CFRA

Industry Surveys

Health Care Facilities

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CHARTS & FIGURES

NEW THEMES

What's Changed: In 2022, 6.7 billion prescription drugs were dispensed, higher than pre-pandemic levels. Check out page 13.

What's Changed: On May 11, the Covid-19 public health emergency in the U.S. officially ended, which brought significant changes on the rollback of Covid-19 programs and flexibilities. More on this on pages 16-17.

EXECUTIVE SUMMARY

In 2020, CFRA decided to replace our former Health Care Providers and Services survey, which included Managed Health Care. We now provide separate surveys for both Managed Health Care and Health Care Facilities. This Health Care Facilities survey includes both health care facilities (primarily hospitals) and health care services companies (primarily laboratories, as well as other service providers).

Hospital Volume Growth Showing Signs of Improvement

The spread of the Covid-19 Omicron variant in early 2022, as well as labor shortages and other staffing challenges that limited the number of patients that could be served, hampered volume growth in 2022. Against somewhat easier comparisons, along with improving staffing levels, health care facilities reported strong volume recovery results during their recent first quarter 2023 earnings reports, with HCA Healthcare's same-facility equivalent admissions rising 7.5% year-over-year (Y/Y), Tenet Healthcare same-hospital adjusted admissions rising 6.7% Y/Y, and Universal Health Services' same-facility acute care admissions rising 10.5% Y/Y. As a percentage of HCA Healthcare's acute care admissions, Covid-19 cases represented roughly 3% of admissions vs. 9.7% in the first quarter of 2022. Peers reflected similar trends, with Tenet Healthcare's Covid-19 cases falling to 4% vs. 12% in the first quarter of 2022, while Universal Health Services saw just 4% of admissions from Covid-19 vs. 14% in the prior-year quarter. We expect hospital volumes will continue to gradually increase over the near-term.

Regulatory Landscape Offers Both Headwinds and Tailwinds for Health Care Facilities

Medicare "sequestration" payment cuts of 1% took place from April 1 through June 30, 2022, followed by 2% cuts beginning July 1, reducing the level of reimbursement that health care facilities stand to receive from a significant segment of their patient population. On August 2, 2022, the Centers for Medicare & Medicaid Services (CMS) released its final rule to increase Medicare inpatient prospective payment system (IPPS) rates by a net 4.3% in FY 23 compared with FY 22. Given the rising labor and supply costs being encountered by health care facilities, we believe that the proposed rate increase is likely to be insufficient in itself to maintain revenues and profits per admission, making it more important for facilities to focus on improving staffing levels and operational efficiency. In April 2023, CMS released proposed updates for FY 24 IPPS, which featured a net 2.8% increase in rates vs. FY 23. Through the recently passed Inflation Reduction Act, the Biden administration extended the ARPA subsidies through 2025. We think this legislation helps health care facilities by supporting the percentage of insured patients.

Health Care Services' Margins and Earnings Declining as Covid-19 Pandemic Fades

Our outlook for the Health Care Services sub-industry for the next year is neutral, weighing both lingering impacts from the recession with an anticipated gradual recovery from Covid-19. We see trends from early in the pandemic reversing as vaccines are widely distributed and the general population gains confidence in returning to the health care system. The federal government ended the public health emergency (PHE) on May 11. Offsetting these trends, we expect growth in base business testing, as well as acquisitions by leading companies like CVS Health, Labcorp, and Quest Diagnostics, to support industry growth in the near term.

Health Care Facilities/Health Care Services

Outlook: Neutral

MARKET CAP BREAKDOWN*

RANK NO.	COMPANY NAME	MARKET CAP ($ billion)
1	CVS Health	86.1
2	HCA Healthcare	72.7
3	Cigna	71.8
4	LabCorp	18.9
5	Quest Diagnostics	15.0
6	Universal Health	9.2
7	DaVita	8.4
8	Chemed Corp	7.9
9	Tenet Healthcare	7.2
10	Others†	57.5

Source: CFRA, S&P Global Market Intelligence.
**Data as of May 31, 2023.*
†Refer to the "Comparative Company Analysis" section of this survey for the list of companies.

ETF FOCUS

XLV Health Care Select Sector SPDR	AUM ($M) 39,728	Expense Ratio 0.10
VHT Vanguard Health Care	AUM ($M) 17,241	Expense Ratio 0.10
IHF iShares U.S. Healthcare Providers	AUM ($M) 1,132	Expense Ratio 0.39
XHS SPDR S&P Health Care Services	AUM ($M) 110	Expense Ratio 0.35

BY THE NUMBERS

6.2% EPS growth expectation for health care facilities in 2023

-11.0% EPS growth expectation for health care services in 2023

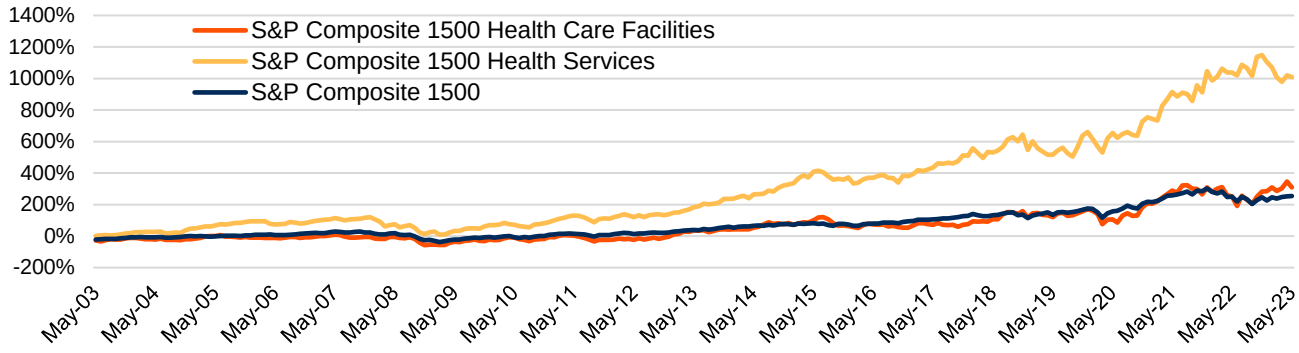
4.3% Net increase by CMS Medicare IPPS rates in FY 23

