.7%
	Average Length of Stay	-2.3%	-1.2%	-1.3%	4.6%
	ED Visits per Calendar Day	2.9%	3.5%	5.6%	17.3%
	Operating Room Minutes per Calendar Day	6.2%	8.1%	5.8%	37.7%
Revenue	Net Operating Revenue per Calendar Day	1.9%	13.4%	10.8%	31.5%
	Gross Operating Revenue per Calendar Day	3.2%	14.4%	11.3%	40.6%
	IP Revenue per Calendar Day	2.1%	11.5%	7.8%	33.2%
	OP Revenue per Calendar Day	4.7%	16.3%	13.6%	54.5%
	IP/OP Adjustment Factor	1.2%	1.0%	2.2%	7.3%
	NPSR per Adjusted Discharge	-0.7%	4.8%	2.5%	21.5%
	NPSR per Adjusted Patient Day	2.3%	8.5%	5.7%	12.5%
	Bad Debt and Charity per Calendar Day	-5.7%	6.2%	15.5%	4.0%
	Bad Debt and Charity as a % of Gross	-7.8%	-6.8%	0.9%	-22.2%
Expense	Total Expense per Calendar Day	-0.1%	7.4%	4.6%	29.1%
	Labor Expense per Calendar Day	-1.4%	3.6%	2.9%	25.3%
	Non-Labor Expense per Calendar Day	-0.1%	10.1%	7.9%	29.4%
	Supply Expense per Calendar Day	5.5%	17.5%	11.6%	37.3%
	Drugs Expense per Calendar Day	5.8%	22.7%	12.2%	40.3%
	Purchased Service Expense per Calendar Day	-3.3%	3.4%	6.9%	24.0%
	Total Expense per Adjusted Discharge	-3.5%	-3.4%	-2.3%	5.9%
	Labor Expense per Adjusted Discharge	-4.2%	-5.3%	-1.8%	6.8%
	FTEs per AOB	-0.4%	-4.8%	-4.8%	-17.6%
	Non-Labor Expense per Adjusted Discharge	-2.5%	-0.7%	-0.7%	8.9%
	Supply Expense per Adjusted Discharge	4.7%	7.0%	1.2%	20.1%
	Drugs Expense per Adjusted Discharge	6.5%	9.1%	6.5%	22.9%
	Purchased Service Expense per Adjusted Discharge	-4.6%	-8.4%	-0.7%	4.5%

Non-Operating

National Non-Operating Results

Key Observations

- U.S. inflation, as measured by the consumer price index (CPI), decelerated in May with a monthly increase of 0.1% and annual increase of 4.0% year-on-year; the smallest increase since March 2021
- Despite cooling prices, inflation remains sticky in non-volatile categories and the Fed has left the door open to further rate increases as the labor market remains strong amidst signs of a wider economic slow down
- On May 31st, Federal Reserve Board Vice Chair nominee Philip Jefferson stated that skipping a rate hike does not mean a pause necessarily but would allow the Federal Open Market Committee (FOMC) more time to evaluate economic data for future rate decisions; Philadelphia Fed President Patrick Harker reiterated the same in favor of a pause
- While the unemployment rate edged up to 3.7%, strong hiring continued in May as U.S. nonfarm payrolls grew by 339,000, marking the 29th straight month of positive job growth
- The U.S. narrowly averted an unprecedented default as The Senate passed wide-ranging legislation that suspends the $31.4 trillion debt ceiling while cutting federal spending, backing the bipartisan deal struck by President Biden and House Speaker Kevin McCarthy
- The S&P 500 was up 0.3% in May, bringing its YTD return to 8.9%, as the largely muted performance was seen as a win by market participants against the backdrop of protracted regional banking volatility and debt limit fears

General Non-Operating Observations

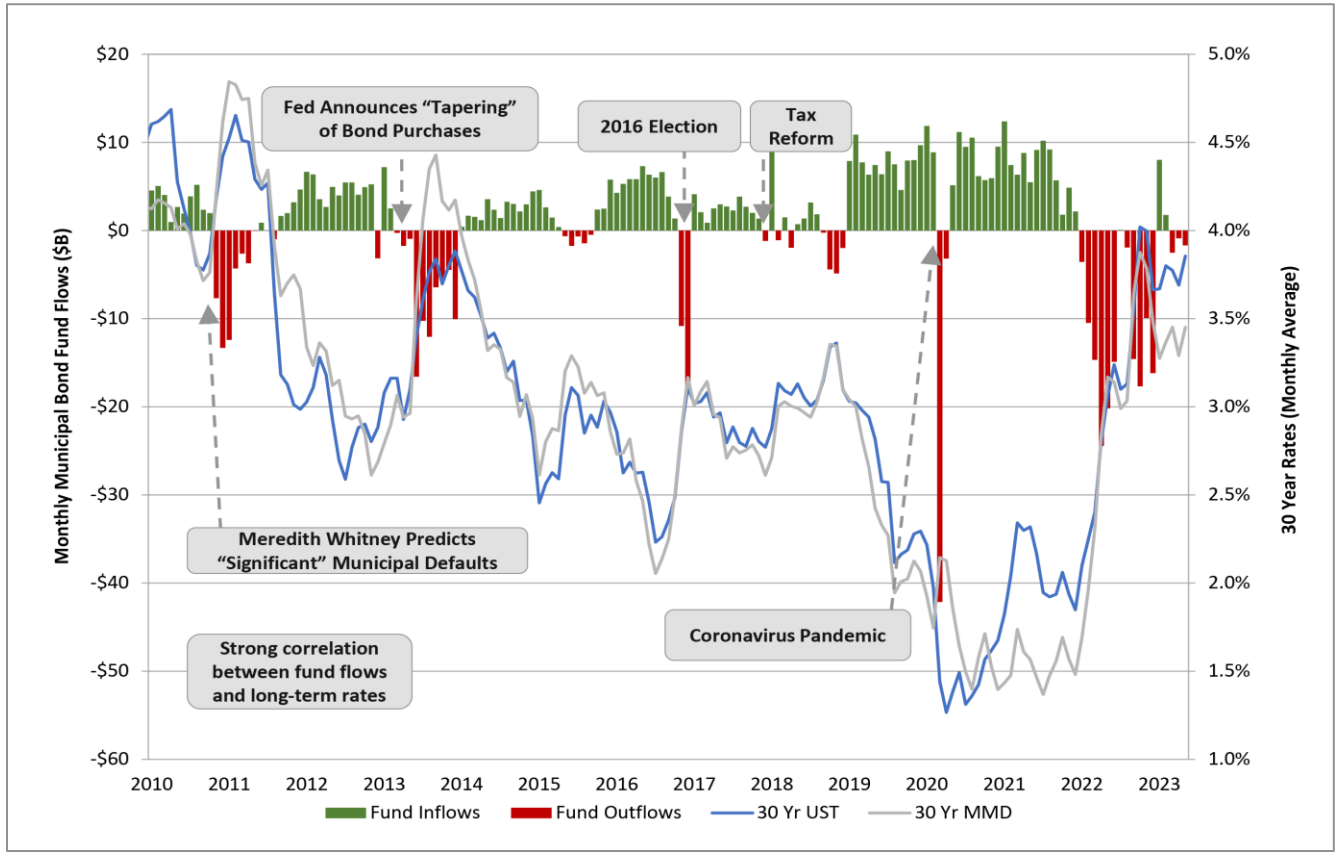
	May 2023	M-o-M Change	Y-o-Y Change
General			
GDP Growth*	1.3%	n/a	n/a
Unemployment Rate	3.7%	+0.3%	+0.1%
Personal Consumption Expenditures (YoY)	4.7%	n/c	-0.2%
Liabilities			
1m LIBOR	5.19%	+13 bps	+407 bps
SIFMA	3.56%	-30 bps	+277 bps
30yr MMD	3.55%	+16 bps	+74 bps
30yr Treasury	3.86%	+19 bps	+82 bps
Assets			
60/40 Asset Allocation†	n/a	-0.8%	-1.2%

*U.S. Bureau of Economic Analysis, Q1 2023 "Second Estimate"

†60/40 Asset Allocation assumes 30% S&P 500 Index, 20% MSCI World Index, 10% MSCI Emerging Markets Index, 40% Barclays US Aggregate Bond Index

Non-Operating Liabilities

Long Term – Monthly Municipal Bond Fund Flows with 30-Year U.S. Treasury and 30-Year MMD



Kaufman Hall, *National Hospital Flash Report* (June 2023)

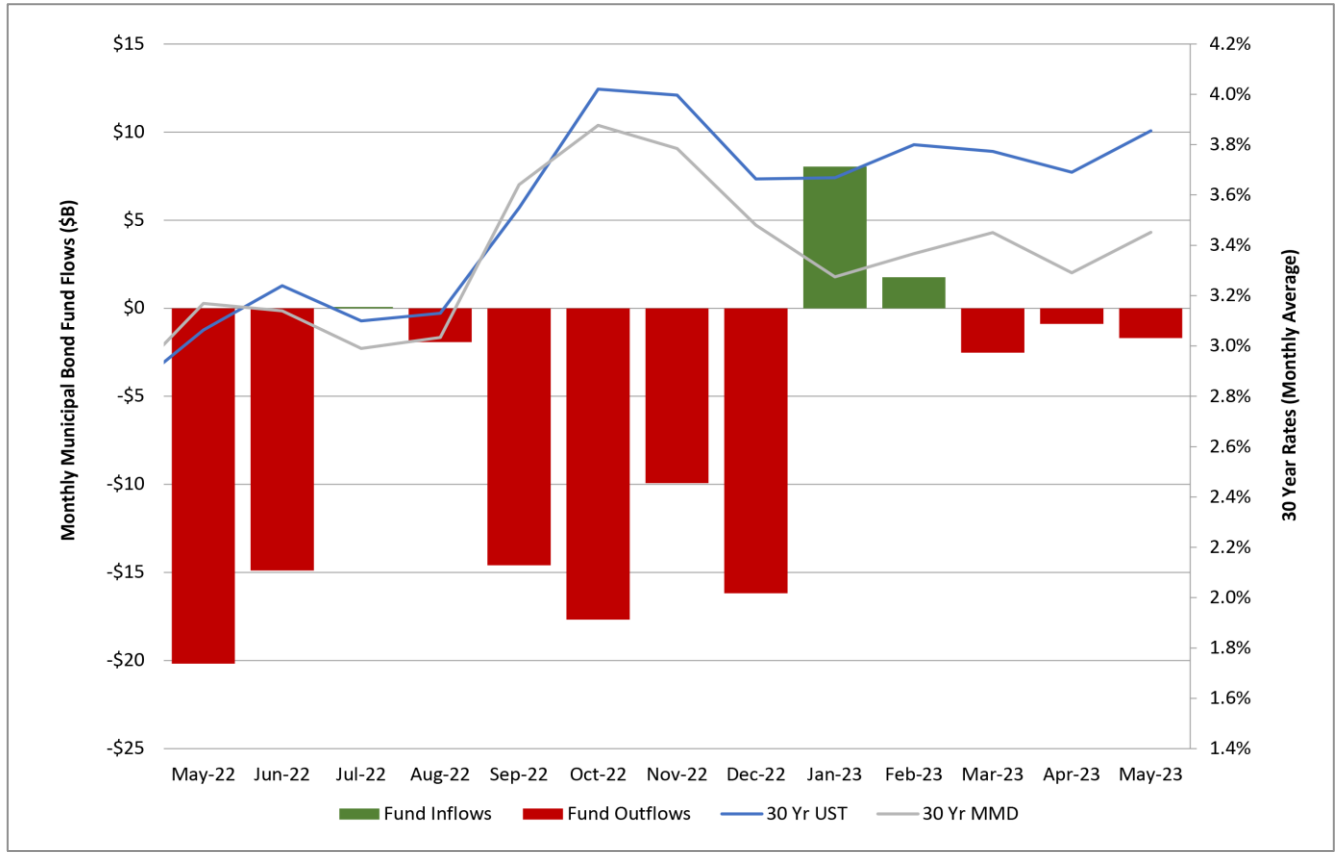
In May, the tax-exempt 30-year MMD and taxable 30-year Treasury moved higher by 16 and 19 basis points, respectively. MMD closed the month at 3.55% while the 30-year Treasury closed at 3.86%. Both MMD and the Treasury yield curves were inverted with 2-year interest rates higher than 10-year levels (the 2-year Treasury is 82 basis points higher than the 10-year Treasury). Comparatively, the yield on the 10-year Treasury increased by 27 basis points and the tax-exempt 10-year AAA MMD increased by 23 basis points.

While the month ended with a firmer tone following the avoidance of U.S. government default, municipal bond fund outflows persisted, and price discovery remained challenging amid a dearth of supply. Municipal bond funds (excluding ETFs) reported $3.3 billion of net outflows during May. In 2023, municipal bond funds have reported net outflows of $6.2 billion. The Investment Company Institute reported investors pulled another $671 million out of municipal bond mutual funds in the week ending May 24, after $132 million of outflows the previous week. Strong municipal bond redemptions in the summer months are set to converge with new-issue supply scarcity and provide a positive technical backdrop for the municipal bond market. Redemptions, which include maturing bonds, called bonds and coupon payments, total over $114 billion over the next four months, according to ICE Data. June demand is expected to be robust with favorable economic indicators on inflation and monetary policy.

Taxable and tax-exempt debt capital markets, as approximated here by the '30-yr U.S. Treasury' and '30-yr MMD Index', are dependent upon macroeconomic conditions, including inflation expectations, GDP growth and investment opportunities elsewhere in the market. A key measure to track is bond fund flows, particularly in the more supply and demand sensitive tax-exempt market. Fund flows are monies moving into bond funds from new investment and principal and interest payments on existing and maturing holdings. Strong fund flows generally signal that investors have more cash to put to work, a boon to the demand. Fund inflows generally are moderate and consistent over time while fund outflows are typically large and sudden, as external events affect investor sentiment, resulting in quick position liquidation which can drive yields up considerably in a short amount of time.

Non-Operating Liabilities *(continued)*

Last Twelve Months – Monthly Municipal Bond Fund Flows with 30-Year U.S. Treasury and 30-Year MMD

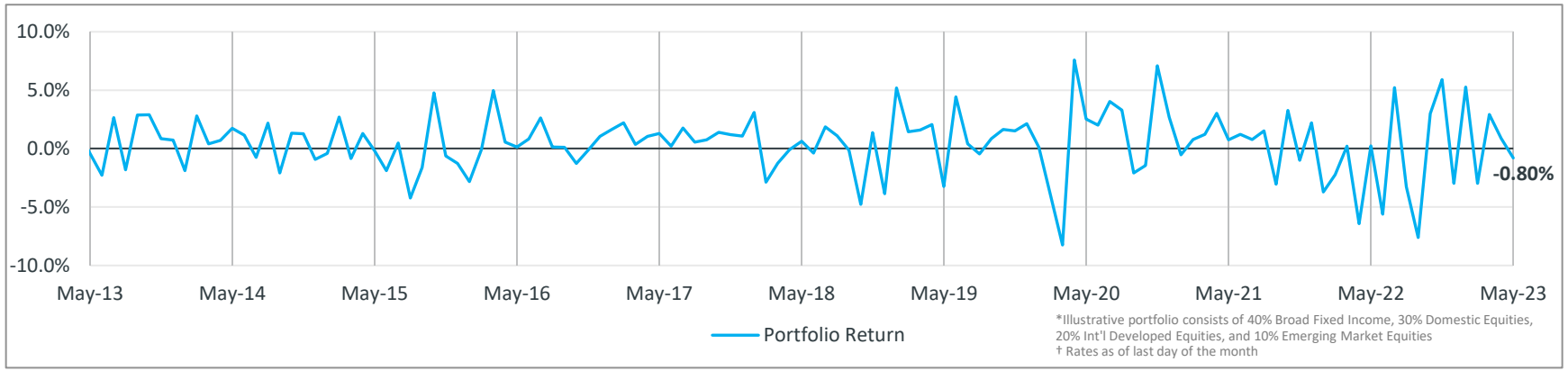


Kaufman Hall, *National Hospital Flash Report* (June 2023)

Taxable and tax-exempt debt capital markets, as approximated here by the '30-yr U.S. Treasury' and '30-yr MMD Index', are dependent upon macroeconomic conditions, including inflation expectations, GDP growth and investment opportunities elsewhere in the market. A key measure to track is bond fund flows, particularly in the more supply and demand sensitive tax-exempt market. Fund flows are monies moving into bond funds from new investment and principal and interest payments on existing and maturing holdings. Strong fund flows generally signal that investors have more cash to put to work, a boon to the demand. Fund inflows generally are moderate and consistent over time while fund outflows are typically large and sudden, as external events affect investor sentiment, resulting in quick position liquidation which can drive yields up considerably in a short amount of time.

