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California Statewide Communities Development Authority Daughters of Charity Health System; System

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California Statewide Comntys Dev Auth (Daughters of Charity Hlth Sys)		
Long Term Rating	B-/Negative	Downgraded

Rationale

Standard & Poor's Ratings Services lowered its rating to 'B-' from 'BBB-' on the California Statewide Communities Development Authority's series 2005A, 2005F, 2005G, and 2005H fixed-rate bonds, issued for the Daughters of Charity Health System (DCHS), and removed the ratings from CreditWatch with negative implications where they had been placed on March 19, 2014. The rating outlook is negative.

The rating action reflects our view of DCHS' escalating operating losses during the past several years and a substantial loss from operations (according to Standard & Poor's calculations) through the first half of fiscal 2014. In addition, the balance sheet has continued to weaken despite the refunding of nearly one-third of DCHS' debt with the proceeds of a gift from the Daughters of Charity Foundation (DCF) in October 2013. In our April 12, 2013, publication, we noted that DCHS' investment-grade rating and developing outlook reflected the possibility as indicated by management that DCHS' affiliation with Ascension Health Alliance (AHA) could potentially evolve into a merger of DCHS into AHA, which we thought might lead us to raise the rating. However, in January 2014, DCHS announced that it would not be merging with AHA and that DCHS would begin to solicit proposals from buyers for the acquisition of DCHS' hospitals individually or the system as a whole. Through discussion with management we understand that the process is progressing; however, we currently have no information about specific acquisition proposals. In addition, the timing of completion of this process is uncertain, as it will likely be dictated by the proposals received and regulatory approvals. We anticipate that operating losses will probably continue to mount because of DCHS' challenging payor mix with a high proportion of uninsured patients or patients with Medi-Cal or Medicare. In addition, we expect reimbursement pressures will likely continue to intensify as the health care operating environment evolves under health care reform. In fact, we expect DCHS' operating losses to be wider through the second half of fiscal 2014 because of the timing of approval of the most recent extension of California's provider fee program. Although the provider fee program was approved by the state for a three-year extension through 2016, approval by the Centers for Medicare and Medicaid Services (CMS) is not expected to occur until later in calendar year 2014. Consequently, the benefit from the program related to 2014 will not likely be reflected until DCHS' fiscal 2015 financial statements, thus resulting in wider operating losses during the last two quarters of the fiscal year and creating a spike in provider fee benefits recorded in fiscal 2015 when current-period and prior-period benefits are recognized. Also, the cash flow benefit from the program

will not be realized until approval is obtained, which we think further strains the organization's financial flexibility. The resulting uneven operating performance is consistent with the effect of approval timing in prior phases of the program. In our opinion, if the time frame for selling the hospitals is longer than management indicated, a further rating downgrade could likely result because we expect losses will continue and we believe that DCHS' currently vulnerable balance sheet offers very limited financial flexibility.

More specifically, the rating action and negative outlook reflect our assessment of DCHS':

- Growing operating losses in the past three audited years and through the first half of fiscal 2014, driven by industrywide challenges and the composition of the economically challenged areas of California that DCHS serves;
- Extremely weak maximum annual debt service (MADS) coverage despite a reduction in debt service following the refunding of the series 2008A bonds;
- Revenue and volume declines since 2009;
- Eroding unrestricted reserves, which now equate to only 36 days' cash on hand at Dec. 31, 2013;
- Announcement that it will not be merging with AHA;
- Heavy reliance on provider fee benefits and disproportionate share (DSH) receipts to help offset operating losses; and
- Substantially underfunded pension plan, with a 50% funded status based on projected benefit obligation at June 30, 2013.

Other credit risks include two pending ballot initiatives that are being pursued in California by the Service Employees International Union that are aimed to cap hospital prices and limit CEO compensation. While these initiatives are not specific to DCHS, we consider them to be potential credit risks that could negatively impact hospitals in the state if enacted into law. We will continue to evaluate these matters as they unfold.

DCHS has six hospitals located in Northern California and Southern California. At Dec. 31, 2013, DCHS had $294.2 million of long-term debt outstanding. Debt has declined considerably since October 2013 because DCHS redeemed at par its $143.7 million series 2008A bonds with a $130 million restricted donation from the DCF and a released debt service reserve fund. DCF also forgave $12.4 million outstanding on a note payable. DCF's sole purpose is to support activities of the Daughters of Charity of St. Vincent De Paul, Province of the West (Province of the West). DCHS is sponsored by Province of the West and therefore has historically received significant funds from the foundation annually in support of operations and for capital needs, which we have historically viewed as a supporting credit strength. We don't anticipate future gifts from the foundation to be material given its October 2013 donation. We understand that to date, DCHS is current on all debt payments and is in compliance with the terms of its covenants as defined in its governing bond documents including its debt service coverage covenant because the calculation factors in debt prepayments that DCHS has historically made.