3% HCA's Q1 2023 hospital admissions attributable to Covid-19

$22,463 Average annual premium for family health care coverage in 2022

15% PAMA CDLT reimbursement rate cuts expected in 2024-2026

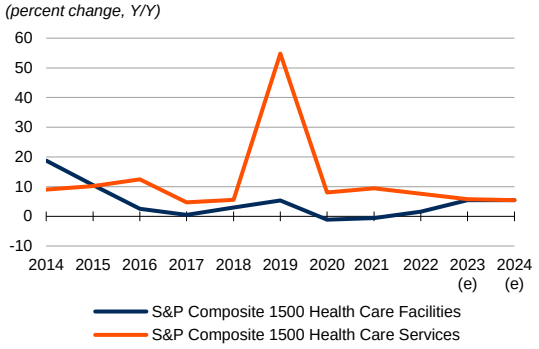
20-YEAR INDEX PERFORMANCE



**Data through May 31, 2023.*
Source: CFRA, S&P Global Market Intelligence.

FINANCIAL METRICS

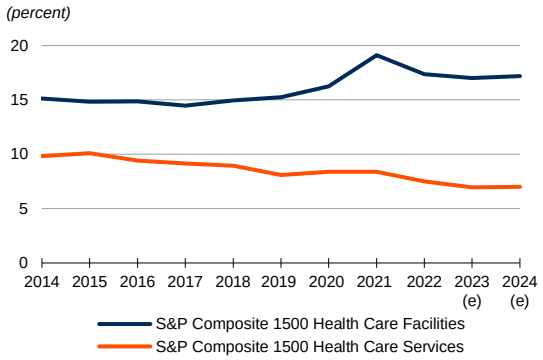
Revenue Growth



Source: S&P Global Market Intelligence, S&P Capital IQ Consensus Estimates.

- Revenue for health care facilities grew 1.6% in 2022, reflecting slow improvement in patient volume trends and higher reimbursement rates, offset by staffing challenges and lower levels of Covid-19 related treatment. As volumes strengthen and pandemic headwinds continue to fade, we expect revenue growth of 5.5% in both 2023 and 2024.
- Health care services companies were less impacted by the pandemic than health care facilities, achieving revenue growth of 7.6% in 2022. In 2023, we expect revenue growth to moderate to near 5.8%, affected by lower Covid-19 testing volumes, followed by 5.5% growth in 2024.

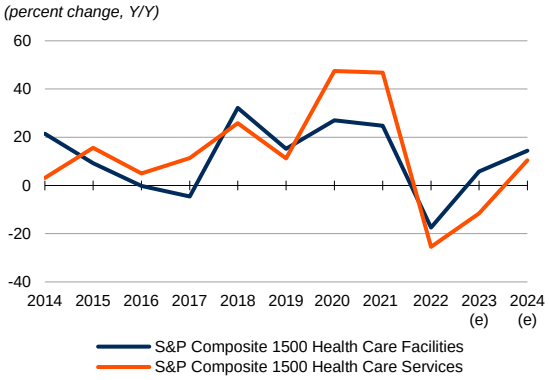
EBITDA Margin



Source: S&P Global Market Intelligence, S&P Capital IQ Consensus Estimates.

- We expect EBITDA margin for health care facilities to decline to approximately 15.5% in 2023 from 15.7% in 2022, with higher labor costs and staffing issues cutting into hospital profits. In 2024, we anticipate modest margin growth to around 15.8%.
- For health care services, we expect the declining EBITDA margin trend to continue. We anticipate average margins of 11.6% in 2023, down from 14.7% in 2022. In our view, this trend reflects recent inflationary pressures, as well as lower Covid-19 testing volumes. We expect modest margin growth in 2024 to an average of 12.0%.

EPS Growth

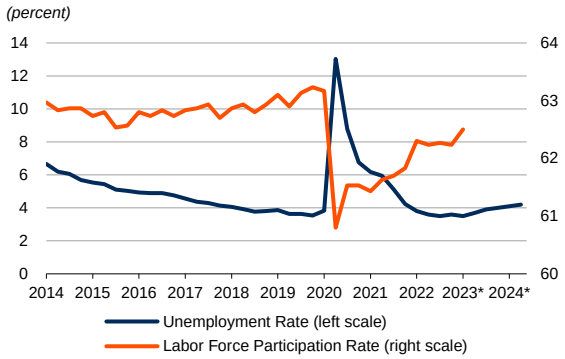


Source: S&P Global Market Intelligence, S&P Capital IQ Consensus Estimates.

- EPS for health care facilities declined 17.4% in 2022, driven by weak patient volume growth, labor shortages, and higher operating expenses. We expect approximately 6.2% EPS growth for health care facilities in 2023, followed by 14.3% growth in 2024, as patient volumes recover and some wage and staffing pressures recede.
- In 2023, we expect EPS for health care services to further decline 11.0%, from an EPS decline of 25.5% in 2022, before recovering by 10.6% in 2024. This is largely attributed to lower Covid-19 vaccine and testing volumes, drawing difficult comparisons against early-pandemic performance, in our view.

KEY INDUSTRY DRIVERS

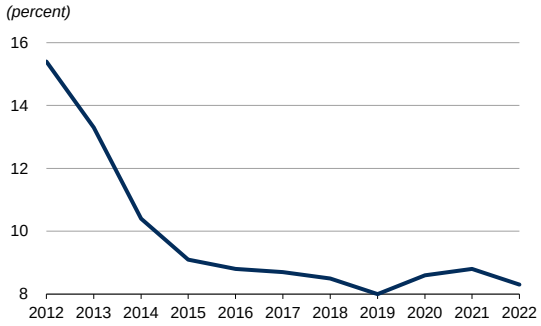
Unemployment Rate



*Actual data until Q1 2023, projected data by Action Economics.
Source: U.S. Bureau of Labor Statistics, Action Economics.

- Most managed care members are enrolled through their employers, so changes in unemployment levels can impact commercial health plan enrollment. Significant increases in unemployment may substantially weaken demand for health care services as well as private insurance coverage.
- As economic activity resumes, the U.S. unemployment rate has steadily declined to near pre-pandemic levels, with recent data showing a rate of 3.4% as of April 2023.
- Action Economics forecasts the unemployment rate to average 3.8% in 2023 and rise to 4.2% in 2024.

Uninsured Rate



Source: U.S. Census Bureau.

- The industry has benefited in recent years from a decrease in the number of uninsured Americans. Based on census data, the percentage of people with health insurance increased to 91.7% as of 2022, compared to 89.6% in 2014, with the majority having private health insurance coverage (61.0%) rather than government coverage (39.5%).
- Higher unemployment levels in a near-term recession could increase the uninsured rate, but we think ARPA subsidy extensions within the Inflation Reduction Act legislation will help health care facilities by supporting the percentage of insured patients.