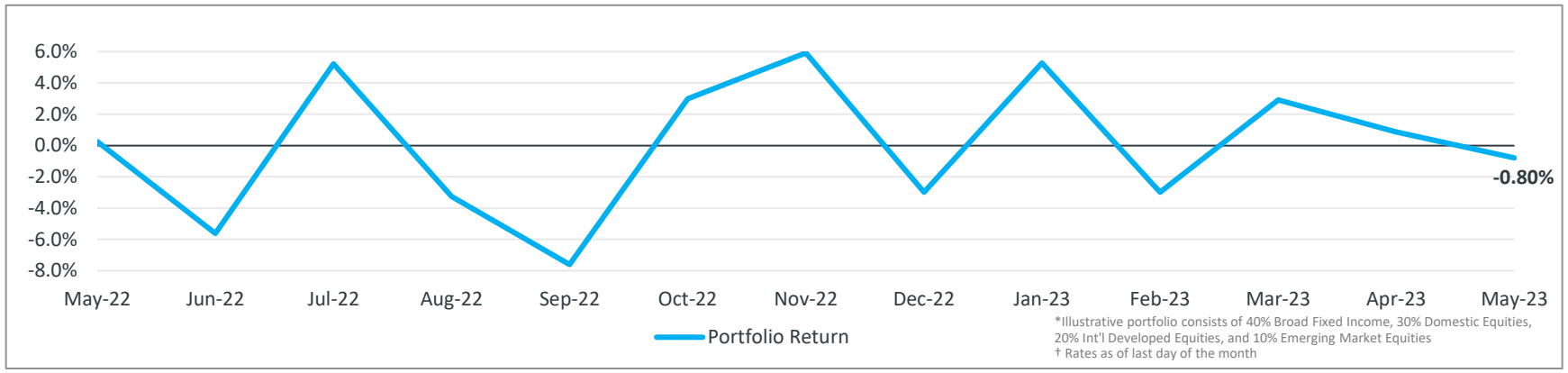
Non-Operating Assets

Long Term – Illustrative Investment Portfolio Returns, Month-over-Month Change



Kaufman Hall, *National Hospital Flash Report* (June 2023)

Last Twelve Months – Illustrative Investment Portfolio Returns, Month-over-Month Change



Kaufman Hall, *National Hospital Flash Report* (June 2023)

The looming prospect of government default made investors jittery as U.S. equities struggled to make headway in May. The narrow stock market rally was overshadowed by headlines of debt ceiling issues and Artificial Intelligence ("AI") stocks as the seven largest US technology-related stocks – which represent nearly 30% of the S&P 500 index – account for nearly all the index's YTD return. The Barclays Aggregate Bond Index fell 1.1% for the month as underlying bond yields moved higher. The blended 60/40 asset allocation fell 0.8% in May with the MSCI World Index and MSCI Emerging Markets down 1.2% and 1.9%, respectively.

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PwC Health Research Institute

Medical cost trend: Behind the numbers 2024

Increased pressure in healthcare

pwc

Heart of the matter: The cost of treating patients is on the rise

In 2022, inflation in the United States reached rates not seen since the 1980s.[1] With rising wages and expenses compounded by clinical workforce shortages, providers across the nation are fighting against declining profit margins. In turn, health plans are pressured to raise reimbursement levels in price negotiations with providers.

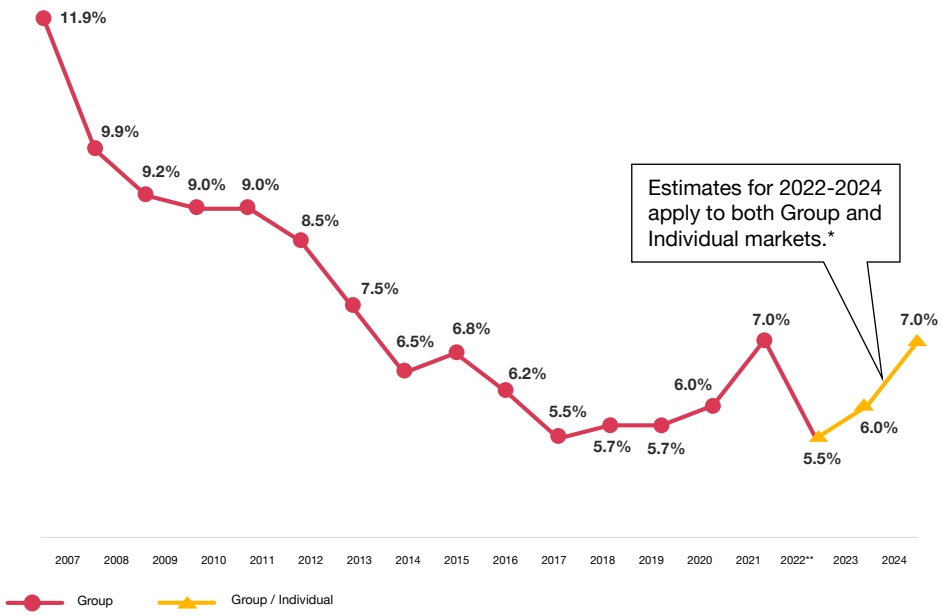
On May 11, 2023, the Public Health Emergency (PHE) officially ended, symbolizing a new stage in the pandemic. The past three years have seen not only a concerted effort to make available safe and effective COVID-19 diagnostics, therapies, and vaccines, but also shifts in how and where Americans gain access to care with an acceleration in technology and alternative sites of care. While some of these changes are temporary, others will likely persist into the post-pandemic world and become a different future.

PwC's Health Research Institute (HRI) surveyed and spoke with actuaries working at US health plans to generate an estimate of medical cost trend for the coming year. After considering various inflators and deflators of cost, HRI is projecting a 7.0% year-on-year medical cost trend in 2024 for both Individual and Group markets. This trend is higher than the projected medical cost trends in 2022 and 2023, which were 5.5% and 6.0%, respectively (see Figure 1). The higher medical cost trend in 2024 reflects health plans' modeling for inflationary unit cost impacts from their contracted healthcare providers, as well as persistent double-digit pharmacy trends driven by specialty drugs and the increasing use of the GLP-1 agonists for Type 2 Diabetes or weight loss. PwC updated its 2022 medical cost projection for the Group market to 5.5%, 1.0% down from the initial projection in 2022, primarily driven by a shift in sites of care from inpatient hospital settings to less costly alternatives such as outpatient and ambulatory surgical centers.

The inflationary impact is further exacerbated by continued clinical workforce shortages in 2023-24, prompting hospitals to increase salaries and consequently seek higher reimbursement from payers. On the pharmacy side, the introduction of new cell and gene therapies (11 approved in the past three years) is a key inflator expected to increase the median price of treatment going into 2024.

Although health plans reported some deflationary relief through shifts in site of care and the introduction of biosimilars, the overall impact is muted by the various inflators.

Figure 1: PwC Health Research Institute medical cost trends, 2009-2024
HRI projects medical cost trend to be 7.0% in 2024, up from 6.0% in 2023



Source: PwC Health Research Institute medical cost trends, 2009-2024

*For 2022-2024, medical cost trend was estimated separately for Group and Individual market based on the surveys and interviews conducted April–May 2023. HRI found no significant difference in the estimates for the two markets.

**The 5.5% medical cost trend for 2022 was revised from 6.5% originally projected in PwC Health Research Institute's "Medical Cost Trend: Behind the Numbers 2022" report, released in 2021. This revision reflects the average medical cost trend that was used for 2022 premium rate setting in 2021, shared with HRI during surveys and interviews.

See "About this research" for more details.

Inflators

Inflation and its ramifications across the healthcare landscape are the main factors driving spending in 2024.

- **Inflationary impacts on healthcare providers.** Hospitals and physicians are expected to seek higher rate increases (potentially also at a higher frequency) in contract negotiations. Workforce shortages and physician consolidation can further amplify the effect. Further, provider "burnout" and increased patient demand are expected to keep the pressure up on clinical workforces across the industry.
- **Increasing cost of pharmaceuticals.** Plans are experiencing inflationary pressure from the rising median price of new drugs, as well as the increasing price of existing drugs. Combined with the accelerated approvals of new cell and gene therapies, pharmacy trends are not expected to slow down in 2024.

Deflators

Some positive changes in the pharmaceutical market and care setting are expected to help counteract inflationary pressure, but their effect will be overshadowed by the inflators.

- **Biosimilars coming to market.** The prices of biosimilars are, on average, more than 50% lower than the reference products at the time of biosimilar launch. The launch of adalimumab biosimilars to Humira in 2023 is a new milestone in the market that is already driving significant savings.
- **Shift in site of care.** Plans reported a decrease in inpatient utilization as well as a shift towards outpatient care, allowing a two-pronged benefit to contain costs.

Recent reports of increases in outpatient utilization among Medicare plans was not commented on during the research period for this report.

Trends to watch

In addition to the inflators and deflators summarized in this report, there were several other factors reported by health plans as being impactful for trend development, but were not considered a significant trend bender as an inflator or deflator.

- **Total cost of care management.** Many health plans continued to invest in total cost of care management initiatives such as value-based care that helped maintain year over year trend. National health plans generally demonstrated better cost management and subsequently achieved lower cost trends. As these national plans continue to grow, they will have a deflator effect overall on medical cost trends.
- **COVID-19.** Impacts of changes in federal and state policies and the need for vaccines, testing and treatment vary, with the net effect likely being neutral. Health plans did not report a causal relationship between pent-up demand for care during the pandemic and utilization of care. The consensus among health plans is that inflationary pressures continuing in 2023 and going into 2024 will be driven by provider unit cost increases and pharmacy trends rather than a recovery in surgery utilization post-pandemic.
- **Health equity.** Health equity is a focus of every health plan. The impact of related efforts to improve population health in the long term has not yet factored into plans' cost of care models. Further, all plans are still working through CMS guidance on health equity.
- **Behavioral health.** While utilization of behavioral health grew during the pandemic and continues to grow, its cost remains relatively lower than other medical costs. Health plans did not account for behavioral health in their pricing and forecasting.
- **Centers for Medicare and Medicaid Services (CMS) Price Transparency Rule.** Health plans expect the impact of this rule on the 2024 trend will be neutral, given the immaturity of the data. In the long run, plans could see both upward and downward pressures.
- **Medicaid redetermination.** The impact is likely to be felt in the Individual market only, with magnitude and direction depending on the number of disenrollees who eventually purchase Individual plans and their risk profile.

This year, the scope of this report was broadened to include both small and large group ("Group")[2] and ACA marketplace ("Individual) plans.

The Individual market has seen significant growth from 12 million in enrollment in 2021 to 16.4 million in 2023. In addition to Individual market-focused plans, all major health plans in the group market also offer plans in the Individual marketplace, where competition has intensified in recent years. The impact of major factors driving medical cost is mostly felt in a similar way across the two markets. Meanwhile, there are distinct considerations that apply to one of the markets, most prominently Medicaid redetermination and network adequacy for the Individual market.

This report does not focus on trends in Medicare and Medicaid.

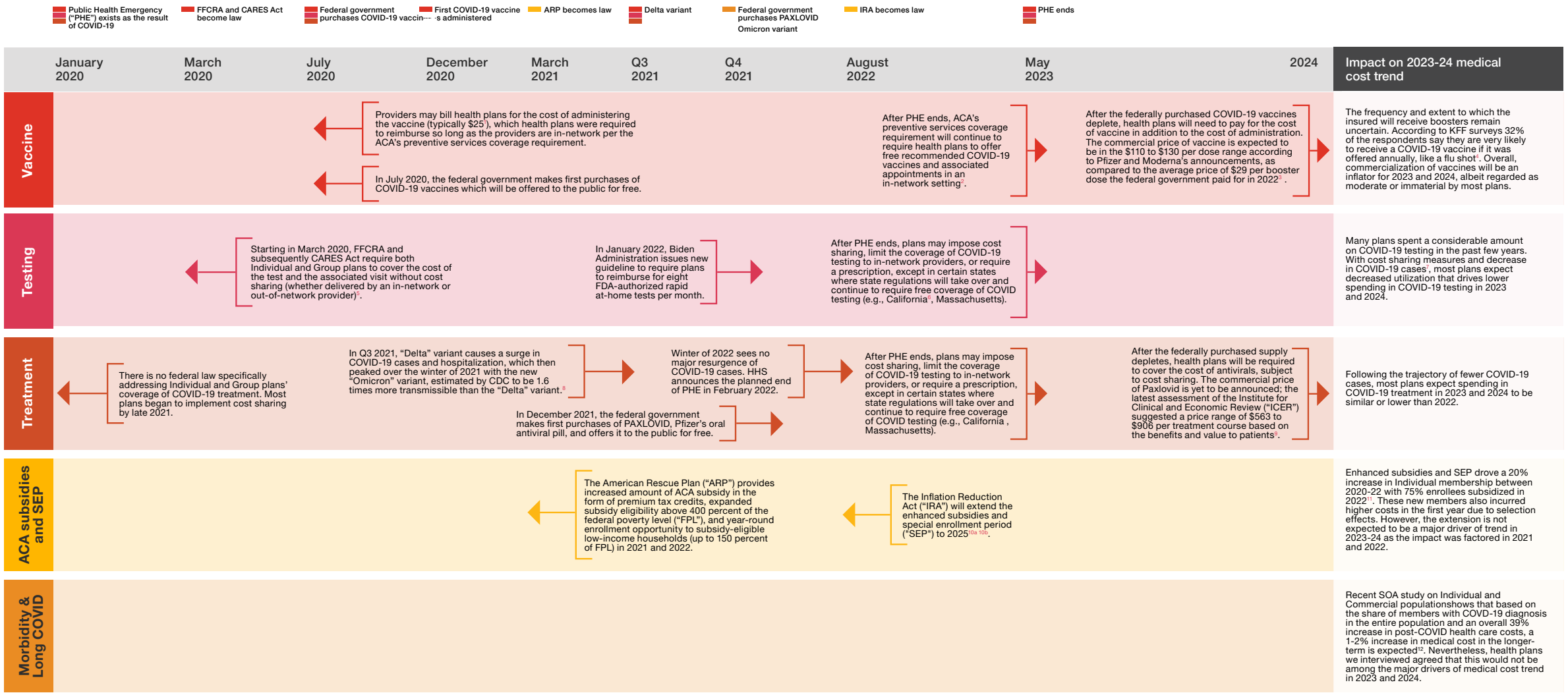
What is medical cost trend?

Medical cost trend is defined as the projected percentage increase in the cost to treat patients from one year to the next, assuming benefits remain the same. While medical cost trends can be defined in several ways, this report estimates the projected increase in per capita costs of medical services and prescription medications that affect insurers' Group and Individual plans. Insurance companies use the projection to calculate health plan premiums for the coming year. For example, a 5.0% trend means that a plan that costs $10,000 per member this year would cost $10,500 next year. The medical cost trend, or growth rate, is influenced primarily by:

- Changes in the price of medical products and services and prescription medications, known as unit cost inflation.
- Changes in the number or intensity of services used or changes in per capita utilization.