Gross revenue from the DCHS obligated group, as well as all property, plant, and equipment secure the bonds. The 'B-' rating is based on our view of DCHS' group credit profile and the obligated group's "core" status. Accordingly, the bonds are rated at the same level as the group credit profile. DCHS has no swaps outstanding, and all long-term debt is fixed rate.

Outlook

The negative outlook reflects our opinion that DCHS' rating could be lowered further within the one-year outlook period if DCHS' plans to sell its hospitals does not materialize or are delayed. We believe this could occur because we expect that the system's operations will continue to be pressured and we believe that DCHS' balance sheet offers very limited cushion for further prolonged losses. Also, if for any reason funds are insufficient to repay debt outstanding in full or if debt service payments are not made in full or in a timely manner, a lower rating would occur.

A higher rating is highly unlikely during the one-year outlook period. In the event the sale of the hospitals does not transpire as planned or is delayed, a return to a stable outlook would be predicated on our seeing sustained, stabilized operations yielding positive cash flow and steady balance sheet metrics.

Enterprise Profile

The system

DCHS' six hospitals staff more than 1,500 beds and are clustered around the San Francisco Bay Area (O'Connor Hospital, St. Louise Regional Hospital, Seton Medical Center, and Seton Medical Center Coastside) and Los Angeles (St. Vincent Medical Center and St. Francis Medical Center). The service areas are competitive, but the DCHS facilities serve a large share of the indigent population. DCHS' payor mix consists of nearly 75% Medicare and Medi-Cal. Also, the patient base includes a substantial amount of uninsured patients resulting in very high charity care and bad-debt expenses.

In April 2012, DCHS began its medical foundation with the acquisition of San Jose Medical Group for a cost of about $13 million. This acquisition initially aligned 75 physicians and other contracted providers through DCHS' medical foundation. Since the initial acquisition, the foundation has grown to include 164 staff physicians and 89 physicians aligned through an IPA (independent practice association). Total clinic sites have increased from three to 28. While this strategy is important from a physician alignment standpoint, it is typically a costly strategy for any provider. This has been the case for DCHS as well and has contributed to the increased operating losses.

In March 2012, DCHS signed a memorandum of understanding with AHA, intended to result in DCHS becoming a part of AHA. Since that time, an affiliation agreement, with a five-year term, was signed between the two parties in December 2012. In January 2014, DCHS announced that it would not be merging into AHA; however, the affiliation agreement would remain in place. We understand that pursuant to the affiliation agreement, DCHS has access to certain of AHA's pricing and contracting leverage and the organizations are now also able to conduct strategic planning through a joint advisory committee (JAC) that was formed as part of the agreement. The JAC includes members of both organizations. Under the affiliation agreement, we understand that there is no change in control at DCHS with respect to governance or management. Also, there is no direct financial tie or debt assumption between the organizations.

Utilization

DCHS admitted 50,168 patients in fiscal 2013, down 2.2% from 51,318 patients in 2012. Adjusted discharges declined by about 1% in fiscal 2013 to 76,943 from 77,664 in the prior year. Through the first half of fiscal 2014, inpatient discharges are down 4.6% compared with the prior year.

Management

In response to the anticipated pressures related to health care reform and the intensified stress related to its lower volumes, reduced reimbursement, and unfavorable payor mix, DCHS' board and management decided to put its hospitals (either individually or as a system) on the market for sale. We understand that management plans to consider offers from all suitors regardless of religious affiliation or whether the organization is for-profit or not-for-profit. The management team continues to focus on clinical quality improvements and cost savings where appropriate as it navigates the organization through the uncertain future. Management indicated that there is significant interest from potential buyers; however, currently, we are not aware of any specific details. Management indicated that there are confidentiality agreements in place with potential buyers, so specific details have not been disclosed.

In our opinion, DCHS has been a significant voice behind the California provider fee program as it is a hospital with considerable Medi-Cal exposure. Management has also been successful in backing a ballot initiative (Measure A in San Mateo County), which was approved by voters in November 2012 and added a five-cent sales tax in the county. Management anticipates that a portion of the funds will go to help operations at Seton Medical Center during the next 10 years.

Financial Profile

Change in accounting for bad debt

In accordance with the publication of our article, "New Bad Debt Accounting Rules Will Alter Some U.S. Not-for-Profit Health Care Ratios But Won't Affect Ratings," published Jan. 19, 2012, on RatingsDirect, we recorded DCHS' fiscal 2012 audit, fiscal 2013 audit, and fiscal 2014 interim financials incorporating the adoption of Financial Accounting Standards Board 2011-07, but not in prior periods. The new accounting treatment means that DCHS' fiscal 2012 and subsequent financial statistics are not directly comparable to the results for fiscal 2011 and prior years. For an explanation of how each financial measure is affected by the change in accounting for bad debt, including the direction and size of the change, please see the above article.