U.S. Real GDP Growth Rate

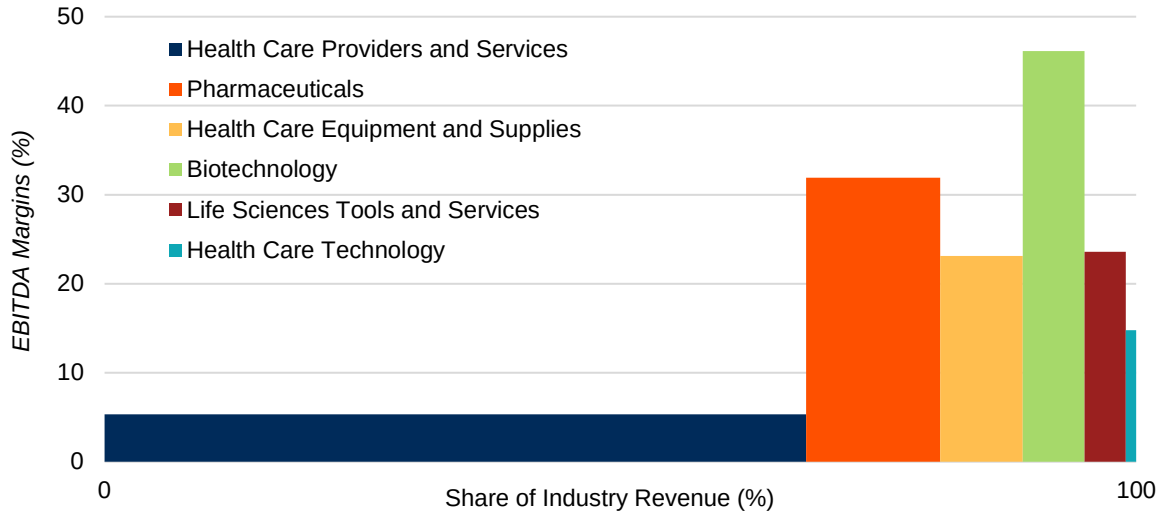
*Projected data by Action Economics.
Source: Federal Reserve Economic Data, Action Economics.

- Action Economics projects U.S. real GDP to grow 1.4% in 2023 vs. 2.1% in 2022, well below the 5.9% growth in 2021, with the recent inflation and higher interest rate environment creating some headwinds against economic growth.
- Action Economics recently projected real GDP growth of 1.5% in 2024 and 2.3% in 2025.

INDUSTRY TRENDS

Profit Pools

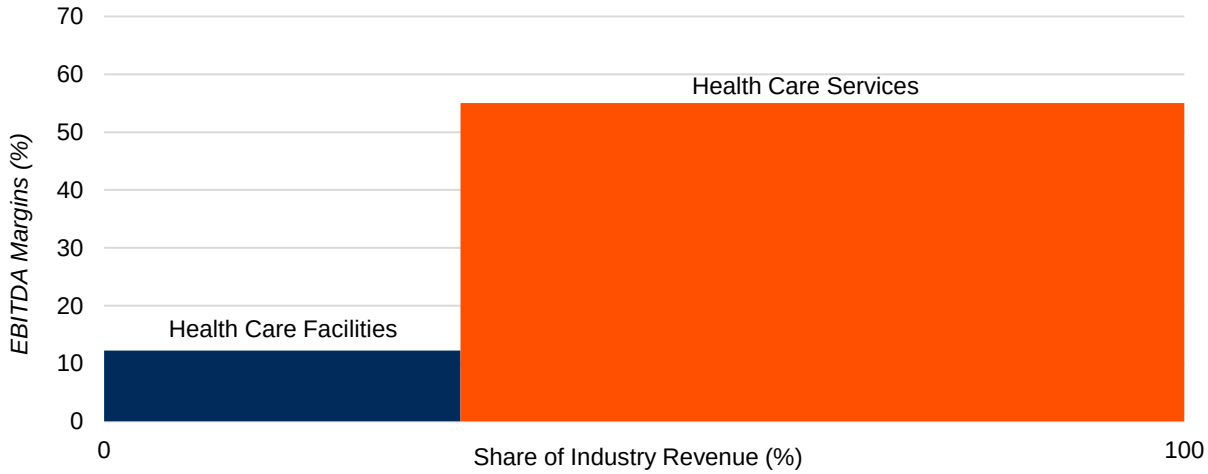
PROFIT SHARE MAP OF HEALTH CARE SECTOR*
(as of the first quarter of 2023)



*Companies within the S&P Composite 1500 Index as of May 11, 2023.
Source: S&P Global Market Intelligence.

The Health Care Providers & Services industry is the largest industry in terms of total revenue in the Health Care sector. Among the sub-industries under the Health Care Providers & Services industry, Health Care Services has the largest revenue share and the highest EBITDA margin, while Health Care Facilities – with frequent high depreciation expenses – has the smallest revenue share and the lowest EBITDA margin. Our profit pool analysis is based on the constituents of the S&P Composite 1500 index.

PROFIT SHARE MAP OF HEALTH CARE FACILITIES AND SERVICES SUB-INDUSTRIES*
(as of the first quarter of 2023)



*Companies within the S&P Composite 1500 Index as of May 11, 2023.
Source: S&P Market Intelligence.

Porter's Five Forces

Power of Buyers: High

Entities that pay for the majority of health care services (primarily private insurance companies, Medicare, and Medicaid) tend to have significant bargaining power over health care facilities and services. These entities often have large membership bases and frequently can afford to choose between competing health care facilities as they choose which ones are in network or out of network. However, buyer power can vary due to regional dynamics and patient demographics.

Power of Suppliers: Moderate

Suppliers include companies that sell drugs, medical devices, and medical supplies. These companies often wield moderate negotiation power because most have significant scale or provide a unique product. Suppliers that provide commoditized goods are less likely to wield significant negotiation power. Suppliers can also include the people or companies that provide labor to health care facilities. Skilled staff have gained more bargaining power in the past few years due to the limited supply of skilled workers.

Threat of New Entrants: Low

The threat of new entrants is low in this industry, as a significant upfront capital investment to achieve scale is necessary to achieve profitability. Existing companies in this industry have a thorough understanding of the health care system and have developed critical industry connections for the success of their businesses; this expertise and network is difficult for new entrants to develop. However, the threat of new entrants appears to have been increasing for some acute care facilities, as the popularity of standalone specialty hospitals, outpatient surgery, and diagnostic centers has grown in recent years.

Threat of Substitutes: Moderate

The threat of substitutes varies significantly across the industry and should be considered on a case-by-case basis. For example, purchasers of managed care services can easily switch to self-paid health care (*i.e.,* no health plan). Companies purchasing health plans can also provide their own insurance plans. In some cases, the threat of substitutes is much lower. For a patient who requires regular dialysis or needs urgent surgery, there may only be one health care facility that can provide the necessary treatment within a reasonable distance, giving those facilities significant power.

Rivalry Among Existing Competitors: Moderate

The level of rivalry also varies significantly in this industry. Health care facilities that are the sole provider of certain health care services or products in an area may face little to no competition (*e.g.,* a hospital in a small town). Meanwhile, competition can be fierce among companies that compete in the same markets or on a national level. For example, the two largest laboratory testing companies, Labcorp and Quest Diagnostics, often compete for large national contracts with managed care insurers. In sub-industries where rivalry is strong, the markets tend to be oligopolistic because scale is often necessary to achieve profitability.