COVID-19 timeline:
From pandemic to present

On May 11, 2023, Public Health Emergency ("PHE") officially ended, symbolizing a new stage in our co-existence with the COVID-19 pandemic. The past three years have seen not only a concerted efforts to make available safe and effective COVID-19 diagnostics, therapies, and vaccines, but also shifts in how and where Americans gain access to care. While some of these changes are temporary, others will persist into the post-pandemic world and become the new-normal. The timeline below looks both past and ahead at the key events that impacted and will impact health plans' spending. Overall, our survey and interview indicated a consistent view among health plans that different factors as laid out below tend to cancel out and the net impact is expected to be neutral or immaterial as compared to other major inflators / deflators.



1. https://www.healthsystemtracker.org/chart-collection/where-do-americans-get-vaccines-and-how-much-does-it-cost-to-administer-them/
2. https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/.
3. https://www.kff.org/coronavirus-covid-19/issue-brief/how-much-could-covid-19-vaccines-cost-the-u-s-after-commercialization/.
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8a. https://coronavirus.jhu.edu/region/united-states 8b. https://www.cdc.gov/museum/timeline/covid19.html
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10a. https://www.healthinsurance.org/glossary/inflation-reduction-act/.
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11. https://www.kff.org/policy-watch/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/
12. https://www.soa.org/resources/research-reports/2023/hcc-covid-effects-longterm/ The study does not publish the total cost of members with versus without COVID-19 diagnosis. Based solely on member count of 626,142 with COVID-19 diagnosis and total membership of 33.0 million over the three-year period, the impact on overall medical cost trend will be approximately 0.7%. However, the members with COVID-19 diagnosis includes high-risk groups and are likely to have higher overall cost than the rest of the population; thus the impact on overall medical cost trend shall be higher than 0.7%.*

Inflator:

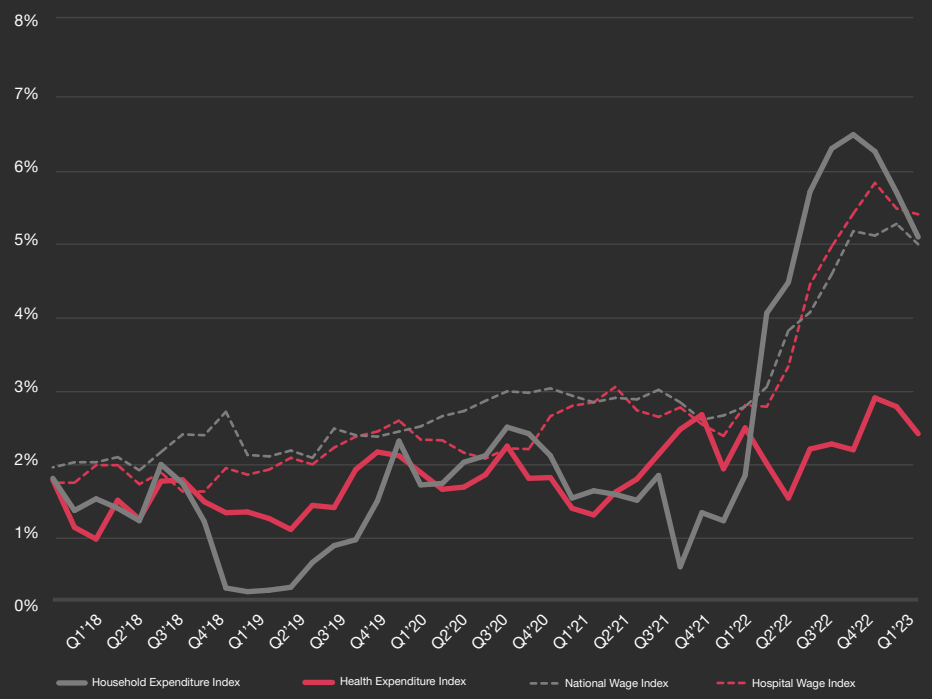
Inflationary impacts on healthcare providers

Inflation in the United States has reached rates not seen in decades. All health plans ranked inflationary impacts on providers among the top three inflators for 2024.

In 2022, while inflation was felt across the US economy, its impact on healthcare spending was dampened by existing annual or multiyear provider contracts. Figure 2 illustrates the lag between the household expenditure index, with a rise starting in the second quarter of 2021 and persisting at a high rate of 6.0% or more throughout 2022, and the health expenditure index, with a modest 2% to 3% increase. Generally, health expenditure inflation lags behind hospital wage inflation.

In a persisting high inflationary environment, hospitals and providers will ultimately be pushed to seek significant rate increases from payers. Many health plan actuaries said they are facing increasing inflationary pressure on unit cost in 2023 and 2024. Their ability to manage price increases during contract renewals will be a key factor in determining how the impact of inflation will materialize in the coming years.

Figure 2: Expenditure and Wage Indices year-over-year growth 2017-2022



Source: Bureau of Labor Statistics Consumer Price Index, PwC analysis

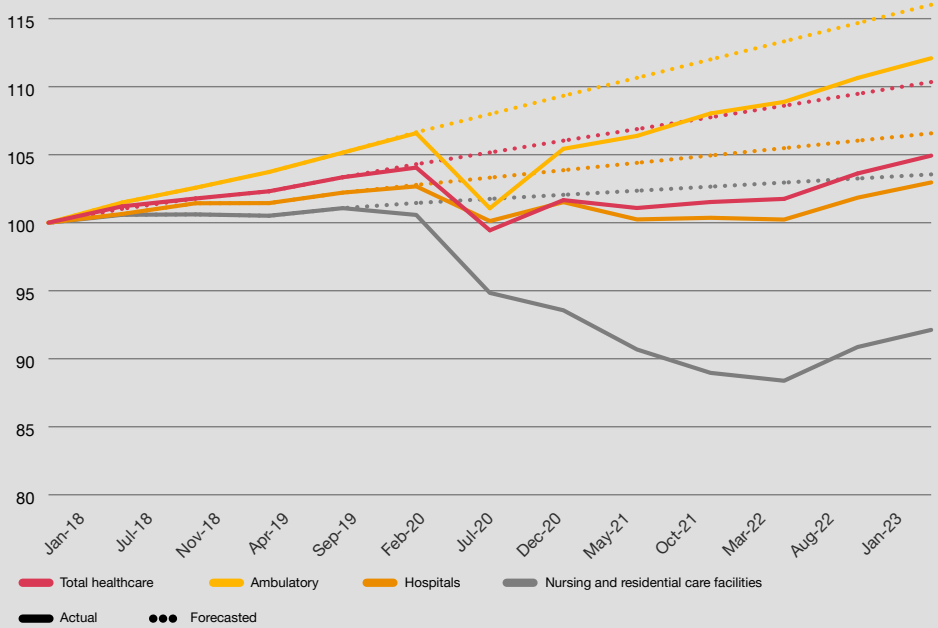
Clinical workforce shortages add to the contractual pressure from providers

Healthcare employment plummeted during the pandemic, leading hospitals to incur much higher labor costs. During the peak of the pandemic in 2021, hospitals experienced an estimated 16% increase in labor expenses per adjusted discharge compared to September 2019[3], not only due to paying higher wages but also from using temporary clinical staff through “traveler agencies” that can often charge high prices.

Though healthcare employment started to steadily recover in 2022, total employment still has not returned to pre-COVID levels, and a noticeable gap persists for the nursing/residential care facilities segment.

Several health plans expect no short-term resolution of the clinical staff shortage. Assuming the persistence of such shortages in 2024, hospitals will continue to be financially challenged and forced to seek higher reimbursement from payers. On the other hand, if healthcare employment levels return to a stable level in 2024, pent-up demand for care is likely to drive utilization up. In both cases, health plans can expect to face inflationary pressure in 2024.

Figure 3: Healthcare employment - actuals vs. pre-COVID forecast index 2017-2022*



Source: Bureau of Labor Statistics Employment Cost Index, PwC analysis
*Forecasted employment (dotted lines) is estimated by applying pre-COVID employment growth rates.

Hospital, private equity and other physician consolidation amplifies the inflationary pressure

Recent physician practice acquisition activities, including actions by hospitals, private equity firms and insurers amplify the inflationary pressure during contract renewals. Studies find that such acquisitions accelerated during the COVID-19 pandemic, and over the three-year period starting from 2019, the percentage of physicians employed by hospitals or corporate entities increased by 62% to 74% (Figure 4).[4] Specifically, private equity activities in the healthcare services sector set record highs in 2020-2022.[5] The ongoing consolidation of physician groups is expected to compound the inflationary pressure on medical cost in the near term.[6] In the long term, many consolidated physician groups aim to enter value-based care and thus lower total cost of care.

Individual market can be most impacted

We note potentially a higher impact of inflation on the Individual market due to network configuration. Compared to the Group market, more Individual plans utilize a narrow network to lower consumer premiums. Plans typically negotiate more favorable rates with select providers through membership steerage. These lower rates are expected to command a higher increase on a percentage basis to compensate for inflation, compared to the higher rates in the wide network plans that dominate the Group market, as illustrated in Figure 5.

Implications

Health plans and payviders: Confront affordability and disrupt costs. Health plans will encounter greater unit cost increase pressure from providers, which can play out for several years to come. Health plans should rethink their strategies as affordability is key to winning in the Individual and Group market. Value-based care, targeted care management, versatile in-house data analytics and harnessing the power of AI technology can help plans aggressively counteract the forces of inflation.

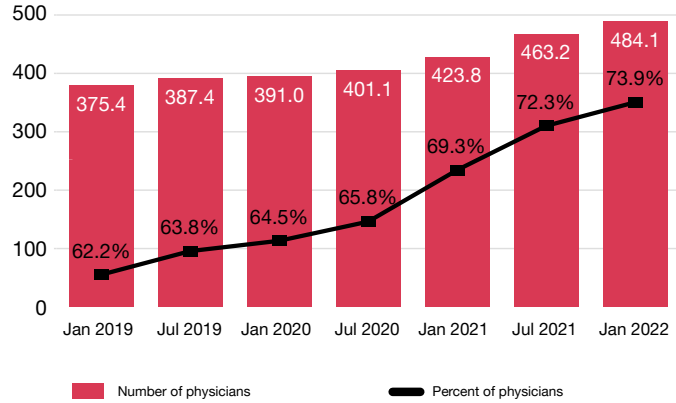
Providers: Solve systemic clinical workforce shortages, which have led to significant margin losses and, in some cases, even hospital closures. Providers should be proactive in attracting healthcare talent and doing more with less while also moving quickly to leverage technology such as AI to ease the workforce strain.

Employers: Because of continued talent concerns, employers are generally not expected to increase employee cost sharing. Instead, there will be an increased emphasis on network strategies, including the use of narrow/high-performing networks, centers of excellence to target high-cost claims (particularly cancer and orthopedic cases), plan designs that steer patients to lower-cost providers, and a renewed attempt at finding effective navigation tools.

Inflation and clinical workforce shortages will continue to exert pressure on healthcare.

Source: PwC Medical cost trend: Behind the Numbers 2024

Figure 4: Number and percentage of U.S physicians employed by hospitals or corporate entitites 2019-21



Source: Physician Advocacy Institute report on COVID-19's impact on acquisitions of physician practices and physician employment 2019-2021

Inflator:

Increasing cost of pharmaceuticals

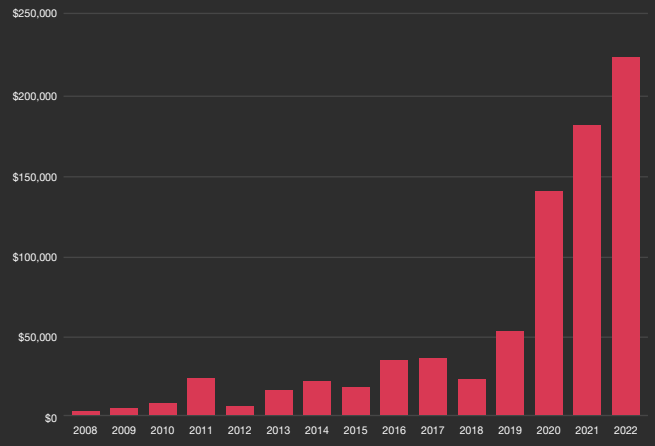
The new pharmaceutical pipeline is anticipated to be a strong headwind to any medical cost trend improvement. The median annual price for new drugs being approved by the U.S. Food and Drug Administration's (FDA) Center for Drug Evaluation and Research (CDER) increased from $180,000 in 2021 to $222,000 in 2022, implying double-digit annual growth in price.[7] This underlines a historical trend that led to median launch prices increasing from ~$2,000 per year in 2008 (37% annualized growth).[8] This surge in price is driven by a concurrent increase in the approval of high-cost drugs. The proportion of approved drugs priced at $150,000 per year or more was 9% in 2008-13 but increased to 47% in 2020-21.

Pharmaceutical manufacturer pricing is expected to be in the high single or double digits from 2023-2024. New drugs typically exist in the market for 15 years on average without competition from generic drugs, along with general increases in drug prices over time. Multiple insurers report that the trend used for pricing 2023 plans was lower than actual experience, driven by higher-than-expected pharmacy trends for both brand and specialty drugs. Plans also reported facing consistently increasing average wholesale price (AWP) over the last two years and do not anticipate this trend to flip.

This inflation is compounded by drug shortages and supply chain issues. In a report to Congress from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), an analysis of the data showed a 16.6% increase in the price of drugs in shortage, driven mostly by an increase in the price of generics (14.6%).[9]

The largest increase in the number of drugs experiencing an increase in price was in 2021-22, and 2022 observed the largest historical increase in the average price (Figure 6).[10]

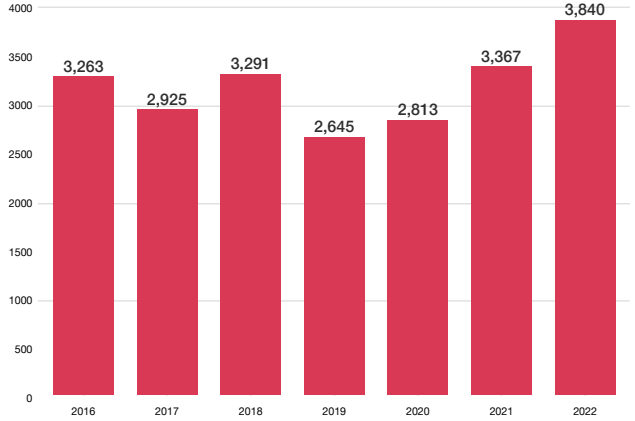
Figure 5: Median price of newly marketed drugs 2008-2022



Source: Trends in Prescription Drug Launch Prices, 2008-2021; Reuters survey[8]

Figure 6: Number of drugs with price increases per year and average dollar price changes per year 2016-2022 (January and July only)

Number of drugs with price increase per year



Average dollar price change per year

Source: Price Increases for Prescription Drugs, 2016-2022[10]
*Based on January and July price increases only; the research finds that these months historically account for most of the increases that occur each year.

New cell and gene therapies

Inflationary impacts from new drugs go hand-in-hand with the introduction of new cell and gene therapies. Of the 29 gene therapies currently approved by the FDA, 11 have been approved since 2021. Another 30 are in late-stage development with the potential for future approval. However, the development of these therapies includes extensive costs that will be passed on to payers who are already navigating an uncertain post-pandemic utilization and cost dynamic.

Payers are responding by more thoroughly assessing the cost/benefit of therapies in their coverage decisions, contracting with manufacturers to tie reimbursement to real-world evidence, exploring alternative financing arrangements (including stop-loss policies), and enacting prior authorization and other controls to manage drug utilization.