Income statement

DCHS' payor mix and location result in a high proportion of governmental-based reimbursement (Medicare and Medi-Cal), which pays much less than commercial insurance generally. This has historically burdened operations, but this strain has been exacerbated in recent years by industrywide hurdles including lower volumes, sequestration, and generally less favorable rate increases from payors. All of these factors have contributed to an escalation of operating losses. In the fiscal year ended June 30, 2013, DCHS' operating loss widened to $107 million (negative 8.1% operating margin) compared with 2012's $82 million operating loss (negative 6.6% operating margin). The fiscal 2013 and fiscal 2012 results include $66.9 million and $53.4 million of net benefit from the California provider fee, respectively. We include the revenue and expense portions of the provider fee in their natural income statement classifications. As such,

our days' cash on hand calculation also includes the expense associated with the provider fee program. Net income of negative $80.3 million, after $27 million of investment income and contributions, generated a negative 5.9% margin and extremely weak MADS coverage of 0.2x. Our calculation assumes MADS of $25.8 million, which was lowered from $40.1 million following the refunding of the 2008A bonds. We understand that DCHS was compliant with its annual debt service coverage requirements for fiscal 2013 and fiscal 2012 because the indenture calculations factor in prepayments on the debt and are based only on the obligated group. Including contributions, five of six hospitals lost money from operations in 2013, with only St. Francis Medical Center posting positive results. Historically, St. Francis Medical Center, the system's largest hospital (located outside Los Angeles), has also been the most profitable hospital as it is the primary recipient of DSH funding and now is the system's largest recipient of provider fee revenue. In fiscal 2013 and fiscal 2012, DCHS received $106.8 million and $103.5 million of combined Medicare and Medi-Cal DSH, respectively.

Through the first half of fiscal 2014 ended Dec. 31, 2013, operating losses have accelerated further (according to Standard & Poor's calculations). To date, DCHS recorded an operating loss of $92.8 million (a negative 14.9% operating margin). This exceeds the loss recorded through the six months ended Dec. 31, 2012, when DCHS recorded a $69.8 million loss from operations. Our operating income calculation for Dec. 31, 2013, excludes the $130 million gift from DCF because we view it as extraordinary in nature.

In response to cash flow pressures, we understand that management is pursuing various strategies, including the sale of noncore assets, to bridge the period prior to the expected asset sale and during the period in which provider fee benefits cannot be realized.

Provider fee update

DCHS' operating losses have been offset somewhat by the net benefit from California's provider fee program, which through three programs was extended through Dec. 31, 2013. An additional three-year extension of the provider fee program was signed into California law in 2013. However, we understand that this extension must still be approved by the Centers for Medicare and Medicaid Services (CMS). To date, there is no definitive time frame as to when this will get approved. We understand that revenues and expenses associated with the provider fee program cannot be accrued to revenue and expense until all approvals (including CMS) are finalized. Consequently, we anticipate that DCHS' income statement will be strained further until approvals are obtained and it is able to book the provider fee benefits for the period beginning Jan. 1, 2014, on the income statement. We expect this could result in a spike in revenue and expenses booked in a future month once approvals are obtained, resulting in uneven results similar to the effect that occurred because of the timing of prior provider fee program approvals. However, we understand that potentially approximately $19 million in previously unbooked net benefit from the provider fee for the period ended Dec. 31, 2013, will be booked in subsequent financial statements.

Balance sheet

The successive years of operating strain have taken a toll on DCHS' unrestricted reserves, with absolute levels declining since fiscal 2011. DCHS reported $134 million in unrestricted reserves at Dec. 31, 2013, which was down from $250 million at the close of fiscal 2012. At Dec. 31, 2013, unrestricted reserves totaled 36 days' cash on hand, down from 71 days at the close of fiscal 2012. Although total debt declined by about one-third with the refunding of the series 2008A bonds, unrestricted reserves as a percentage of debt remains slim, in our opinion, at 46% as of the

interim period.

Debt as a percentage of capitalization improved as a result of the October 2013 refunding but is still very high, in our view, at 71%, due to an erosion of unrestricted net assets since 2011 caused by operating losses and unfavorable trends in the funded status of the pension plan.

The system's defined-benefit pension plan was frozen for all nonunion employees effective Feb. 28, 2011. During the past two years, management has negotiated to freeze the defined benefit plan for three of its four union contracts effective Jan. 1, 2012, and Jan. 1, 2013. Only employees who are members of California Nurses Association (CNA) are still active in the defined benefit plan. DCHS' union contract with CNA expired on June 30, 2013, but was extended to Sept. 30, 2014. About 70% of DCHS' total staff is unionized.