Deal-Making Environment

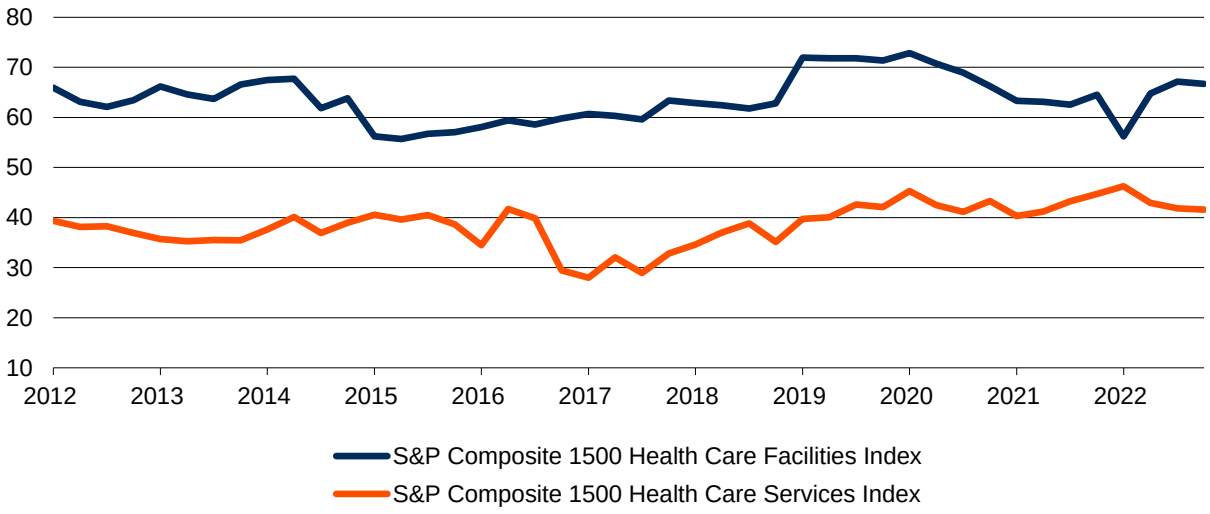
To diversify lines of business and offset industry headwinds, many health care providers and services companies have turned to consolidation for scale and increased influence over suppliers and customers. As of May 12, 2023, companies currently in the Health Care Facilities sub-industry have completed eight merger or acquisition deals over $1 billion, with roughly $17.9 billion in total deal value, since 2020. Meanwhile, companies currently in the Health Care Services sub-industry have completed 16 merger or acquisition deals over $1 billion, with roughly $56.3 billion in total deal value within the same period.

Notable recent deals include Humana's $5.7 billion acquisition of Kindred at Home in 2021, UnitedHealth Group's $4.9 billion acquisition of DaVita Medical in 2019, CVS's $69 billion acquisition of Aetna in 2018, and Cigna's $67 billion acquisition of Express Scripts in 2018. CVS recently announced it will acquire Oak Street for $10.6 billion, which could help CVS add primary care to its portfolio. Oak Street owns 169 medical centers in 21 states.

To assess the ability of companies in the industry to make acquisitions, we typically consider cash and debt levels. Total cash and short-term investments for the 30 companies in the S&P Composite 1500 Health Care Facilities and S&P Composite 1500 Health Care Services sub-industries was roughly $102 billion as of the fourth quarter of 2022, down from $163 billion in the third quarter.

Meanwhile, the debt-to-capital ratio for the Health Care Services sub-industry has been stable relative to its historical level of 40%-50%, with the average near 47% as of year-end 2022. The average debt-to-capital ratio for the Health Care Facilities sub-industry increased in recent years as companies took advantage of low interest rates, rising from around 65% in 2012 to 81% as of year-end 2022. Companies have used debt to fund strategic expansions, merger and acquisition (M&A) activity, and stock repurchases.

DEBT-TO-CAPITAL RATIO
(in percent, quarterly)



Source: S&P Global Market Intelligence.

Health care facilities companies, unlike those in other sub-industries in this industry, usually have very high debt-to-equity ratios, as these companies typically use debt to finance their extensive infrastructure and capital equipment needs. According to the Centers for Medicare & Medicaid Services (CMS), these companies have three main categories of capital spending: 1) land and land improvements; 2) buildings, fixtures, and building improvements; and 3) fixed and movable equipment.

Competitive Environment

Health Care Services

In the long term, a shift in demographics toward an older population will likely drive higher demand for health care services. The U.S. population aged 65 and over is projected to increase from 55.7 million in 2020 (latest available) to 94.7 million by 2060, according to the U.S. Administration on Aging (AOA).

The Health Care Services sub-industry encompasses many different business models with different revenue drivers. Revenues for companies like CVS Health, which is primarily a pharmacy benefit manager (PBM), are very sensitive to changes in drug pricing and the number of prescriptions filled in a given period, whereas revenues for clinical laboratory service companies like Quest Diagnostics and Labcorp are affected by laboratory testing volumes.

Health Care Facilities

Revenues for companies within the Health Care Facilities sub-industry are largely affected by admission volumes and the mix of patients. With the start of the Affordable Care Act's individual mandate and Medicaid expansion, inpatient admissions began increasing in 2014. Health care facilities also benefited from more insured patients coming through their doors, driving up both inpatient and outpatient services and resulting in lower uncompensated care, charity care, and bad debt.

HEALTH CARE FACILITIES INPATIENT ADMISSIONS

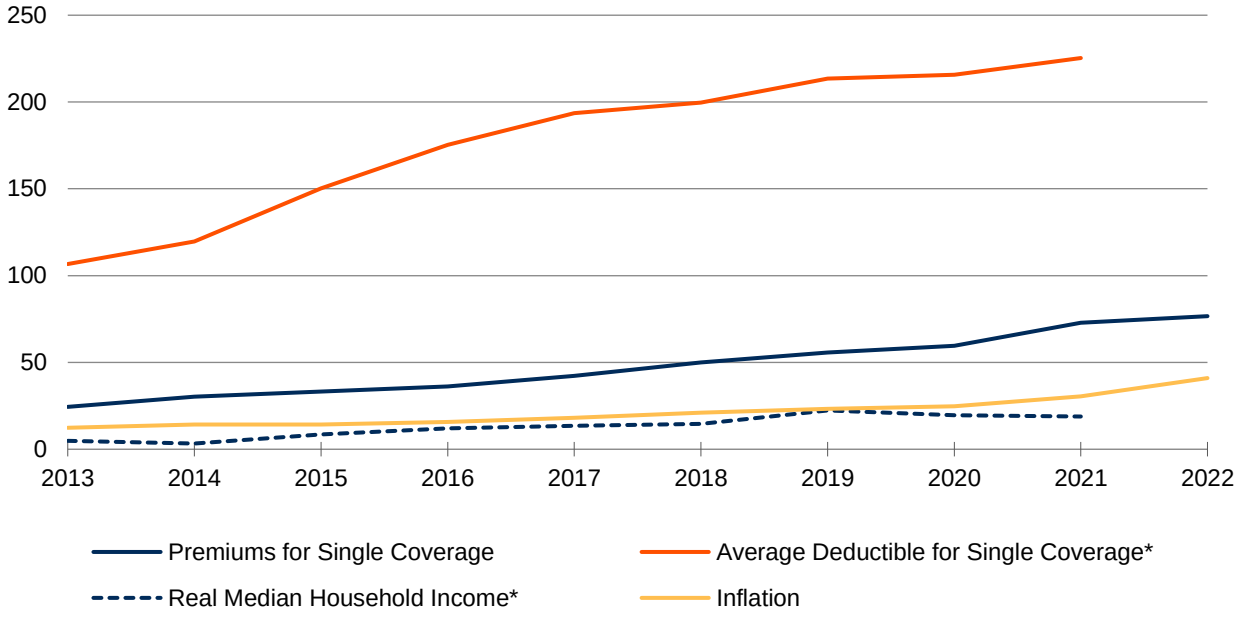
(arranged by 2022 figures, in thousands)