Some key gene therapies on payers' radars include Hemgenix, which was approved by the FDA in November 2022 as a one-time treatment for patients with Hemophilia B and cost $3.5 million; and Roctavian for severe Hemophilia A, expected to be approved in 2023 following European approval in 2022. In the first half of this year, three additional gene therapies are expected to be approved, and they will likely be highly priced, putting increased pressure on the healthcare system.[11]

GLP-1 (Glucagon-like Peptide-1) Agonist drugs in diabetes and obesity

In the US alone, about 130 million adults may become eligible for GLP-1 agonist medications because of their weight and other health conditions.[12] The prohibitive cost (upwards of $10,000 a year), however, has kept utilization down. Ozempic, Novo's weekly GLP-1 shot for diabetes, went on sale in 2018, followed in 2021 by Wegovy, a higher dose of the same medication developed for obesity.

Eli Lilly's Mounjaro, approved for diabetes last year, has shown even more dramatic weight loss results through a large trial published last year and reinforced through another trial this year.[13] Lilly is filing for approval to treat obesity. Wegovy, which has approval as an obesity treatment, costs more than $17,000 a year — 40% more than Ozempic, which is the same drug in a smaller dose.[14]

At the moment, most health plans do not cover the use of GLP-1 agonists for nondiabetic treatment unless specifically approved as a prescription weight-loss drug, meaning a drug like Ozempic is not being covered for weight-loss use. However, the FDA has already set a precedent after approving Wegovy in 2021[15] and perhaps Lilly's Mounjaro in the future. Should the FDA approve all of these drugs for weight-loss, utilization can be expected to increase substantially going forward.

Figure 7: List of gene therapies to watch

Gene Therapy	Estimated Cost
Abecma™	$482,000 per suspension
Astiladrin*™	$160,000 - $260,000 per therapy
Breyanzi™	$471,000 per suspension
Carvykti™	$500,000 per suspension
Hemgenix™	$3,500,000 per dose
Omisrige™	$338,000
Rethymic™	$2,700,000 per implant
Skysona™	$3,000,000 per infusion (single use)
Vyjuvek™	$25,000 per vial
Zynteglo™	$2,800,000 per infusion (single use)

Source: PwC analysis
*Forthcoming in 2H 2023

Implications

Health plans and payviders: Track new pipeline and related costs closely for accurate modeling

Payers are anticipating the new pharmaceutical pipeline will increasingly drive the medical cost trend. Plans have begun modeling double-digit pharmacy trends into their cost projection models to avoid underestimating overall cost trend heading into 2024 and beyond. The recent growth in the number of approved gene therapies is expected to drive cost to a historic high as consumers shift to alternative medicines. Adding to this, as the scope of physician prescriptions widens to allow GLP-1 agonist drugs to be prescribed for weight loss, plans will have a new challenge in 2024. Formulary management will be a key consideration for health plans.

Pharmaceutical manufacturers: Adjusting to regulations, removal of Medicaid rebate cap, and other impacts while navigating continued public pressures

Pharmaceutical manufacturers face pricing and Gross-to-Net impacts from regulatory changes, such as the Inflation Reduction Act (IRA) and the removal of the cap on Medicaid rebates based on average manufacturer price (AMP) in 2024. Pressure continues to be applied from potential federal and state government legislation, increased PBM/payer utilization management and competitive RFPs, patient copay and assistance program dynamics, and other key trends. Manufacturers will face continued challenges as they balance optimally enabling patients access to their therapies while continuing to invest in R&D and innovation.

Deflator:

Biosimilars coming to market

The FDA defines biosimilars as a biological product that is “highly similar” to and has “no clinically meaningful differences” from an existing FDA-approved reference product.[16] The adoption of biosimilars to specialty drugs has substantial potential to manage rising drug costs.

Research finds that, on average, biosimilar sales prices are more than 50% lower than the reference product’s price was at the time of the biosimilar launch, and similarly, the sales price of brand biologics competing with biosimilars fell on average 25% since the biosimilar launch.[17]

This year, there is a new milestone in the biosimilar market — the arrival of the first biosimilar to a major specialty drug — adalimumab biosimilars to Humira™. In 2022, the revenue from this blockbuster drug totaled more than $18 billion in the US.[18] In January 2023, Amgen launched its adalimumab biosimilar, Amgevita™, and to date, the FDA has approved nine adalimumab biosimilars and most others are likely launching within a year following Amgevita™. [19]

As a reference point for the potential savings, Amgevita™ was launched with two price points, one 55% below Humira™’s list price and the other 5% below, the latter likely coming with larger rebates to the payers[20] and plan sponsors. Health plan actuaries also reported manufacturers offering larger rebates for their flagship drugs to retain market share.

Overall, the biosimilar market continues to accelerate. Figure 7 shows biosimilars to 15 reference biologics in the pipeline for 2023-25, as compared with only two approved by the FDA in 2020-22. Moreover, heightened regulatory interest and support have been reflected in a comprehensive plan for addressing high drug costs published by the US Department of Health and Human Services (HHS) earlier in 2021, which calls out “promote biosimilars and generics” in one of the three guiding principles.[21]

Many health plans are watching biosimilar trends and conducting assessments to understand their impact. For 2024, the savings from biosimilars are expected to have a relatively moderate impact on the overall medical cost trend (two health plans cited expected impacts close to -0.5%), given biologics with existing biosimilars make up a small portion of the overall medical cost. Nevertheless, 65% of health plans surveyed ranked biosimilars coming to market among their top three deflators, and many have hopes of more savings to come.

Implications

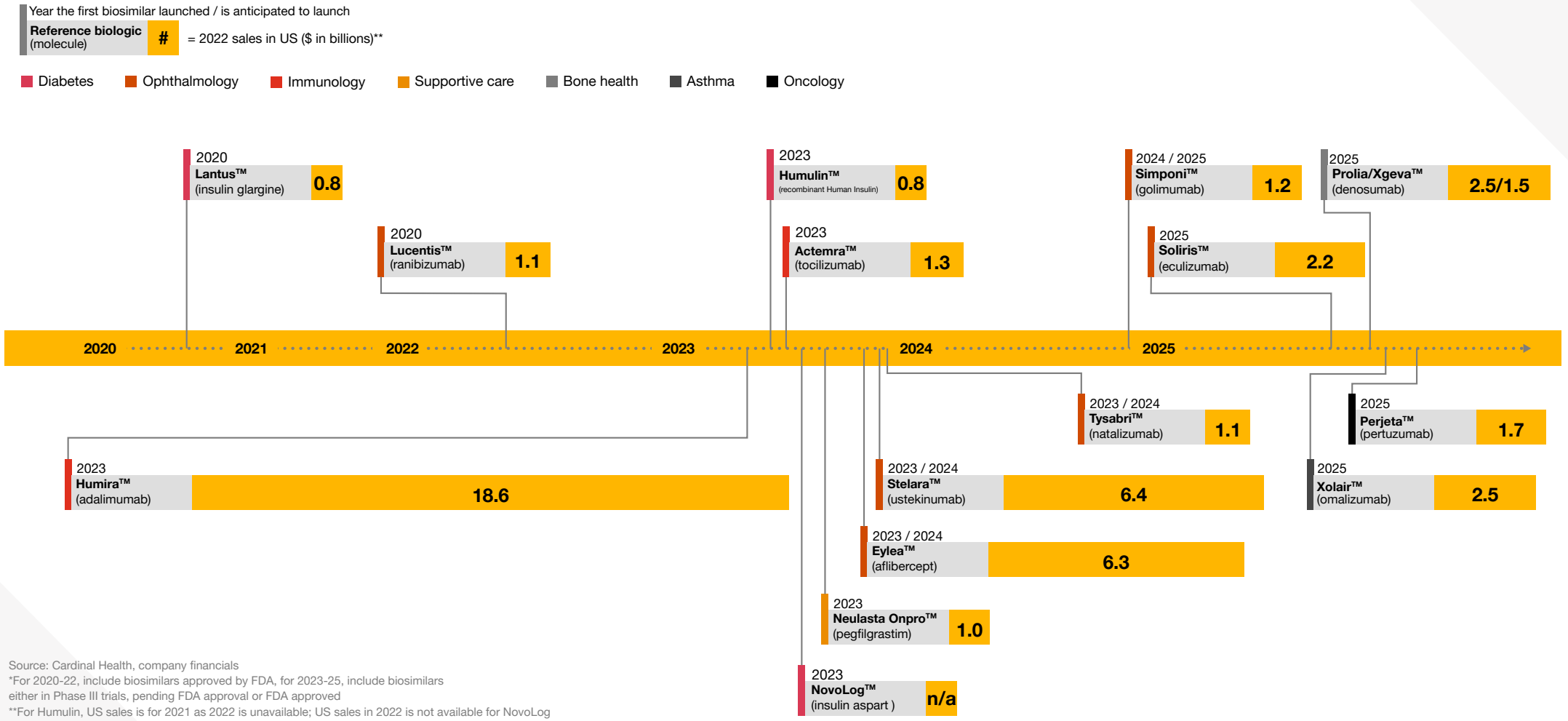
Health plans and payviders: Evaluate options to integrate biosimilars into pharmacy benefits

The idea that biosimilars offer lower-cost alternatives to biologics is simple, but the actual implementation can be complex. For health plans, the first step is likely to be working closely with pharmacy benefit managers to understand which biologic/biosimilar(s) is the most cost-efficient — sometimes staying with the existing biologics might be as cost-efficient as switching to biosimilars through competition-driven larger rebates. Next, health plans may explore alternative cost sharing design and utilization management tools, such as prior authorization that can be leveraged to incentivize members towards more cost-efficient options. An important consideration is the impact on member experience should the plans change existing benefit terms. Additionally, plans should consider potential increased utilization if the price of previously expensive drugs becomes more accessible. All the various factors need to be weighed and each health plan may make a different decision depending on its unique priority and membership characteristics.

Pharmaceutical manufacturers

While biosimilars have grown and carved out a space on the medical benefit side, particularly within physician-administered drugs in oncology, biosimilar market maturity within the pharmacy benefits space is just beginning. The entry of Lantus biosimilars last year and Humira™ this year have provided the first and largest tests of biosimilar penetration on the pharmacy benefit, with growing tests throughout 2023 (January Amgevita™ launch, multiple launches in July). Despite the uncertainty, there are some early strategies and implications emerging. First, manufacturers have launched with both high and low wholesale acquisition cost versions to appeal to different market segments, a trend that shows no sign of stopping with the Coherus + Mark Cuban Cost Plus Drugs recent announcement. Second, biosimilar entry in some cases replaces the innovator on the formulary and in other cases is disadvantaged / excluded vs. the innovator. Every entry has come at the expense of the innovator’s Gross-to-Net. Payers/PBMs are leveraging biosimilar entry to lower the cost of these drugs, and at times the entire class/therapeutic area. The industry will keep watching for any future regulatory/legislative actions that impact the biosimilar market as many players appear to remain committed to near and long-term growth of the biosimilar market.

Figure 8: Historical and anticipated future biosimilar launches 2020-25*



Source: Cardinal Health, company financials
*For 2020-22, include biosimilars approved by FDA, for 2023-25, include biosimilars either in Phase III trials, pending FDA approval or FDA approved
**For Humulin, US sales is for 2021 as 2022 is unavailable; US sales in 2022 is not available for NovoLog

Deflator:

Shift in site of care

The pandemic revolutionized the dynamics of the US healthcare system by rapidly shifting the site of care from more expensive inpatient hospitals to less expensive outpatient. While this trend started before the pandemic with cataracts and cosmetic surgery in the 2000s, it accelerated toward the end of the pandemic when employment in ambulatory care settings recovered the fastest.

As a result, lower-cost freestanding and non-acute sites were able to absorb a large portion of the demand for these healthcare services that were previously only available through inpatient settings.

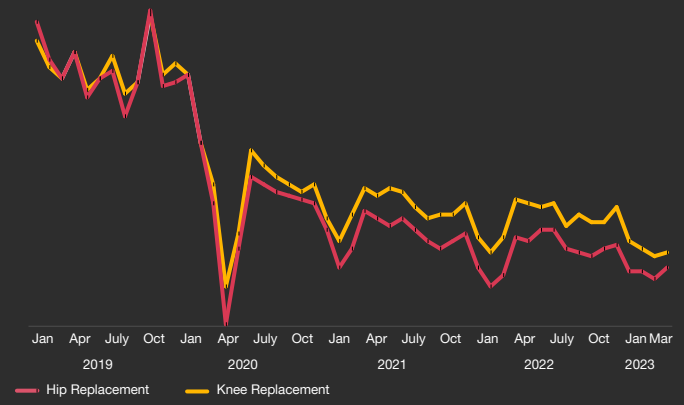
With the increased demand for outpatient surgeries, home-based services and virtual care, the healthcare delivery system has reached a new phase. Plans are factoring in higher utilization of less expensive in-person settings and virtual care going forward when pricing their 2023 plans and beyond.

Non-acute sites have lower costs for plans, which in turn is expected to decrease the share of revenue received by inpatient hospitals. With lower-cost in-person settings and virtual delivery setting the path going forward, the overall cost of care is expected to decline,[22] helping plans offset the trend inflators.

Plans have noted a material difference in the 2022 and 2023 expected trends as compared to actual experience when factoring in the uptick in utilization in less expensive in-person settings.

Figure 9: Shift in primary hip / knee replacement to Outpatient

National Volume Changes - Inpatient



National Volume Changes - Outpatient

Source: Strata National Patient and Procedure Volume Tracker

Implications

Health plans and payviders: Model trend impact from shifting site of care and associated reduction in costs

The pandemic decreased inpatient utilization over the last two years — which has helped control the cost of care while also shifting care towards outpatient, allowing plans to reap the benefits from both aspects.

As inpatient surgery trends continue to decline every year, health plans do not know yet how much lower they will go and what their models will look like. There is enough evidence to support a deflationary impact on trend until inpatient utilization in general and surgery utilization, in particular, recovers to pre-pandemic levels, if at all.

Providers: Incentivize shift of care to gain a share in profits

Providers also have an important role to play. They can work with plans to establish ownership models that share financial gains and incentivize physicians to accelerate the shift to outpatient care. This will help ease the pressure on inpatient settings whose capacity has been the slowest to recover across the country driven by an acute lack of skilled labor.

It's important to note, however, that not all care can be shifted to ambulatory service settings and may not be appropriate for frail patients, for instance, or those with complex comorbidities. There needs to be clear criteria for defining use cases and when patients can safely be shifted to less costly in-person settings.

Recent reports of increased outpatient utilization among Medicare plans was not commented on by health plans during the research period for this report.

Employers: Encourage telemedicine for primary care and behavioral health

Through plan design changes and adding new third-party telemedicine vendors, employers will likely continue to encourage the use of telemedicine. Virtual visits for behavioral health have exploded in recent years, allowing for increased flexibility in addressing the pressing need for mental health treatment, especially to address significantly increased anxiety and depression issues among adolescent patients. Virtual primary care visits are expected to increase in the coming years as well.

Trends to watch

Not all trends are new or clear inflators or deflators of the medical cost, but they are important influencers to watch. These are the areas that we will be following over the next year to track and forecast medical cost trend.

Continued efforts to manage total cost of care

To confront the ever-rising costs, health plans have continued to execute and innovate.

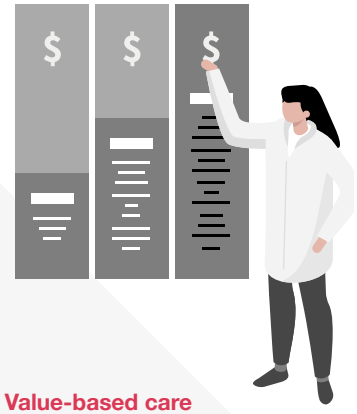
Value-based care, which better aligns incentives across payers and providers, has gained ground in recent years — analyses show that around 60% of health care payments in 2020 included some form of quality and value component, up from 38% in 2015.[23] For some plans, value-based care has proven to be a cost deflator. Meanwhile, long-standing efforts such as payment integrity and care management have continued to evolve with more sophisticated approaches and more advanced digital intelligence.