At the end of fiscal 2013, DCHS' pension plan was underfunded by $229 million (or a 50% funded status) based on the projected benefit obligation. We view this as an additional weakness of the financial profile that will need to be addressed through the plans with the sale of the system's assets.

Managed by the Catholic Healthcare Investment Management Company (effective April 1, 2012), a subsidiary of AA+' rated AHA, most of DCHS' assets are available on a daily basis. DCHS has invested less than depreciation expense for the past five years given the financial challenges. Through Dec. 31, 2013, DCHS has spent about $18.7 million on capital and is curtailing spending as appropriate to preserve unrestricted reserves.

With the exception of St. Vincent Medical Center in Los Angeles and Seton Medical Center, the system's facilities are seismically compliant. However, due to its proximity to the San Andreas fault, Seton Medical Center will need to be replaced or will not be able to be used for inpatient acute services.

Daughters of Charity Health System*

		Fiscal Year Ended June 30,			Selected Medians§
	Unaudited Six-Month Interim Ended Dec. 31, 2013†	2013	2012	2011	Healthcare system BBB/BBB- 2012
Financial performance					
Net patient revenue ($000s)	562,500	1,230,875	1,178,957	1,248,580	914,543
Total operating revenue ($000s)	624,572	1,325,799	1,252,812	1,308,636	MNR
Total operating expenses ($000s)	717,356	1,433,242	1,334,861	1,369,015	MNR
Operating income ($000s)	(92,784)	(107,443)	(82,049)	(60,379)	MNR
Operating margin (%)	(14.86)	(8.10)	(6.55)	(4.61)	1.20
Net nonoperating income ($000s)	26,511	27,119	34,565	40,523	MNR
Excess income ($000s)	(66,273)	(80,324)	(47,484)	(19,856)	MNR
Excess margin (%)	(10.18)	(5.94)	(3.69)	(1.47)	1.30
Operating EBIDA margin (%)	(7.49)	(1.63)	(0.02)	1.24	5.40
EBIDA margin (%)	(3.11)	0.40	2.67	4.20	5.50
Net available for debt service ($000s)	(20,269)	5,451	34,360	56,718	MNR
Maximum annual debt service ($000s)‡	25,767	25,767	25,767	25,767	MNR
Maximum annual debt service coverage (x)	(1.57)	0.21	1.33	2.20	2.50

Daughters of Charity Health System* (cont.)					
Operating lease-adjusted coverage (x)	N.A.	0.56	1.21	N.A.	1.80
Liquidity and financial flexibility					
Unrestricted reserves ($000s)	134,443	188,109	249,626	309,078	234,572
Unrestricted days' cash on hand	35.9	50.0	71.3	85.6	86.9
Unrestricted reserves/total long-term debt (%)	45.7	43.0	54.2	65.9	85.0
Average age of plant (years)	N.A.	14.8	15.0	16.3	13.5
Capital expenditures/depreciation and amortization (%)	55.3	82.8	72.0	71.8	105.2
Debt and liabilities					
Total long-term debt ($000s)	294,175	437,344	460,227	468,891	MNR
Long-term debt/capitalization (%)	71.2	95.5	88.3	74.7	73.9
Contingent liabilities ($000s)	0	0	0	0	MNR
Contingent liabilities/total long-term debt (%)	0.0	0.0	0.0	0.0	MNR
Debt burden (%)	1.98	1.90	2.00	1.91	2.50
Defined benefit plan funded status (%)	N.A.	49.95	45.05	51.67	58.40

N.A.: Not available. MNR: Median not reported. *Fiscal 2012, 2013, and 2014 results stated by Standard & Poor's with bad debt as an offset to revenues pursuant to FASB ASU 2011-07 . §2012 medians reflect FASB 2011-07 accounting for bad debt. Speculative grade medians are not available for 2012 due to limited sample size of systems with speculative grade ratings. †Financial performance metrics for Dec. 31, 2013 exclude $130 million gift from foundation used to refund the series 2008A bonds. ‡Reflects MADS following the October 2013 refunding of the series 2008A bonds.

Related Criteria And Research

Related Criteria

- USPF Criteria: Not-For-Profit Health Care, June 14, 2007
- General Criteria: Group Rating Methodology, Nov. 19, 2013

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- The Outlook For U.S. Not-For-Profit Health Care Providers Is Negative From Increasing Pressures, Dec. 10, 2013
- U.S. Not-For-Profit Health Care System Ratios: Metrics Remain Steady As Providers Navigate An Evolving Environment, Aug. 8, 2013
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- U.S. Speculative-Grade Not-For-Profit Health Care Providers Continue To Face Rating Volatility And Operating Pressures, Nov. 14, 2013
- U.S. Not-For-Profit Health Care Providers Hone Their Strategies To Manage Transition Risk, May 16, 2012
- Standard & Poor's Earthquake Model, Oct. 25, 2012