RANK NO.	COMPANY NAME	INPATIENT ADMISSIONS					PERCENTAGE CHANGE			
		2018	2019	2020	2021	2022	2018-2019	2019-2020	2020-2021	2021-2022
1	HCA Healthcare	2,004	2,109	2,010	2,090	2,075	5.2	(4.7)	4.0	(0.7)
2	Tenet Healthcare	689	684	604	548	523	(0.8)	(11.6)	(9.3)	(4.5)
3	Community Health Systems	627	558	470	442	435	(11.1)	(15.7)	(5.9)	(1.7)
4	Universal Health Services	787	806	735	762	771	2.5	(8.8)	3.7	1.1
	TOTAL	4,107	4,157	3,820	3,842	3,804	1.2	(8.1)	0.6	(1.0)

Source: Company reports.

According to the Kaiser Family Foundation, from 2012 to 2022, average premiums for single coverage increased from $5,615 to $7,911, a compound annual growth rate (CAGR) of 3.5%. Meanwhile, average premiums for family coverage increased by 43%, from $15,745 to $22,463, at a CAGR of 3.6%. From 2011 to 2021 (latest available), real household median income increased at just 1.6% CAGR, according to data from the Federal Reserve Bank of St. Louis. This suggests that Americans may be inclined to forgo health insurance and health expenditures in the case of a weaker job market, which would negatively impact hospitals and managed care organizations. Due to a shift towards high-deductible health plans (HDHP), patients typically must pay out-of-pocket for more of their medical bills before insurance kicks in, resulting in patient preferences for lower-cost options (*e.g.*, outpatient facilities). To cater to the increasing demand for lower-priced services, hospitals (*e.g.*, HCA Healthcare and Tenet Healthcare) have invested heavily in outpatient facilities, which typically offer lower priced services than hospitals themselves.

CUMULATIVE GROWTH IN HEALTH INSURANCE COSTS SIGNIFICANTLY OUTPACED WAGE GROWTH
(percent)



*Latest available data as of 2021.
Source: Kaiser Family Foundation, Federal Reserve Economic Data, Minneapolis Fed.

Operating Environment

Health Care Spending on the Rise

CMS projections estimate that U.S. prescription drug spending will increase by 4.6% in 2022 from 2.7% in 2021 and will average at a CAGR near 5.1% from 2022 to 2030, an acceleration from the 3.1% CAGR seen between 2016 and 2021.

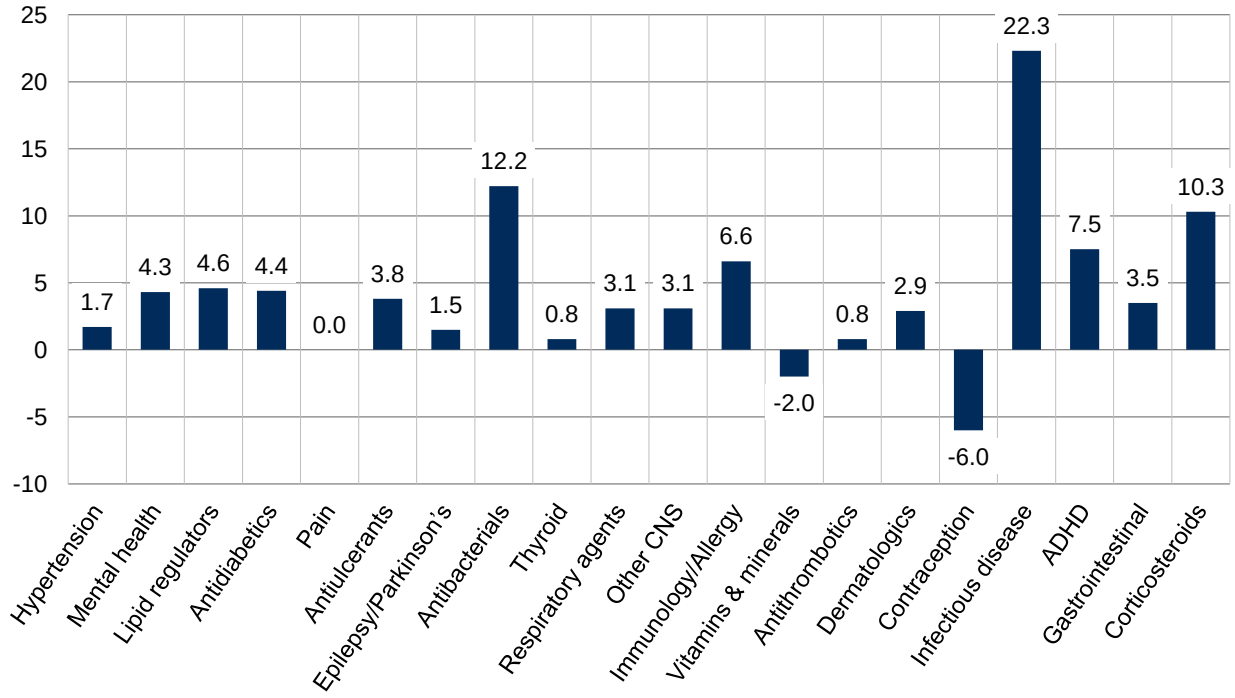
GROWTH IN NATIONAL HEALTH CARE EXPENDITURES, BY SOURCE
(annual growth rates, in percent)

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Consumer out-of-pocket	(3.7)	4.6	6.1	5.5	5.2	4.7	4.3	4.0	4.0	3.9	3.8
Total health insurance	3.0	9.1	6.9	5.5	5.8	6.0	5.8	5.7	5.9	5.8	4.8
Private health insurance	5.2	4.0	4.9	5.0	5.0	5.0	5.0	5.0	4.9	4.9	4.9
Employer-sponsored PHI	5.2	3.5	4.3	4.4	4.3	5.0	4.9	4.9	4.9	4.9	4.9
Direct Purchase	5.8	8.0	10.4	10.6	10.6	5.5	5.5	5.5	5.6	5.6	5.6
Public funds	21.3	2.8	2.0	3.3	4.3	5.6	5.9	6.1	6.4	0.0	0.0
Medicare	3.5	11.3	7.5	5.9	7.0	7.4	7.6	7.3	7.3	7.1	4.3
Medicaid	4.5	5.5	5.9	5.7	5.1	6.0	6.8	5.7	5.7	5.7	5.7
CHIP	2.1	1.0	4.9	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0
Other public funds	4.8	4.7	5.0	4.6	4.5	4.7	4.8	4.8	4.8	4.8	4.8
Total health expenditures	9.7	4.2	4.6	5.0	5.1	5.4	5.3	5.3	5.5	5.4	4.7

Source: Centers for Medicare and Medicaid Services.