None of these cost strategies is new to the healthcare industry. National plans tend to lead in this sphere, given the high return on investment through scale. Meanwhile, more regional plans have been catching up — one plan actuary cited achieving a negative medical cost trend in 2022 by launching refocused cost of care programs. Any plan that has not made similar investments will likely to need to do so soon to keep up with the market.

Overall, the largest players in the market reported a greater impact of cost of care initiatives on trend than smaller plans. Some regional players, however, reported large one-time deflators as they catch up in the implementation of these programs. As National plans acquire smaller regional plans, this category is expected to be a deflator for medical cost trend. In the meantime, for plans that are mature in managing total cost of care, the effects of such efforts have become part of the year-over-year baseline, not explicitly a deflator but helping to keep the trend at the same level.

The COVID hangover

Impacts of changes in federal and state policies and the need for vaccines, testing and treatment vary, with the net effect likely being neutral. Health plans did not report a causal relationship between pent-up demand for care during the pandemic and utilization of care. The consensus among health plans is that inflationary pressures continuing in 2023 and going into 2024 will be driven by provider unit cost increases and pharmacy trends rather than a recovery in surgery utilization post-pandemic.



Value-based care

Move along the pathway to value from fee-for-service to shared savings and capitation arrangements

Payment integrity

Intelligent and automated process both pre- and post-payment to reduce duplication, errors and fraud or abuse with minimal provider abrasion

Utilization management

Fast but informed decisions that ensure appropriateness and drive overall value of care

Care management

Target at the right member at the right time, broaden sources of value from both medical cost and revenue sides

Advanced data analytics

Accessible to all functions, help Identify new opportunities and support existing business cases

Preventive Care & Wellness Programs

Improve both member experience and health outcomes

Behavioral health

While utilization of behavioral health grew during the pandemic and continues to grow, its cost remains relatively lower than other medical costs. Most health plans are not accounting for behavioral health in their pricing and forecasting.

During the COVID-19 pandemic, behavioral health (BH) and mental health/substance abuse services (MH/SA) saw a significant and consistent uptick in utilization. Outpatient visits related to this category trended upward in double digits year over year, reaching a new level of utilization. Omitting care for COVID-19, behavioral health visit volume was 16.8% above pre-pandemic levels in the first quarter of 2022.[24] Although the increase has slowed, health plans do not anticipate usage to go back down to pre-pandemic levels.

This large increase has been sustained across all types of BH services, whether it be in-person or telehealth and virtual care. When it comes to BH, plans reported a significant push from their consumer base for telehealth services during the pandemic that has continued since, growing from 32% pre-pandemic to 60% of all BH visits in the first quarter of 2022.[25] The growing focus on access to care improvement further motivated the use of telehealth services. An America's Health Insurance Plans (AHIP) survey covering 95 million lives showed that the number of in-network BH providers increased by an average of 48% in three years among commercial health plans, and that all plans provided coverage for telehealth services specifically for BH.[26] This trend to improve access will continue to be a hot topic as provider networks credentialled to provide these services grow and expand.

A related concern in this category is fraud, waste and abuse. A common example has been out-of-state behavioral health facilities that are covered by health plans to allow access to care but have limited, if any, oversight on the cost, quality and quantity of services being rendered. Striking the balance between network adequacy and fraud, waste and abuse will be a challenge for health plans going forward.

In most cases, while the dollars associated with these services are growing, they are still low and do not materially impact the trend development compared to other inflators. Additionally, recent studies have shown that promoting outpatient behavioral health (OPBHT) as a part of a population health strategy can help improve overall medical spending. Results indicate that healthcare costs for patient groups with OPBHT use were 10%-15% lower compared to those without OPBHT visits.[27] These findings support the cost-effectiveness of OPBHT utilization, which can act as a deflator on overall medical cost trend in the long term.

Health equity

Health equity is a focus area for health plans, although the impact of population health efforts was not factored into their medical cost trend. A broad array of factors within and beyond the healthcare system — including social, economic, and environmental factors —drive disparities in health and healthcare. Recent years have seen increasing attention and resources invested to address such disparities. On the regulatory side, the CMS published its Framework for Health Equity 2022-2032, stating its "unwavering commitment to advancing health equity" and, in practice, introduced new policies with reference to health equity to Medicare (ACO REACH benchmark adjustment)[28] and the individual marketplace (network adequacy).[29] Health equity is an important topic among health plans.

Network adequacy is a measure to ensure more equal access to care in the rural areas. On the Individual market, in the 2023 Final Rule[30] CMS set forth that it will resume its network adequacy review, which was paused in 2018, evaluating Qualified Health Plans (QHPs) for compliance with quantitative standards based on time and distance standards starting plan year (PY) 2023. As mentioned before, narrow networks are common in the Individual market. Many health plans can become noncompliant with their current network configuration — as of August 2022, CMS identified 243 out 375 issuers that were not in compliance with network adequacy standards as part of the agency's certification review of QHPs for PY 2023, either out of errors in completing the paperwork or actual noncompliance.[31] To stay compliant, many plans need to rapidly broaden their networks and contract with more providers, which will highly likely drive the unit cost up.

Setting network adequacy aside, for 2024, all of the health plans regarded health equity as having a neutral or low impact on the medical cost trend. At this stage, most plans are gathering data and forming necessary analyses to come up with actionable plans to address the disparities in health and health care and have not factored health equity into their cost of care models with respect to shifts in near-term utilization pattern changes nor long-term population health impact.

Centers for Medicare and Medicaid (CMS) Health Plan and Hospital Price Transparency Rule

Starting January 1, 2021, hospitals have been required by CMS to provide clear, accessible pricing information online, including a comprehensive machine-readable file listing gross charges, discounted cash prices and charges negotiated between the hospital and third-party payers for all the items and services provided. In July 2022, the rule was extended to include both plans and Issuers as well.[32]

In theory, the implementation of the Price Transparency Rule would expand visibility into unit prices and have wide implications for all stakeholders, including both hospitals and payers. On the one hand, hospitals could analyze the price transparency data to identify services where their charges are low relative to the market, or payers that are more generous in their reimbursements for competitor hospitals, and demand greater price increases for these services or with these payers in future contract negotiations. On the other hand, payers could similarly leverage price transparency data to improve their contracted prices as related to high-cost services or hospitals.[33]

Nevertheless, in the short term, the utility of price transparency data could be limited given several practical issues. Data accuracy is one concern. One plan reported that it found that the prices published by the hospitals could not be reconciled with the contracted prices per their own database. In addition, published in various formats, machine-readable files require data analytics efforts to be transformed and merged into a meaningful dataset.

Overall, 75% of the plans surveyed deemed the impact of the Price Transparency Rule on 2024 medical cost trend to be neutral or immaterial mainly given the immaturity of the data. In the long run, plans could see both upward and downward pressures during the contract negotiation (for example, price increases demanded by low-paid providers and price control on high-cost providers). The extent to which more transparency will shift the balance of power in negotiations, which currently favor providers and payers with higher market share and in less competitive markets, remains to be seen.

Medicaid redetermination

In response to the public health crisis, Congress passed the Families First Coronavirus Response Act in 2020, which prohibits state Medicaid agencies from disenrolling people unless they specifically request it. The Kaiser Family Foundation reported that, as a result, enrollment in Medicaid and Children's Health Insurance Program (CHIP) has grown by 21.9 million to nearly 93.0 million from February 2020 to January 2023.[34] This continuous enrollment provision ended on March 31, 2023, after which states have 12 months to initiate redeterminations of Medicaid and CHIP eligibility for all enrollees and two additional months (14 months total) to complete all pending actions.

The HHS projects the unwinding of the continuous enrollment provision to result in 15 million people losing Medicaid/CHIP coverage.[35] Specifically, among the disenrolled, 6.8 million are still eligible for Medicaid/CHIP but lost coverage due to administrative churning (they will not qualify for ACA subsidies[36]). For the remaining 8.2 million who are no longer Medicaid/CHIP eligible, HHS estimates 3.6 million to obtain employer-sponsored insurance (ESI), 2.7 million to qualify for ACA premium tax credits (PTC), including 1.7 million also eligible for zero-premium Individual plans under the provisions of the ARP and IRA. A separate study by the Urban Institute estimates 18 million people losing Medicaid/CHIP coverage, of which 2.5 million will be eligible for PTCs.[37]

A consensus among health plans is that the impact of Medicaid redetermination is likely to be felt predominantly in the Individual market. Disenrollees who obtain employer-sponsored insurance can either be previously double-covered by Medicaid/CHIP and ESI or obtain ESI through new employment as unemployment recovers back to the pre-pandemic level. It is uncertain how many will eventually be covered by small or Large Group plans, but these new members are not expected to significantly alter the risk pool of Group plans. On the Individual side, among the 2 million to 3 million disenrollees who become eligible for PTCs, not all of them will enroll in Individual plans. Many health plans expect a selection effect in which those who choose to enroll in Individual plans tend to have higher risk. Nevertheless, per the HHS projection, the Medicaid/CHIP disenrollees are much younger than the existing Individual market population and thus potentially lower risk.[38] Overall, the net impact of Medicaid redetermination could be an inflator or deflator, as believed by most health plans, and 80% of the plans indicated the impact to be neutral or low on the 2024 medical cost trend.

Between 2.5 to 2.7 million members disenrolled from Medicaid/CHIP are estimated to qualify for ACA subsidies.

About this research

Each year, PwC's Health Research Institute (HRI) projects the growth of employer medical costs in the coming year and identifies the leading trend drivers. Health insurance companies use the medical cost trend to help set premiums by estimating what this year's health plan will cost next year. In turn, employers use the information to make adjustments to benefit plan design to help offset health insurance cost increases. The report identifies and explains what it refers to as "inflators" and "deflators" to describe why and how the healthcare spending growth rate is affected.

This forward-looking report is based on the best available information through June 2023. HRI conducted 21 surveys and 12 interviews from April through May 2023 with health plan actuaries whose companies cover nearly 100 million employer-sponsored large and small group members and 10 million ACA marketplace members. Participants were asked about their trend experience for 2022, and trend estimates for 2023-24, and the factors driving those trends.

Results from the surveys and interviews were aggregated using a weighted average approach based on the number of self-reported lives in the survey. Results for Group and Individual trend were not aggregated for any purposes or results during this process.

Acknowledgements

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Excellus BlueCross BlueShield

Florida Blue

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Highmark Health

Horizon Blue Cross Blue Shield

Independence Blue Cross

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Slide 1/Main Trend Chart:
Source: PwC Health Research Institute medical cost trends, 2009-2024

Slide 2/Medical Inflation/ wages:
Source: Bureau of Labor Statistics Consumer Price Index, PwC Analysis

Slide 3/Employment:
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Slide 4/Physician acquisitions:
Source: Physician Advocacy Institute report on COVID-19's impact on acquisitions of physician practices and physician employment 2019-2021
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Slide 5/Median price of newly marketed drugs:
Source: Article on Trends in Prescription Drug Launch Prices, 2008-2021 published in The Journal of the American Medical Association
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Slide 6/ Number of drugs with price increases:
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Slide 7/Gene Therapies Table:
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Slide 9/Both knee charts:
Source: Strata National Patient and Procedure Volume Tracker
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2023 Median Ratios: Not-for-Profit Hospitals and Healthcare Systems

"Fitch views the expected year-over-year deterioration in sector medians as a full reversal from certain all-time highs seen in 2022 (based on 2021 data) to what will likely be defined as operational all-time lows this year.

Longer-term industry dynamics continue to suggest protracted margin compression compared to historical trends as additional expenses, primarily labor, remain elevated. We continue to expect a return to monthly break-even in 2023 for the majority of the rated portfolio, albeit at a slower pace than anticipated heading into the year. While we believe 2023 financial results will be better than those of 2022, this will not represent a full rebound, given the tremendous ongoing pressures on many credits in the sector."

Kevin Holloran, Senior Director, USPF Healthcare

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Investment Value Declines Erode Not-for-Profit Hospitals' Liquidity (January 2023)

Staff Shortages Improving for U.S. NFP Hospitals (December 2022)

Labor Pains to Intensify for U.S. NFP Hospitals in 2023 (December 2022)

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Median Ratios: Significantly Weaker vs. Prior Year

In 2022, we warned that the 2022 medians (based on 2021 data) would likely be the sector peak, and that the 2023 medians would show a significant reversal. To that end, Fitch Ratings' 2023 medians (using audited 2022 data) largely show sizable and widespread deterioration in operating margins and balance sheet metrics, a stark contrast to last year (*See Summary Table on page 5).* Similarly, last year, the 2021 medians also reflected a reversed trend from the prior-year medians (i.e. were much stronger).

The difficult start to 2022 began with a deepening financial deficit caused by acuity reductions and labor challenges. Macro headwinds started to form in late 2021 and accelerated in early 2022, with labor shortages, inflationary expenses, reduced elective volumes and surgeries, and increased medical admissions to varying degrees across the rated portfolio. These trends continued for much of the rest of the year for the majority of the rated credits, with the median operating margin now at just 0.2%. This means that approximately one-half of our rated portfolio recorded a negative operating margin in 2022, ranging widely from a high of 27% to a low of negative 21.5%.

The more significant signs of operational challenges (defined as operating EBITDA margin) were seen at the lower end of the rating spectrum (the below-investment-grade [BIG] categories). The BIG categories reported a very modest 0.3% operating EBITDA margin, compared with 6.9% in fiscal 2021, a 95.6% decrease. The mid investment-grade (IG) category (A category) reported a 4.8% operating EBITDA margin, versus 8.8% in fiscal 2021, a 45.5% decrease.

Losses were more modest at the high end of the IG rating spectrum (AA category), with only a 29.2% decrease to 6.8% operating EBITDA margin from 9.6% the prior year.

Most significantly, the lower end of the rating spectrum (BIG categories) saw a 37.5% decrease in cash to adjusted debt, to 47%. Equally notable, there were also significant downward adjustments to key balance sheet metrics concentrated at the high end of the rating spectrum, with a 16.8% decrease in cash to adjusted debt to 207% for 'AA' category credits.

On a more positive note, despite the loss of about 44 days' cash on hand in the 2022 medians to 216 days, the key balance sheet metrics remained comparable to favorable with pre-pandemic levels; days' cash on hand averaged approximately 206 days for the 2013 through 2019 medians. The same can be said for other key measurements such as cash to debt and leverage (debt to capitalization).

Pandemic to "Labordemic"

The coronavirus pandemic has morphed into an endemic issue, akin to seasonal influenza. Access to vaccines and inherent immunity through exposure have removed the coronavirus as a meaningful rating event at this time.

What dominates now is the sectors' need for significant additional staffing, particularly nursing, which emerged as a critical weakness in the sector, resulting in massively increased staffing expenditures (employed and contracted) as the new norm for much of the sector.

Labor shortages, both clinical and non-clinical, will continue through 2023, and likely longer in many markets, with high-growth markets generally better able to mitigate staffing shortages.

Key Takeaways

Some key takeaways from the 2023 medians include the following.

- Across-the-board deterioration in operating margins, regardless of size or rating category, of approximately 300 basis points.
- The median rating remained at 'A+', while the most common (mode) rating remained at 'AA-'.
- Reduced strength in all key balance sheet metrics, across all rating categories, highlighted by a reduction in median days' cash on hand by 44 days.
- Key balance sheet metrics (such as days' cash on hand, cash to debt and leverage) remained comparable to favorable with pre-pandemic levels, indicating that much of the financial cushion built up during 2021 has greatly eroded, but credits still remain commensurate with historical levels.

Complex/Difficult Sector Environment

As 2022 will likely be the worst operational year on record for many providers (even compared to the 2008-2009 "Great Recession"), the sector did take a step back. It remains to be seen if, as 2023 progresses and operations gradually improve, this step back will become a sidestep along a very complicated sector journey, or the new normal.