According to a report published by IQVIA, there were 6.7 billion prescriptions dispensed in 2022, growing 3.6% from pre-pandemic levels. Most therapy areas experienced a rebound in usage in 2022 except for vitamin & minerals and contraception, which had modest declines.

DRUG PRESCRIPTION GROWTH
(for 2022, in percent)



Source: IQVIA.

Drug pricing has been under increased scrutiny in the past few years, with politicians, doctors, and health care facilities saying that many prescriptions are inaccessible to patients. Drug companies have defended their prices, adding that they offer rebates and other discounts. The Trump administration had investigated the cause of rising drug prices and put pressure on pharmacy benefit managers (PBMs), but PBMs said they are crucial to lowering drug prices because they have negotiating power. The Trump administration also considered eliminating rebates; however, we do not think such an action would lower drug prices substantially, as PBMs would simply adjust their business models to account for the removal of rebates. In fact, a report by the Congressional Budget Office (CBO) in mid-2019 estimated that eliminating rebates would result in higher spending for government health programs. According to the Kaiser Family Foundation, the recently passed Inflation Reduction Act aims to lower prescription drug costs by allowing Medicare to negotiate with drug manufacturers, enforcing rebates from manufacturers when drug costs outpace inflation growth, and introducing annual ceilings on prescription drug spending by seniors.

Hospital Volumes Still Working Towards Pre-Pandemic Levels

With the imposition of lockdowns and travel restrictions due to the Covid-19 pandemic, many health care facilities were severely impacted by a significant decline in patient volumes in 2020. Volumes recovered well during 2021 despite the ongoing pandemic. However, the spread of the Covid-19 Omicron variant in early 2022, as well as labor shortages and other staffing challenges that limited the number of patients that could be served, hampered volume growth in 2022. Against somewhat easier comparisons, along with support from improving staffing levels, health care facilities reported strong volume recovery results during their recent first quarter of 2023 earnings reports, with HCA Healthcare's same-facility equivalent admissions rising 7.5% year-over-year (Y/Y), Tenet Healthcare's same-hospital adjusted admissions rising 6.7% Y/Y, and Universal Health Services' same-facility acute care admissions rising 10.5% Y/Y. As a percentage of HCA Healthcare's acute care admissions, Covid-19 cases represented roughly 3% of admissions vs. 9.7% in the first quarter of 2022. Peers reflected similar trends, with Tenet Healthcare's Covid-19 cases falling to 4% vs. 12% in the first quarter of 2022, while Universal Health Services saw just 4% of admissions from Covid-19 vs. 14% in the prior-year quarter. We expect hospital volumes will continue to gradually increase over the near term.

Health Care IT: Technology Investments Could Continue to Drive Lower Costs

Improved health care information technology (HCIT) capabilities have driven and may continue to drive costs lower for health care facilities. The 2009 economic stimulus package, called the American Recovery and Reinvestment Act of 2009, provided $20 billion for investments and incentives between 2011 and 2015 to spur the adoption of HCIT. The industry is much more mature now than in 2010, but we think there is still room for innovation.

Studies have indicated that HCIT and electronic health records (EHRs) will likely improve health care quality, care effectiveness, and patient safety – improvements that should lead to lower costs. Ideally, HCIT and electronic health records should work seamlessly with all medical devices, instruments, and systems to enable real-time health information from multiple sources, including medical records, test results, and prescription drug information. Comprehensive real-time data and information should enable a physician to make the most informed medical decisions. In addition, the system should be able to detect and warn a physician or other health care practitioner of potential issues that may arise, such as adverse drug-to-drug interaction, medication errors, and drug allergies.

Workforce shortages and burnout have been health care leaders' predominant concerns of potentially disrupting the health care system in the long run. According to the World Economic Forum, there is a likelihood of global shortfall of 13 million nurses by 2030, attributed by the exhaustion from the brunt of the pandemic causing millions of health care workers to leave the workforce. Furthermore, health care professionals are now battling to pick up the backlog of routine treatments that had been set aside during the pandemic. Considering these workforce obstacles, we foresee health care providers to leverage on

automation, supported by AI, to improve efficiencies and elevate staff capabilities. For example, AI would come in handy in increasing productivity in radiology departments by enabling faster scan times with higher resolution in imaging modalities such as magnetic resonance (MR). In addition, AI will also be able to improve productivity and lessen intra-user variability in ultrasound use by minimizing health care professionals' tedious manual work with the help of automatic measurements. We also view automation becoming a rising trend that could help to reduce the burden of repetitive administrative tasks for physicians, nurses, and technologists, and contribute to more time on patient interactions.

Accountable Care Organizations

A shift toward bundled payments from the fee-for-service model will likely affect revenue for health care facilities. In an effort to combat the rising cost of providing health care, the Affordable Care Act introduced the concept of an "accountable care organization," or ACO. An ACO is an organization run by a group of health care providers in which the participating providers are collectively responsible for the care of an enrolled population. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more efficiently, the ACO will share in the savings it achieves for the Medicare program.

Regulatory Environment

The End of Public Health Emergency

The Covid-19 public health emergency (PHE) in the U.S. officially ended on May 11, 2023. The end of the PHE brings significant changes on the rollback of many Covid-19 programs and flexibilities, including blanket waivers issued by CMS and the Drug Enforcement Agency (DEA), and statutory protections (commonly referred to collectively as "waivers"), impacting hospitals as highlighted below.

ITEM	DESCRIPTION
Emergency of Medical Treatment and Labor Act (EMTALA) Enforcement	During the PHE, CMS waived the enforcement of EMTALA, allowing hospitals to screen patients at a location offsite, away from the hospital's campus, to prevent the spread of Covid-19. Hospitals should plan to reimplement policies and procedures to ensure that EMTALA-required screening of patients occurs onsite.
Nursing Services and Other Conditions of Participation	CMS waived the requirements that a hospital's nursing staff must develop a nursing care plan for each patient and maintain policies and procedures in place establishing which outpatient departments need a registered nurse present. This was designed to present flexibility and opportunity to stretch nursing services, which were also subjected to many market and other pressures causing turnover, throughout the PHE. Hospitals should ensure that their nursing services policies have been reviewed and are consistent with the conditions of participation in 42 CFR* § 482.23.
Remote Prescription of Controlled Substances	During the PHE, the Drug Enforcement Administration (DEA) adopted policies allowing DEA-registered practitioners to prescribe controlled substances without having to interact in person with their patients.
Use of Temporary Expansion Sites	CMS authorized use of temporary expansion sites (*e.g.*, convention centers, tents, onsite hospital rooms, and surgical suites) for the duration of the PHE. CMS also permitted use of provider-based departments that were relocated to settings outside the hospital, including patients' homes, after receipt of an extraordinary circumstances waiver, and that provide education and therapy services to hospital outpatients. When the PHE ends, hospitals will be required to provide services to patients within their hospital departments pursuant to Medicare conditions of participation. In addition, to retain any "exempted status" the provider-based department enjoyed prior to the PHE, CMS is taking the position that the relocated department must return to the same location from which it operated prior to the PHE. For hospital systems engaged in space management projects during the three-year PHE that may have rearranged departments, the end of the PHE could bring reduced reimbursement if the exempted provider-based department cannot return to its original location.
Return of the 'Walls' Between Excluded Units	During the PHE, CMS waived certain requirements to allow hospitals to house acute care patients in excluded distinct part units (*i.e.*, inpatient psychiatric units and inpatient rehabilitation units). The waiver permitted the hospital to bill for the care under the inpatient prospective payment system (IPPS) and required the hospital to document in the medical record that the patient is an acute care patient being housed in the excluded unit because of capacity issues related to the PHE. Simultaneously, CMS allowed the opposite and permitted hospitals to relocate patients from the excluded distinct part units to an acute care unit, annotate the

	medical record accordingly, and bill for services under the inpatient psychiatric facility prospective payment system (IPF PPS) and the inpatient rehabilitation facility prospective payment system (IRF PPS), as applicable. At the end of the PHE, hospitals will not be reimbursed for services provided to acute care patients housed in excluded distinct part units and vice versa. Hospitals must resume treating patients in their designated unit in order to receive payment for services.
Expanded Use of Swing Beds	During the PHE, CMS waived the eligibility requirements to allow hospitals to apply for swing bed services that were needed to provide skilled nursing facilities (SNF) level care for non-acute care patients. During the Covid-19 PHE, hospitals could call the Medicare provider enrollment hotline to request swing bed approval instead of submitting a Form CMS-855A. With the end of the PHE, hospitals should consider whether submitting an application is required to maintain enrollment for swing beds approved through the waiver process.
Increased Critical Access Hospital (CAH) Beds and Lengths of Stay and Other Rural Hospital Flexibilities	CMS waived the requirements that CAHs be located in a rural area for certain surge locations, limited to 25 beds, and that the length of stay be limited to 96 hours under the Medicare conditions of participation. The location, bed count, and length of stay requirements return with the end of the PHE, and CAHs should ensure that their operations comply. Similarly, CMS will begin evaluating the eligibility requirements for sole community hospitals and Medicare-dependent hospitals under Sections 42 CFR § 412.92(a) and 42 CFR § 412.108(a), respectively, that have not been enforced during the PHE. Given the duration of the PHE, hospitals should ensure that the criteria for these special Medicare designations remain in effect.
Minimal Information for Discharge Planning	CMS waived the requirements that hospitals (and other providers) engage in detailed information sharing for discharge. After May 11, hospitals must assist patients in selecting a post-acute care provider by collecting and sharing quality measures and resource use measures to ensure that a patient is discharged to an appropriate setting with the necessary medical information and goals of care.
Admission Requirements for Skilled Nursing Facility (SNF)	CMS waived the requirement for a three-day prior hospitalization for coverage of a SNF stay. Once the waiver expires on May 11, hospitals must be cognizant of whether patients have been admitted long enough to be referred to SNFs for post-acute care.
Stark Law	During the PHE, CMS issued blanket waivers of certain provisions of the Stark Law, permitting certain referrals and the submission of related claims that would otherwise violate the Stark Law, if all requirements of the waivers were met. When the PHE ends, the waivers will terminate and hospitals must immediately comply with all provisions of the Stark Law.
*CFR = Code of Federal Regulations. Source: Morgan Lewis.	

In addition to the preparation for the waivers described above, hospitals should anticipate further changes to hospital operations and reimbursement when the next set of waivers expires on December 31, 2023, and still more waivers expire over the course of 2024.

U.S. Federal Government Responses to Covid-19

The CARES Act became law in March 2020 with the goal of addressing the economic fallout of the Covid-19 pandemic in the U.S. The Act appropriates more than $2 trillion, including provisions for health-related funding, as well as other economic stimulus through the expansion and extension of unemployment benefits, the issuance of one-time checks, small business loans and grants, support loans and loan guarantees for large businesses and local governments, food stamps, child and family services funding, disaster assistance, the reduction of individual taxes, and business tax cuts.

The Provider Relief Fund was announced in April 2020 to support American families, workers, and health care facilities in the battle against Covid-19. $50 billion was allocated for targeted distribution to facilities in areas particularly impacted by the Covid-19 outbreak. The initial $30 billion was distributed automatically based on each facility's share of Medicare fee-for-service reimbursements in 2019, while the remaining $20 billion is allocated based on CMS cost reports or incurred losses.

The Coronavirus Preparedness and Response Supplemental Appropriations Act was signed into law in March 2020 with the intent to provide emergency supplemental appropriations of $8.3 billion in FY 20 to combat the spread of Covid-19 in the U.S.

The objective of **the Families First Coronavirus Response Act** is to respond to economic impacts of the ongoing Covid-19 pandemic by providing $3.5 billion in funding for free Covid-19 testing, 14-day paid leave for American workers affected by the pandemic, and increased funding for food stamps.

The Paycheck Protection Program and Health Care Enhancement Act provides funding of $75 million for the reimbursement of hospitals and other eligible health care facilities for Covid-19-related expenses or lost revenues and $25 million of funding for Covid-19 testing.

The Public Health and Social Services Emergency Fund is designed to provide an influx of money to hospitals and other health care entities responding to the coronavirus pandemic. This $100 billion fund averages out to about $108,000 per hospital bed in the U.S. Hospitals across the country said they needed resources as they struggled to treat Covid-19 patients.

Telehealth: Changes to Post-Pandemic Regulation

During the Covid-19 PHE, the U.S. Department of Health and Human Services (HHS) had taken steps to ease the process of providing telehealth services. Telehealth – sometimes referred to as telemedicine – describes the use of two-way communication technology for certain health services.

HHS has provided flexibility to HIPAA-covered (Health Insurance Portability and Accountability Act) health care during the pandemic. HIPAA-covered health care providers may seek to communicate with patients and provide telehealth services through remote communications technologies. CMS has also issued temporary measures to make it easier for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to receive medical care through telehealth services during the Covid-19 PHE.

As of April 12, 2023, 21 U.S. states have adopted long-term or permanent provisions allowing the practice of telemedicine across state lines, while 3 states had waivers in place that allow interstate telemedicine, according to the Federation of State Medical Boards.