- We are likely still another year away from some level of "normal" for the sector, particularly in terms of labor availability.
- For some providers, volumes continue to fall short of pre-pandemic trends. For others, volumes are at or even above pre-pandemic levels. More notable is the shift from surgical to medical, particularly for the first half of 2022, combined with the longstanding inpatient to outpatient migration.
- Some services have been curtailed, either from lack of demand or lack of staffing, both of which limited traditional top-line revenue growth in 2022. However, this also demonstrates to contract labor companies the limits to labor spending that many providers have hit.
- Some risk-based business still appears to be on the backburner due to the unpredictability of the expense base, with a continued focus on basic costs, instead of price, quality, equality, transparency, etc.
- While there was, surprisingly, no sectorwide significant change in payor mix due to the pandemic, Fitch still believes the sector will see a gradually eroding payor mix overall with Medicare and Medicaid volumes accounting for an increasing percentage of inpatients.

Overall 'A+' Median Rating; 'AA–' Most Common

The median rating in Fitch's portfolio remains at 'A+', while the most common rating in the agency's portfolio remains at 'AA–'. About 27% of the rated hospitals and health systems in this median report have a 'AA–' rating, with 40.5% in the overall 'AA' rating category. Another 37.2% of Fitch's ratings are in the broad 'A' rating category, 15.8% are in the 'BBB' rating category, and only 6.5% are rated BIG. (*See the Ratings Distribution chart on page 6.*)

Operating Performance: Weaker for All

Median operating and operating EBITDA margins declined notably to 0.2% and 5.8%, respectively, in fiscal 2022 from 3.0% and 8.9% in the prior year. The deterioration seen in operating income is attributed to multiple factors but is primarily due to the cost of labor shortages, generationally elevated inflation and the depletion of prior pandemic-era relief funding. Moreover, the decline in operating margins may be slightly understated, as many health systems with June 30 fiscal year ends had a stronger start to the fiscal year (which for them began the second half of 2021).

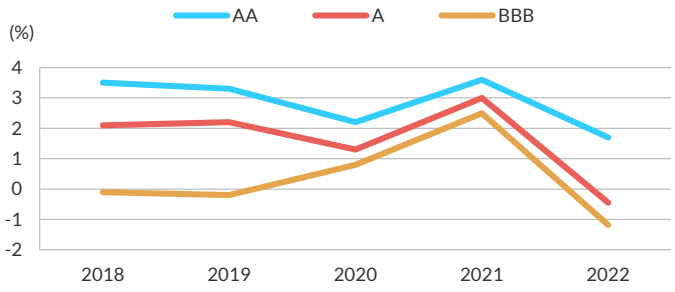
Median excess margin and EBITDA are even more negatively affected compared to operating margins at 1.9% and 7.3%, respectively. This is far removed from last year's 6.6% and 12.4% margins, respectively. Non-operating income sources (e.g. investment returns) were notable diluted due to the market volatility seen in 2022.

Trends Vary by Rating Category

The 'AA' category operating margin median declined the least of any rating category, falling to 1.7% from 3.6% the prior year. The operating EBITDA margin followed suit, decreasing to 6.8% from 9.6% yoy. The pattern for 'A' rating category medians was more pronounced, decreasing to 0% from 3.0% the prior year. Of note, the 'AA' and 'A' category credits account for some three-quarters of Fitch's rated portfolio. However, when comparing individual ratings versus categories, the 'A+' and 'A-' ratings show negative median operating margins.

The 'BBB' category operating margin medians notably trended to the negative at -1.2% versus 2.5% the prior year. The BIG category suffered the largest losses, shifting downward from 1.3% the prior year to a very weak negative 6.1% for the current set of medians (although the small sample size of BIG credits is noted). (*See tables on pages 7 and 8.*)

Operating Margin



Source: Fitch Ratings

Fitch believes that different strategies will be necessary to advance healthcare on a transformative level, and return to sustainable levels of cash flow and, ultimately, to break-even or better on Medicare rates - a long-stated, but rarely achieved sector goal.

Liquidity Metrics Deteriorate Significantly

Key median liquidity metrics (days' cash on hand and cash to debt) were markedly reduced compared to the prior year. Days' cash declined by approximately 44 days (down 17%) to 216 from 260, and cash to debt saw a similar percentage decline to 147% from 186% yoy. Despite the precipitous decline, which comes after a rapid strengthening in 2021, liquidity metrics remain strong for the sector, and while no longer at all-time highs, still compare favorably to pre-pandemic levels. The metrics continue to provide some cushion against equity market volatility, inflationary pressures and added expenses due to labor scarcity. (*See tables on pages 7 and 8.*)

Spiking Leverage Metrics

Median 2022 leverage ratios worsened by a substantial amount. Median debt to capitalization deteriorated to 34.2%, compared with 31.7% the prior year, and is the highest level since the 2017 median level of 34.3%

Fitch utilizes cash to adjusted debt to find measures consistent across the sector and rating spectrum. Adjusted debt comprises underfunded defined benefit pension liabilities below an 80% funded level (for traditional Employee Retirement Income Security Act [ERISA] and church plans) as a long-term debt equivalent.

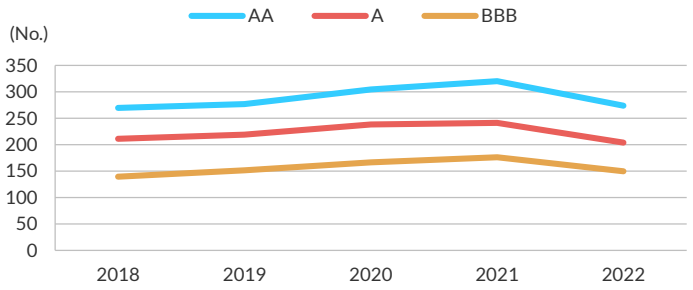
Overall cash to adjusted debt declined notably to 143% from 180% yoy, or a 20.4% decrease. Cash to adjusted debt is the most highly correlated metric in Fitch medians across the various rating categories, highest in the 'AA' category and lowest in the BIG category, with all rating categories seeing declines in this year's medians. (*See tables on pages 7 and 8.*)

Balance Sheet Ratios

The overall median for cash to debt declined to 147% from 186% yoy. Fitch's 'AA' rating category decreased to 215% from 253%, and the 'A' rating category declined to 130% from 153% yoy. Market losses suffered in 2022 and added operating expenses account for the decreases.

At the higher end of the rating scale, days' cash declined, to 273 and 204 days for the 'AA' and 'A' categories, respectively, versus 320 and 241 days in the prior year. Similar declines on a percentage basis occurred in the 'BBB' rating category, which saw a dip to 149 days from 176 days in the prior year, and the compression in cash on hand in the BIG rating category declined to 75 days from 90 days the prior year.

Days Cash on Hand



Source: Fitch Ratings

Fitch credits the similarity (on a percentage basis) for the decline in days' cash on hand at higher-rated providers compared to the lower-rated providers, despite generally more aggressive asset allocations at the higher ratings, to a better ability to flex capital projects; and the lack of egregious declines in operating margins and operating EBITDA margins.

Capital Spending

Average age of plant changed little, with the 2022 level at 12.1 years, compared with 11.9 years for 2021. Maintenance of the average age of plant was driven by a somewhat surprising increase in overall capital spending, particularly at the 'AA' and 'BBB' category ratings, with capital spending as a percentage of depreciation expense increasing to 119% and 103%, respectively.

A narrow band remains in Fitch's rated portfolio around the median average age of plant (11.1 years to 15.1 years), and the accounting treatment when an asset is acquired (or whether the depreciation schedule aligns with the life of the assets) can swing this calculation up and down. Consequently, Fitch places more emphasis on the multiyear trend of capital spending compared to annual depreciation expense (capital spending ratio), rather than average age of plant, in its ratings.

The annual capital spending ratio is more mixed but up overall, increasing unexpectedly for the sector to about 110% in 2022, compared with 100% the prior year.

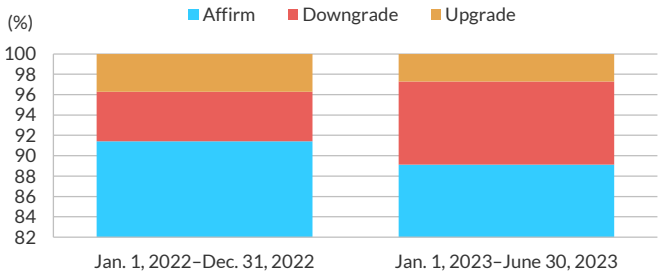
There is variability at the different rating categories, as expected. For example, at the high end of the rating scale, the capital spending ratio was most acute (the AA category was at 119%, compared with 101% the prior year). This was mirrored by a similar shift in capital spending at the 'BBB' category, to 103% from 83% yoy. The 'A' category saw flat spending compared to the prior year at about 105% in both years, while the BIG category saw the only decline, to 72% from 94% the prior year (as lower-rated credits scrambled to preserve liquidity in a challenged environment). As noted, the BIG category is a small sample size and more susceptible to shifts in capital spending. (*See tables on pages 7 and 8.*)

Rating Actions: Tilting Negative

Rating actions in 2022 displayed general credit stability, notwithstanding the dire tone of the medians. Fitch affirmed 91% of its healthcare ratings while downgrading 5% and upgrading 4%. While Stable Rating Outlooks still dominate the sector, with 92% Stable in 2022, Negative Rating Outlooks are beginning to outpace Positive Rating Outlooks, at 6% and 2%, respectively.

Affirmations are generally consistent, with trends for the first six months of 2023 (Jan. 1, 2023 through June 30, 2023) showing a similar trend, albeit with a smaller sample size, but rating actions have taken a decidedly negative tone. During this time frame, Fitch affirmed 89% of its ratings, but upgraded only 3% of issuers while downgrading 8%. Similarly, year to date, Negative Rating Outlooks continue to outpace Positive Rating Outlooks (3% to 1%). (*See Ratings Actions Chart on page 6.*). Even as macro-wide operating margins slowly rebound in 2023, Fitch expects the trend of downgrades and Negative Rating Outlooks to outpace upgrades and Positive Rating Outlooks, particularly for systems whose operating margins in 2023 are no better, or worse than, in 2022.

Not-for-Profit Hospitals and Healthcare Systems – Rating Actions



Source: Fitch Ratings

Summary

As we close out fiscal 2022 with this set of medians, our goal, as always, is to provide thoughtful and clear forward-looking analysis and communications. When we released last year's medians, there was a belief that the sector had peaked in 2021 and would experience stress in 2022, with recovery beginning in 2023. As we have seen year to date, the negative associated pressures have lingered longer than expected due to continued labor shortages, inflationary expenses and shifting volume composition.

For 2023 and beyond, Fitch forecasts the following.

- The sector will continue to experience weak margins in 2023 and into 2024, due to an inelastic revenue model, pronounced labor challenges and lingering inflationary pressures, unless payors, governmental or otherwise, begin to hike annual rate increases more in line with this new normal.
- The credit gap between stronger and weaker credit profiles will continue to widen, with a growing credit split within the upper end of the rating scale, with some providers easing through 2022 and 2023 with very little difficulty compared to others.
- Many providers will seek to engage in a wave of significant M&A, although the current regulatory and legislative environment may limit activity for health systems operating in the same market, encouraging more out-of-market mergers.
- Organizations will likely need to find transformative ways to move from traditional fee-for-service reimbursement and the potential benefits of accepting first-dollar coverage.

Methodology

Fitch included its rated standalone hospitals and health systems for this report; children's hospitals are not included (children's hospital medians are reported separately). In addition, some credits are excluded for analytical purposes or lack of data. Fitch notes that the small sample size for some of the individual rating categories can create greater volatility in the data and that sample size should be considered when reviewing yoy changes.

For all data points in this report, Medicare Accelerated and Advance Payment Program funds were excluded from Fitch's cash and cash-equivalent ratios, as Fitch has always viewed these funds as a temporary loan, and not permeant cash on the balance sheet.

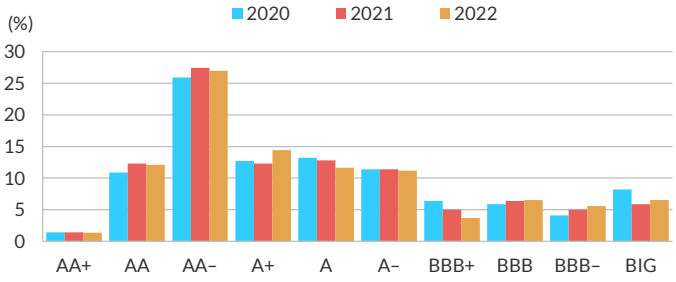
Data Appendix

Nonprofit Hospital and Healthcare System Overall Medians — 2022

	2022	2021	2020	2019	2018	2017	2016	2015	2014	2013
Sample Size	215	219	213	220	220	232	249	246	235	243
Days Cash on Hand	216.1	260.3	241.4	219.8	214.9	213.9	195.5	203.8	203.4	193.9
Days in Accounts Receivable	47.3	47.2	44.6	46.8	45.9	47.0	47.3	47.9	48.2	49.3
Cushion Ratio (x)	25.6	29.7	25.3	22.8	22.5	20.9	18.7	18.2	17.6	16.4
Days in Current Liabilities	69.6	89.4	91.4	64.3	62.8	61.7	63.8	65.7	66.4	64.8
Cash to Debt (%)	147.1	185.5	162.8	159.3	155.4	159.0	142.8	138.5	141.8	127.7
Cash to Adjusted Debt (%)	143.4	180.1	150.6	138.9	130.6	130.4				
Operating Margin (%)	0.2	3.0	1.5	2.3	2.1	1.9	2.8	3.5	3.0	2.2
Operating EBITDA Margin (%)	5.8	8.9	7.3	8.7	8.6	8.5	9.5	10.3	9.7	9.2
Excess Margin (%)	1.9	6.6	3.3	4.5	4.0	4.2	3.8	5.2	4.8	3.7
EBITDA Margin (%)	7.3	12.4	9.3	10.6	10.4	10.3	10.5	12.2	11.7	10.9
Net Adjusted Debt to Adjusted EBITDA	-2.0	-2.1	-2.1	-1.3	-1.1	-1.1				
Personnel Costs as % of Total Op. Revenue	54.3	52.8	55.0	53.3	54.0	54.9	54.8	53.6	54.4	55.0
EBITDA Debt Service Coverage (x)	3.2	5.7	4.0	4.1	4.0	3.8	3.6	4.3	4.0	3.5
Op. EBITDA Debt Service Coverage (x)	2.4	3.8	3.1	3.3	3.4	3.2	3.2	3.7	3.5	3.0
Maximum Annual Debt Service as % of Revenues	2.2	2.2	2.3	2.4	2.5	2.6	2.6	2.8	2.9	3.1
Debt to EBITDA (x)	4.2	2.7	3.8	3.3	3.4	3.3	3.5	3.1	3.1	3.6
Debt to Capitalization (%)	34.2	31.7	33.6	33.1	33.7	34.3	37.0	38.4	36.6	37.8
Average Age of Plant (Years)	12.1	11.9	11.7	11.6	11.2	11.2	11.0	10.8	10.6	10.6
Capital Expenditures as % of Depreciation Expense	109.5	100.4	109.5	117.7	117.0	121.4	115.8	111.9	106.6	115.7

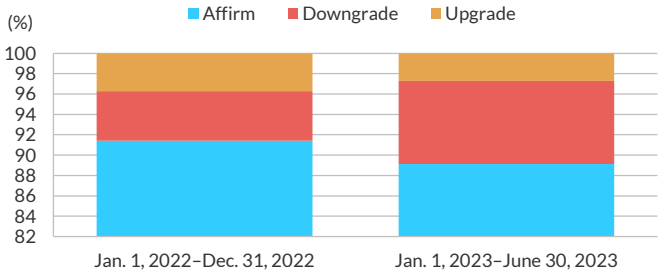
Source: Fitch Ratings

Rating Distribution



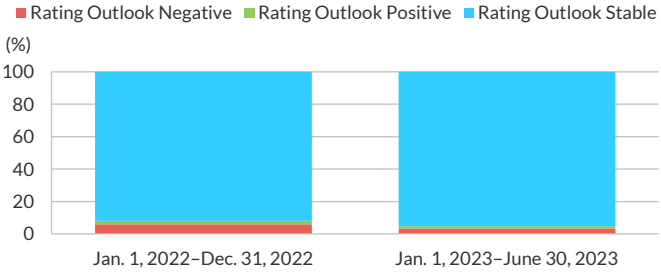
Source: Fitch Ratings

Not-for-Profit Hospitals and Healthcare Systems – Rating Actions



Source: Fitch Ratings

Not-for-Profit Hospitals and Healthcare Systems – Rating Outlooks



Source: Fitch Ratings

Data Appendix — Medians by Rating Category

Nonprofit Hospital and Healthcare System Category Medians — 2022

	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
	Median	Median	AA	AA	A	A	BBB	BBB	BIG	BIG
Sample Size	215	219	87	90	80	80	34	25	14	13
Total Operating Revenue ($ Mil.)	1,227,013	1,160,179	2,118,856	2,125,216	1,162,916	1,012,531	791,168	748,682	410,242	445,803
Days Cash on Hand	216.1	260.3	273.4	319.7	203.8	241.2	149.4	175.7	75.1	90.4
Days in Accounts Receivable	47.3	47.2	46.0	46.1	47.9	48.2	51.1	50.3	49.4	47.9
Cushion Ratio (x)	25.6	29.7	40.1	44.0	21.7	25.0	14.9	16.6	7.8	10.1
Days in Current Liabilities	69.6	89.4	74.7	92.8	64.6	83.9	67.7	94.7	74.6	92.1
Cash to Debt (%)	147.1	185.5	215.0	252.9	130.4	153.0	98.5	107.3	54.8	75.9
Cash to Adjusted Debt (%)	143.4	180.1	207.1	249.1	129.0	151.8	90.4	102.3	47.2	75.5
Operating Margin (%)	0.2	3.0	1.7	3.6	0.0	3.0	-1.2	2.5	-6.1	1.3
Op. EBITDA Margin (%)	5.8	8.9	6.8	9.6	4.8	8.8	4.7	7.9	0.3	6.9
Excess Margin (%)	1.9	6.6	3.7	8.5	1.8	5.7	-0.2	4.8	-1.0	3.6
EBITDA Margin (%)	7.3	12.4	8.6	13.9	7.1	11.9	5.6	10.8	4.8	9.8
Net Adjusted Debt to Adjusted EBITDA	-2.0	-2.1	-3.5	-3.2	-1.3	-1.6	0.3	-0.1	2.4	1.0
Personnel Costs as % of Total Operating Revenue	54.3	52.8	54.4	52.0	55.1	52.8	52.8	51.6	59.3	55.1
EBITDA Debt Service Coverage (x)	3.2	5.7	4.6	7.4	3.0	4.9	2.0	4.0	1.6	3.3
Op. EBITDA Debt Service Coverage (x)	2.4	3.8	3.5	4.7	2.1	3.7	1.8	3.0	0.1	2.5
Maximum Annual Debt Service as % of Revenues	2.2	2.2	1.9	2.0	2.4	2.4	2.5	2.5	2.6	2.8
Debt to EBITDA (x)	4.2	2.7	3.5	2.3	4.4	3.1	6.6	3.4	8.0	3.5
Debt to Capitalization (%)	34.2	31.7	26.1	24.4	38.6	34.7	40.4	41.1	58.7	56.6
Average Age of Plant (Years)	12.1	11.9	11.1	10.8	13.0	12.5	12.7	13.0	15.1	15.6
Capital Expenditures as % of Depreciation Expense	109.5	100.4	119.2	100.8	105.5	105.3	103.3	83.4	72.3	94.4

EBITDA – Earnings before interest, taxes, depreciation and amortization. CFFOBI – Cash flow from operations before interest.
Source: Fitch Ratings

Data Appendix — Medians by Individual Rating

Nonprofit Hospital and Healthcare System Medians for Investment-Grade Ratings — 2022

	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
	AA	AA	AA–	AA–	A+	A+	A	A	A–	A–	BBB+	BBB+	BBB	BBB	BBB–	BBB–
Sample Size	26	27	58	60	31	28	25	30	24	25	8	12	14	15	12	13
Total Operating Revenue ($ Mil.)	2,947,733	3,112,121	1,760,019	1,508,520	1,508,818	1,572,435	943,480	711,659	846,332	794,763	999,436	819,097	799,890	772,286	563,749	650,596
Days Cash on Hand	322.9	380.3	242.5	293.7	204.8	252.9	222.3	247.5	187.6	230.9	179.7	206.4	126.9	150.3	152.2	169.9
Days in Accounts Receivable	45.3	47.0	45.9	45.1	47.1	49.2	46.7	48.2	48.9	46.6	53.5	54.4	46.8	43.7	51.2	52.0
Cushion Ratio (x)	50.2	55.6	33.2	36.3	23.1	30.7	21.8	22.6	17.3	22.5	20.7	20.5	14.4	14.9	12.2	12.7
Days in Current Liabilities	81.3	101.2	69.3	86.7	64.3	77.9	61.9	84.4	73.6	91.6	71.8	108.5	68.5	96.2	63.5	81.3
Cash to Debt (%)	273.9	317.1	196.6	226.4	146.2	162.8	122.1	153.0	111.3	132.0	143.0	108.9	87.9	106.8	87.0	82.9
Cash to Adjusted Debt (%)	272.2	300.5	190.7	213.9	139.6	159.9	118.4	153.0	108.3	129.1	137.4	127.6	80.5	103.6	67.8	59.3
Operating Margin (%)	2.5	5.4	1.1	3.2	-1.8	3.1	1.1	2.8	-1.3	4.6	1.5	3.2	-3.0	0.4	0.1	3.5
Op. EBITDA Margin (%)	7.7	10.9	6.5	9.4	4.1	8.8	6.2	8.6	3.3	9.8	7.6	7.9	2.8	6.2	5.5	10.8
Excess Margin (%)	4.6	10.8	2.8	8.0	1.7	6.9	3.2	5.5	1.0	5.7	0.8	5.6	-0.8	3.4	-0.1	4.6
EBITDA Margin (%)	9.3	15.0	8.0	13.5	6.7	12.5	8.6	11.3	6.0	11.9	6.8	10.9	4.5	8.2	6.1	11.4
Net Adjusted Debt to Adjusted EBITDA	-4.0	-3.5	-3.2	-2.9	-2.0	-2.1	-0.7	-1.6	-0.3	-1.3	-1.7	-0.7	1.2	-0.1	1.2	1.3
Personnel Costs as % of Total Operating Revenue	54.1	50.8	54.6	53.3	54.3	51.9	54.7	54.9	60.5	50.5	51.3	50.9	55.5	53.5	52.2	53.1
EBITDA Debt Service Coverage (x)	6.9	9.9	4.2	6.7	3.1	5.6	3.5	4.7	2.6	4.6	3.0	4.8	1.7	3.7	2.2	3.5
Op. EBITDA Debt Service Coverage (x)	5.2	5.9	3.2	4.3	1.9	3.7	2.7	3.5	1.7	3.6	2.8	3.3	1.1	2.5	2.4	3.3
Maximum Annual Debt Service as % of Revenues	1.6	1.7	2.0	2.1	2.5	2.4	2.4	2.5	2.4	2.2	2.3	2.6	2.4	2.5	2.7	2.5
Debt to EBITDA (x)	3.0	1.8	3.5	2.4	4.5	2.8	3.8	3.2	6.3	3.4	3.6	3.5	6.4	3.2	7.9	2.8
Debt to Capitalization (%)	23.7	21.1	29.3	27.0	38.0	33.0	38.6	34.9	41.6	37.9	37.5	41.8	42.1	39.7	40.2	43.3
Average Age of Plant (Years)	10.7	9.9	11.4	11.1	13.2	12.4	13.5	12.8	12.0	11.6	12.4	12.8	12.3	11.7	13.7	15.0
Capital Expenditures as % of Depreciation Expense	122.5	127.4	112.4	97.2	129.7	107.2	103.7	90.2	92.1	97.9	168.1	101.5	117.9	86.3	88.9	74.2

Source: Fitch Ratings

Data Appendix — Medians (Standalone)

Standalone

	2022	2021	2020	2019	2018	2017	2016	2015
Sample Size	103	104	99	97	99	93	90	85
Days Cash on Hand	209.7	237.5	232.1	213.3	214.5	211.1	203.1	202.3
Days in Accounts Receivable	46.8	46.2	44.4	46.2	45.5	46.4	46.3	48.0
Cushion Ratio (x)	24.3	24.7	23.3	21.7	20.4	19.7	18.0	16.4
Days in Current Liabilities	68.2	89.4	88.1	61.2	59.7	62.0	60.4	65.2
Cash to Debt (%)	145.4	179.7	150.5	157.6	147.4	156.0	143.0	138.0
Cash to Adjusted Debt (%)	138.6	175.7	135.8	131.7	118.3	122.1	111.7	110.9
Operating Margin (%)	0.2	3.8	1.7	2.0	1.6	2.3	3.2	3.8
Op. EBITDA Margin (%)	5.8	9.7	8.4	8.7	8.4	8.8	9.7	10.8
Excess Margin (%)	2.0	7.0	3.7	3.8	3.7	4.2	4.6	5.7
EBITDA Margin (%)	7.5	13.0	10.4	10.6	10.5	10.4	10.4	12.0
Net Adjusted Debt to Adjusted EBITDA (%)	-1.6	-1.6	-1.6	-1.0	-0.8	-0.9	-0.4	-0.4
Personnel Costs as % of Total Operating Revenue	54.7	53.1	55.1	54.4	54.6	55.4	54.2	54.1
EBITDA Debt Service Coverage (x)	3.1	5.2	4.1	3.8	3.3	3.5	3.6	4.0
Op. EBITDA Debt Service Coverage (x)	2.2	3.8	3.1	3.0	2.6	3.0	3.2	3.4
Maximum Annual Debt Service as % of Revenues	2.3	2.5	2.7	2.6	2.7	2.9	3.0	3.2
Debt to EBITDA (x)	3.8	2.5	3.4	3.2	3.5	3.3	3.2	2.9
Debt to Capitalization (%)	33.6	29.7	32.6	32.8	35.0	34.3	37.2	37.0
Average Age of Plant (Years)	12.7	12.3	12.0	11.7	11.2	11.1	10.7	10.6
Capital Expenditures as % of Depreciation Expense	103.7	101.2	108.4	107.0	114.6	131.4	120.3	111.9

Source: Fitch Ratings

Data Appendix — Medians (Systems)

Systems

	2022	2021	2020	2019	2018	2017	2016	2015
Sample Size	112	115	114	106	103	98	96	82
Days Cash on Hand	219.0	270.4	255.0	230.2	224.6	241.4	215.2	230.5
Days in Accounts Receivable	47.8	47.7	44.6	46.8	46.2	47.7	47.9	48.0
Cushion Ratio (x)	26.0	31.7	29.0	26.5	24.2	23.0	20.8	22.2
Days in Current Liabilities	72.5	89.8	95.0	66.8	65.1	63.9	66.2	67.4
Cash to Debt (%)	152.4	189.4	169.9	165.7	167.5	170.9	165.2	169.5
Cash to Adjusted Debt (%)	147.0	185.0	161.1	149.9	147.3	145.3	132.4	137.9
Operating Margin (%)	0.2	2.7	1.3	2.5	2.4	1.9	3.1	3.8
Op. EBITDA Margin (%)	5.7	8.1	6.7	8.9	8.7	8.7	9.3	10.3
Excess Margin (%)	1.7	6.1	3.1	4.9	4.7	4.3	4.3	5.6
EBITDA Margin (%)	7.1	12.1	8.5	10.6	10.5	10.4	10.4	12.0
Net Adjusted Debt to Adjusted EBITDA (%)	-2.4	-2.5	-2.6	-1.5	-1.3	-1.5	-1.2	-1.1
Personnel Costs as % of Total Operating Revenue	54.2	52.3	55.0	53.0	53.9	54.9	54.8	53.2
EBITDA Debt Service Coverage (x)	3.4	5.8	3.9	4.5	4.1	4.1	3.7	4.4
Op. EBITDA Debt Service Coverage (x)	2.7	3.8	3.2	3.7	3.5	3.2	3.4	3.7
Maximum Annual Debt Service as % of Revenues	2.0	2.1	2.2	2.2	2.5	2.7	2.7	2.7
Debt to EBITDA (x)	4.3	2.8	4.4	3.4	3.4	3.3	3.4	2.9
Debt to Capitalization (%)	34.9	31.9	35.2	32.9	32.4	33.1	33.8	33.0
Average Age of Plant (Years)	11.9	11.8	11.4	11.5	11.3	10.9	10.6	10.5
Capital Expenditures as % of Depreciation Expense	110.7	99.1	110.1	125.0	128.3	126.1	122.1	121.8

Source: Fitch Ratings

Data Appendix — Rated Credits

List of Rated Credits — Hospitals

As of June 30, 2023	Long-Term Rating
AdventHealth (FL)	AA
Adventist Health (CA)	A
Advocate Aurora Health, Inc. (WI)	AA
Allina Health System (MN)	AA–
Altru Health System (ND)	BBB–
AnMed Health (SC)	AA–
Asante Health System (OR)	A+
Ascension Health Alliance (MO)	AA+
Ashtabula County Medical Center (OH)	BBB+
Atlanticare Health System, Inc. and Affiliates (NJ)	AA–
Ballad Health (TN)	A
Banner Health System (AZ)	AA–
Baptist Health Care Corporation Obligated Group (FL)	BBB
Baptist Healthcare System (KY)	A+
BayCare Health System Inc. (FL)	AA
Bayhealth Medical Center, Inc. (DE)	AA
Baystate Medical Center (MA)	A+
Beacon Health System, Inc. (IN)	AA–
Beloit Health System (WI)	A
Benefis Health System (MT)	A+
Berkshire Health System and Affiliates (MA)	AA–
Bexar County Hospital District (TX)	AA+
Billings Clinic (MT)	AA–
Blanchard Valley Health Association (OH)	A+
Bon Secours Mercy Health, Inc. (OH)	AA–
Brooks Rehabilitation (FL)	A–
Bryan Medical Center (NE)	AA–
Butler Health System (PA)	BBB
Cape Cod Healthcare, Inc. and Affiliates (MA)	AA–
Care New England (RI)	BB–
Carle Foundation (IL)	AA–
CaroMont Health, Inc. and Affiliates (NC)	AA–
Carson Tahoe Healthcare (NV)	A–
Catholic Health Services of Long Island (NY)	A–
Cedars-Sinai Health System (CA)	AA–
Centra Health (VA)	A–
Centracare Health System (MN)	AA–
Christus Health (TX)	A+
Columbia Memorial Hospital (OR)	A–
CommonSpirit Health (CO)	A–
Commonwealth Health Corporation, Inc. (KY)	AA–
Community Foundation of Northwest Indiana (IN)	AA
Concord Hospital and Subsidiaries (NH)	AA–
Cone Health (NC)	AA
Confluence Health Obligated Group (WA)	A–

List of Rated Credits — Hospitals

As of June 30, 2023	Long-Term Rating
Conway Hospital, Inc. (SC)	A–
Cottage Health System Obligated Group (CA)	AA–
Covenant Health (MA)	BBB
Covenant Health (TN)	A+
CoxHealth (MO)	A
Dallas County Hospital District (TX)	AA–
Dartmouth-Hitchcock Obligated Group (NH)	A
Deaconess Health System (IN)	AA
Denver Health & Hospital Authority (CO)	BBB
Duke University Health System, Inc. (NC)	AA–
Eisenhower Medical Center (CA)	BBB–
El Camino Hospital (CA)	AA–
El Paso County Hospital District (TX)	A–
Emanate Health and Affiliates (CA)	A+
Erlanger Health System (TN)	BBB+
Essentia Health (MN)	A–
FirstHealth of the Carolinas, Inc. (NC)	AA
Forrest County General Hospital (MS)	A+
Franciscan Alliance, Inc. (IN)	AA
Fred Hutchinson Cancer Center (WA)	A+
Frederick Health Hospital, Inc. (MD)	A–
Froedtert Health (WI)	AA
Good Shepherd Rehabilitation Network and Controlled Entities (PA)	A–
Grande Ronde Hospital (OR)	BBB–
Greater Baltimore Medical Center, Inc. (MD)	A+
Greater Fairbanks Community Hospital Foundation, Inc. (The) (AK)	A+
Guadalupe Regional Medical Center (TX)	BB
Guthrie Clinic (PA)	A+
Hackensack Meridian Health (NJ)	AA–
Halifax Community Health System (FL)	A–
Hannibal Regional Healthcare System (MO)	A–
Harris County Hospital District (TX)	AA
Hartford HealthCare (CT)	A+
Hawai'i Pacific Health (HI)	AA–
Heritage Valley Health System (PA)	AA–
Hoag Memorial Hospital Presbyterian (CA)	AA
Holland Community Hospital (MI)	AA–
Holy Redeemer Health System (PA)	BB+
HonorHealth (AZ)	A+
Hospital Sisters Services Inc. (IL)	A+
Hunterdon Medical Center (NJ)	A+
Hurley Medical Center (MI)	BBB–
Indiana University Health (IN)	AA

List of Rated Credits — Hospitals

As of June 30, 2023	Long-Term Rating
Inspira Health Network (NJ)	AA–
Jennie Stuart Medical Center (KY)	BBB–
John Fitzgibbon Memorial Hospital (MO)	CCC
Johns Hopkins Health System (MD)	AA–
Jupiter Medical Center (FL)	BBB
Kaiser Permanente (CA)	AA–
Karnes County Hospital District (dba Otto Kaiser Memorial Hospital) (TX)	A
King's Daughters Medical Center (KY)	A
Lifespan Corporation (RI)	BBB+
Loma Linda University Medical Center (CA)	BB+
Main Line Health System, Inc. (PA)	AA–
Maricopa County Special Health Care District dba Valleywise Health (AZ)	BBB
Marietta Area Health Care Inc. dba Memorial Health System (OH)	B+
Marin General Hospital (CA)	BBB
Marshall Medical Center (CA)	BB+
Martin County Hospital District (TX)	BBB+
Mary Free Bed Guild (MI)	A
Mary Washington Healthcare (VA)	A
Mayers Memorial Hospital District (CA)	BBB
McLaren Health Care Corporation (MI)	AA–
McLeod Regional Medical Center (SC)	AA–
Memorial Health Services (CA)	AA–
Memorial Hospital at Gulfport (MS)	BBB–
Memorial Sloan-Kettering Cancer Center (NY)	AA
Mercy Health Corporation (IL)	A
Meritus Health (MD)	A
Methodist Hospitals, Inc. (The) (IN)	BBB–
Midland County Hospital District (TX)	AA–
MidMichigan Health (MI)	AA–
Montage Health and Related Corporations (CA)	AA
Monument Health (SD)	AA–
Mosaic Health System (MO)	AA–
Mount Nittany Medical Center (PA)	A+
Mount Sinai Hospital (NY)	A
Mount Sinai Medical Center of Greater Miami, Inc. (FL)	A–
MultiCare Health System (WA)	A+
Munson Healthcare Obligated Group (MI)	AA
Murray-Calloway County Public Hospital Corporation and Subsidiaries (KY)	BBB
Nebraska Medicine (NE)	AA–
Nebraska Methodist Health System, Inc. (NE)	A
New York and Presbyterian Hospital (NY)	AA
North Mississippi Health Services (MS)	AA
North Oaks Health System (LA)	A–
Northeast Georgia Health System (GA)	A

List of Rated Credits — Hospitals

As of June 30, 2023	Long-Term Rating
Northwell Health (NY)	A–
Norton Healthcare, Inc. and Affiliates (KY)	A+
Novant Health, Inc. (NC)	AA–
Oaklawn Hospital (MI)	BBB–
OhioHealth Corporation (OH)	AA+
Oregon Health & Science University (OR)	AA–
Orlando Regional Healthcare System (FL)	AA–
OSF Healthcare System (IL)	A+
Owensboro Health, Inc. (KY)	BBB–
Palomar Health (CA)	BBB–
PeaceHealth (WA)	A+
Penn Highlands Healthcare (PA)	A–
Peterson Regional Medical Center (TX)	A
Pioneers Memorial Healthcare District (CA)	B
Premier Health Partners (OH)	A–
Presbyterian Healthcare Services (NM)	AA
Prime Healthcare Foundation (CA)	BBB
Prisma Health (SC)	A–
ProMedica Health System, Inc. (OH)	BB–
Providence Health and Services (WA)	A
Redlands Community Hospital (CA)	A–
Regional West Health Services and Affiliates (NE)	BB+
Rehabilitation Institute of Chicago (IL)	A
Reid Hospital and Health Care Services (IN)	A
Renown Health (NV)	A+
Rex Healthcare, Inc. (NC)	A+
Rush System for Health (IL)	AA–
Saint Francis Healthcare System (MO)	AA
Salem Hospital (OR)	AA–
Sanford Health (SD)	AA–
Sarasota County Public Hospital District (FL)	AA–
Scripps Health (CA)	AA
Shands Jacksonville HealthCare, Inc. (FL)	BBB–
Sierra View Local Health Care District (CA)	A
Silver Cross Health System (IL)	A–
Sky Lakes Medical Center (OR)	A
South Nassau Communities Hospital (NY)	BBB+
South Shore Hospital (MA)	BBB
Southcoast Health System, Inc. (MA)	A–
Southern Illinois Healthcare (IL)	AA–
SSM Health Care (MO)	AA–
St. Clair Hospital (PA)	AA–
St. Elizabeth Medical Center (KY)	AA
St. Francis Regional Medical Center (MN)	A
St. Joseph's/Candler Health System, Inc. (GA)	A
St. Luke's Episcopal Presbyterian Hospitals (MO)	A+
St. Luke's Health System, Ltd. (ID)	A+

List of Rated Credits — Hospitals

As of June 30, 2023	Long-Term Rating
St. Tammany Parish Hospital Service District No. 1 (LA)	AA–
Stamford Health System (CT)	BBB+
Stanford Hospital and Clinics (CA)	AA
Summa Health System and Subsidiaries (OH)	BBB+
Sutter Health (CA)	A+
Tampa General Hospital (FL)	A
Tarrant County Hospital District (TX)	AA
Temple University Health System (PA)	BBB
The Queen's Health Systems and Subsidiaries (HI)	AA
ThedaCare, Inc. (WI)	AA–
Tower Health (PA)	CCC+
TriHealth (OH)	AA–
Trinity Health Credit Group (MI)	AA–
Tufts Medicine (MA)	BBB
UMass Memorial Health Care, Inc. (MA)	A–
UnityPoint Health (IA)	AA–
University Health System, Inc. (TN)	BBB
University Hospital (NJ)	BB–

List of Rated Credits — Hospitals

As of June 30, 2023	Long-Term Rating
University of Chicago Medical Center (IL)	AA–
University of Colorado Health, Inc. (CO)	AA
University of Kansas Hospital Authority (KS)	AA–
University of Vermont Medical Center Inc. (VT)	A+
UofL Health, Inc. (KY)	BBB+
UPMC Health System (PA)	A
Valley Health System Obligated Group (NJ)	A+
Vanderbilt University Medical Center (TN)	A
Virginia Hospital Center Arlington Health System (VA)	AA–
Virtua Health (NJ)	AA–
WakeMed Health & Hospitals (NC)	A+
Wayne Healthcare (OH)	BB+
WellSpan Health (PA)	AA–
Willis-Knighton Medical Center (LA)	AA–
Wise Health System (TX)	BB+
Wright Memorial Hospital (JB WrightTrust) (MO)	BBB–
Yale New Haven Health Obligated Group (CT)	AA–
Yavapai Community Hospital (AZ)	A+

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El Camino Health

Summary of Financial Operations

Fiscal Year 2023 – Period 12

7/1/2022 to 06/30/2023

Operational / Financial Results: Period 12 – Jun 2023 (as of 06/30/2023)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	304	268	36	13.6%	283	21	7.6%	---	---	---
	Total Acute Discharges	1,884	1,755	129	7.3%	1,842	42	2.3%	---	---	---
	Adjusted Discharges	3,691	3,535	156	4.4%	3,735	(44)	(1.2%)	---	---	---
	Emergency Room Visits	7,270	5,488	1,782	32.5%	7,420	(150)	(2.0%)	---	---	---
	OP Procedural Cases	11,073	13,212	(2,139)	(16.2%)	12,706	(1,633)	(12.9%)	---	---	---
	Gross Charges ($)	492,577	452,954	39,623	8.7%	445,643	46,934	10.5%	---	---	---
Operations	Total FTEs	3,292	3,371	(79)	(2.3%)	3,208	84	2.6%	---	---	---
	Productive Hrs. / APD	27.3	30.0	(2.7)	(9.0%)	26.9	0.5	1.7%	---	---	---
	Cost Per CMI AD	13,028	18,036	(5,008)	(27.8%)	13,195	(167)	(1.3%)	---	---	---
	Net Days in A/R	57.3	54.0	3.3	6.2%	57.3	(0.0)	(0.0%)	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	114,367	114,773	(406)	(0.4%)	117,911	(3,543)	(3.0%)	138,547	82,105	
	Total Operating Revenue ($)	119,289	118,932	357	0.3%	122,341	(3,051)	(2.5%)	152,743	109,602	
	Operating Margin ($)	**35,850**	**12,987**	**22,864**	176.1%	**36,416**	**(566)**	(1.6%)	**1,915**	**3,836**	
	Operating EBIDA ($)	**44,303**	**20,276**	**24,027**	118.5%	**44,553**	**(250)**	(0.6%)	**11,188**	**10,741**	
	Net Income ($)	73,280	16,000	57,279	358.0%	(12,442)	85,721	689.0%	8,124	7,343	
	Operating Margin (%)	**30.1%**	**10.9%**	**19.1%**	175.2%	**29.8%**	**0.3%**	1.0%	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**37.1%**	**17.0%**	**20.1%**	117.8%	**36.4%**	**0.7%**	2.0%	**8.3%**	**9.8%**	
	DCOH (days)	263	325	(62)	(19.0%)	285	(21)	(7.5%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021. Dollar amounts have been adjusted to reflect monthly averages.
DCOH total includes cash, short-term and long-term investments.

El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Operational / Financial Results: YTD FY2023 (as of 06/30/2023)

($ thousands)

		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	306	264	42	15.8%	276	30	10.9%	---	---	---
	Total Acute Discharges	22,045	21,063	982	4.7%	21,371	674	3.2%	---	---	---
	Adjusted Discharges	42,719	42,358	361	0.9%	41,886	833	2.0%	---	---	---
	Emergency Room Visits	77,844	66,191	11,653	17.6%	68,778	9,066	13.2%	---	---	---
	OP Procedural Cases	135,523	161,064	(25,541)	(15.9%)	153,129	(17,606)	(11.5%)	---	---	---
	Gross Charges ($)	5,757,133	5,356,197	400,936	7.5%	5,122,895	634,238	12.4%	---	---	---
Operations	Total FTEs	3,297	3,323	(26)	(0.8%)	3,101	196	6.3%	---	---	---
	Productive Hrs. / APD	27.9	30.3	(2.4)	(7.9%)	28.6	(0.8)	(2.7%)	---	---	---
	Cost Per CMI AD	17,593	18,036	(443)	(2.5%)	16,167	1,426	8.8%	---	---	---
	Net Days in A/R	57.3	54.0	3.3	6.2%	57.3	(0.0)	(0.0%)	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	1,378,049	1,357,918	20,131	1.5%	1,309,152	68,898	5.3%	1,662,567	985,255	
	Total Operating Revenue ($)	1,439,351	1,407,654	31,697	2.3%	1,353,519	85,832	6.3%	1,822,912	1,315,225	
	Operating Margin ($)	**160,954**	**143,786**	**17,168**	11.9%	**195,086**	**(34,132)**	(17.5%)	**22,978**	**46,033**	
	Operating EBIDA ($)	**256,853**	**233,216**	**23,638**	10.1%	**286,044**	**(29,190)**	(10.2%)	**134,260**	**128,892**	
	Net Income ($)	284,696	178,692	106,004	59.3%	43,765	240,930	550.5%	97,493	88,120	
	Operating Margin (%)	**11.2%**	**10.2%**	**1.0%**	9.5%	**14.4%**	**(3.2%)**	(22.4%)	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**17.8%**	**16.6%**	**1.3%**	7.7%	**21.1%**	**(3.3%)**	(15.6%)	**8.3%**	**9.8%**	
	DCOH (days)	263	325	(62)	(19.0%)	285	(21)	(7.5%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021
DCOH total includes cash, short-term and long-term investments.

El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Consolidated Balance Sheet (as of 06/30/2023)

($000s)

ASSETS		Audited
CURRENT ASSETS	**June 30, 2023**	**June 30, 2022**
Cash	230,539	196,067
Short Term Investments	129,402	125,816
Patient Accounts Receivable, net	218,528	209,668
Other Accounts and Notes Receivable	20,411	21,044
Intercompany Receivables	15,186	13,998
Inventories and Prepaids	45,037	36,476
Total Current Assets	**659,102**	**603,068**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	20,731	18,721
Plant & Equipment Fund	407,526	310,045
Women's Hospital Expansion	30,735	30,261
Operational Reserve Fund	207,898	182,907
Community Benefit Fund	17,743	18,299
Workers Compensation Reserve Fund	13,498	14,029
Postretirement Health/Life Reserve Fund	24,242	29,783
PTO Liability Fund	35,252	33,709
Malpractice Reserve Fund	1,885	1,906
Catastrophic Reserves Fund	28,042	24,668
Total Board Designated Assets	**787,551**	**664,329**
FUNDS HELD BY TRUSTEE	**-**	**0**
LONG TERM INVESTMENTS	**472,514**	**495,751**
CHARITABLE GIFT ANNUITY INVESTMENTS	**948**	**940**
INVESTMENTS IN AFFILIATES	**33,262**	**30,376**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,862,363	1,872,501
Less: Accumulated Depreciation	(791,528)	(778,427)
Construction in Progress	168,956	96,603
Property, Plant & Equipment - Net	**1,239,791**	**1,190,676**
DEFERRED OUTFLOWS	57,204	19,474
RESTRICTED ASSETS	36,339	31,200
OTHER ASSETS	153,023	216,842
TOTAL ASSETS	**3,439,734**	**3,252,657**

LIABILITIES AND FUND BALANCE		Audited
CURRENT LIABILITIES	**June 30, 2023**	**June 30, 2022**
Accounts Payable	50,629	51,286
Salaries and Related Liabilities	24,408	46,502
Accrued PTO	36,104	34,449
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	11,295	14,942
Intercompany Payables	12,362	13,489
Malpractice Reserves	1,863	2,096
Bonds Payable - Current	10,400	9,905
Bond Interest Payable	7,890	8,096
Other Liabilities	11,968	20,955
Total Current Liabilities	**169,217**	**204,021**
LONG TERM LIABILITIES		
Post Retirement Benefits	24,242	29,783
Worker's Comp Reserve	13,498	14,029
Other L/T Obligation (Asbestos)	29,543	37,944
Bond Payable	454,806	466,838
Total Long Term Liabilities	**522,088**	**548,593**
DEFERRED REVENUE-UNRESTRICTED	**1,103**	**12,312**
DEFERRED INFLOW OF RESOURCES	**74,491**	**104,367**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,419,180	2,136,565
Board Designated	209,043	210,197
Restricted	44,611	36,601
Total Fund Bal & Capital Accts	**2,672,834**	**2,383,363**
TOTAL LIABILITIES AND FUND BALANCE	**3,439,734**	**3,252,657**

El Camino Health