According to the Kaiser Family Foundation, several states set their temporary license waivers for interstate telemedicine to end at the conclusion of the PHE. For example, the scope of technologies that providers can use for telehealth treatment will narrow to just "HIPAA compliant" mediums, as opposed to a broader array of allowable methods during the PHE. However, under the Consolidated Appropriations Act of 2023, relaxed telehealth regulations will remain intact for Medicare beneficiaries through December 31, 2024. For Medicaid beneficiaries, states have the authority to reimburse telehealth regardless of

federal policy, according to the Kaiser Family Foundation, adding that several states have recently expanded their efforts to support telehealth services for Medicaid beneficiaries. Another notable change is that following the PHE, prescriptions for controlled substances must be based on in-person medical evaluations, rather than through telehealth mediums.

Moratorium on Medicare Sequestration
On March 25, 2021, the Senate passed, by a 90-2 vote, a bill that extended a moratorium on 2% Medicare Sequester cuts until the end of 2021. To pay for the change, the bill will increase the fiscal year 2030 sequester cuts. Sequestration was later extended through March 2022, although Medicare payment cuts of 1% were to take place from April 1 through June 30, followed by 2% cuts beginning July 1.

CMS Issues Medicare Hospital Inpatient Prospective Payment System Final Rule for FY 23
On April 18, 2022, CMS announced its proposed rule to increase Medicare inpatient prospective payment system (IPPS) rates by a net 3.2% in FY 23 compared with FY 22. On August 2, 2022, CMS released its final rule to increase Medicare IPPS rates by a net 4.3% in FY 23 compared with FY 22. Given the rising labor and supply costs being encountered by health care facilities, we believe that the proposed rate increase is likely to be insufficient in itself to maintain revenues and profits per admission, making it more important for facilities to focus on improving staffing levels and operational efficiency. In April 2023, CMS released proposed updates for FY 24 IPPS, which featured a net 2.8% increase in rates vs. FY 23.

Protecting Access to Medicare Act
The Protecting Access to Medicare Act (PAMA), signed into law in 2014, aims to align Medicare reimbursement rates for Clinical Diagnostic Laboratory Tests (CDLTs) with the rates private insurers pay. The Covid-19 pandemic has caused delays in reporting requirements and rate cuts under PAMA. Legislation from December 2022 delayed the next round of rate cuts until 2024, with certain tests receiving reimbursement cuts of up to 15% a year from 2024 through 2026. In the near term, we think these delays will support revenues for many health care services companies, as well as health care facilities with in-house testing.

Affordable Care Act
The Affordable Care Act (ACA), commonly known as Obamacare, has been a significant force in the health care sector over the past decade. Passed into law in March 2010, the ACA set regulations to govern the health care sector and strengthen the overall U.S. health care system. This reform has affected all health care stakeholders, but CFRA thinks it has had a disproportionately large impact on health care facilities. In spite of the numerous concessions and additional fees and taxes imposed on the health care sector, the estimated addition of 20 million insured patients (through 2019, according to the Center on Budget and Policy Priorities) has likely been a net positive for health care facilities.

In 2020, as the Covid-19 pandemic sent the U.S. into a recession and 44 million Americans filed for unemployment benefits in the 12 weeks ended May, many of them also lost their company-offered health insurance. Some people used this as a “qualifying event” (losing their company health insurance) to get coverage through ACA plans. The administration extended the enrollment period for the ACA, aiming to offer consumers ample time to sign up for insurance after the Covid-19 aid legislation boosted subsidies. HHS extended the deadline for consumers to sign up for health plans from May 15, 2021, to August 15, 2021. The special enrollment period began on February 15, 2021, to aid people who had lost jobs due to the pandemic to gain health insurance coverage. More than 200,000 Americans gained health coverage during the first two weeks of the special enrollment session.

In December 2018, a judge in Texas ruled the ACA to be unconstitutional. In early 2020, the Supreme Court agreed to hear the ACA case, and in June 2021, the Supreme Court reversed the Texas judge’s ruling, meaning the ACA remains intact. Following this case, we feel the repeal of the ACA is far less likely to occur in the near-term under the Biden administration.

American Rescue Plan Act
Through the March 2021 Covid-19 stimulus package known as the American Rescue Plan Act or ARPA, the U.S. government temporarily expanded health care assistance under the ACA. Under the ACA, people who earn 400% of the federal poverty level are not eligible for the tax credits, also known as subsidies, that help offset the cost of purchasing health plans. The Covid-19 aid legislation eliminates the income cap that limits who is eligible for ACA tax credits to reduce monthly insurance premiums and also limits the premiums paid by higher income enrollees to no more than 8.5% of their income. It also offers financial incentives to support individuals in states that have not expanded access to Medicaid for low-income individuals.

Inflation Reduction Act
Through the recently passed Inflation Reduction Act, previously known as the Build Back Better Act, the Biden administration extended the ARPA subsidies through 2025. We think this legislation helps health care facilities by supporting the percentage of insured patients.

Private Insurers Are Reluctant to Participate in ACA Marketplaces
In 2018, a number of large insurers had withdrawn from certain ACA marketplaces, citing increasing losses on health plans sold through the exchanges. This dynamic had negative implications for consumers and affected predominantly rural areas. Things appeared to be turning around in 2020, as the Kaiser Family Foundation projected that 78% of consumers in the U.S. would have had three or more insurance options in 2021 (latest available), up from 68% in 2020 and 58% in 2019. Consumers with only one insurance option are expected to decrease to 3% in 2021 (latest available) from 10% in 2020 and 17% in 2019. In markets without competition, consumers may face steep premiums and high deductibles, although federal subsidies should reduce the impact of premium increases for many consumers.

Price Transparency Initiative by Trump Administration, Continuation Under Biden Administration
The Trump administration won a court ruling in June 2020, defending its plan to require insurers and hospitals to disclose the actual prices for common tests and procedures with the intention to promote competition and push down costs. The level of detail is critical to determining the impact of the price transparency measures because the HHS could require hospitals to disclose information at a low level of granularity (*e.g.*, the average rate that insurers pay) or at a higher level of detail (*e.g.*, the price that each insurer pays). We believe that the more detailed and nuanced the disclosure requirement is, the bigger the impact will be for health care facilities.

According to The Wall Street Journal, hospitals that have published their previously confidential prices to comply with a new federal rule have blocked the information from web searches with special coding embedded on their websites. The federal government has ruled the information mandatory with the goal of making the $1 trillion sector more consumer-friendly. However, hundreds of hospitals have embedded a code in their websites that prevented Alphabet Inc.'s Google and other search engines from displaying pages with the price lists on more than 3,100 sites.

As of January 1, 2021, hospitals are required to make payer-negotiated rates for common services available to consumers on an online tool, and for all services in a machine-readable file. A second rule requires insurers in the individual and group markets and self-funded employer plan to make rates and individualized cost-sharing estimates for certain common services available to enrollees by January 1, 2023, and for all services by the following year.

In November 2021, CMS issued its Calendar Year 2022 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule. The rule increases the penalty on hospitals that do not comply with the price transparency guidelines, with a minimum penalty of $300 per day for smaller hospitals with 30 or fewer beds and $10 per bed per day for hospitals with over 30 beds,

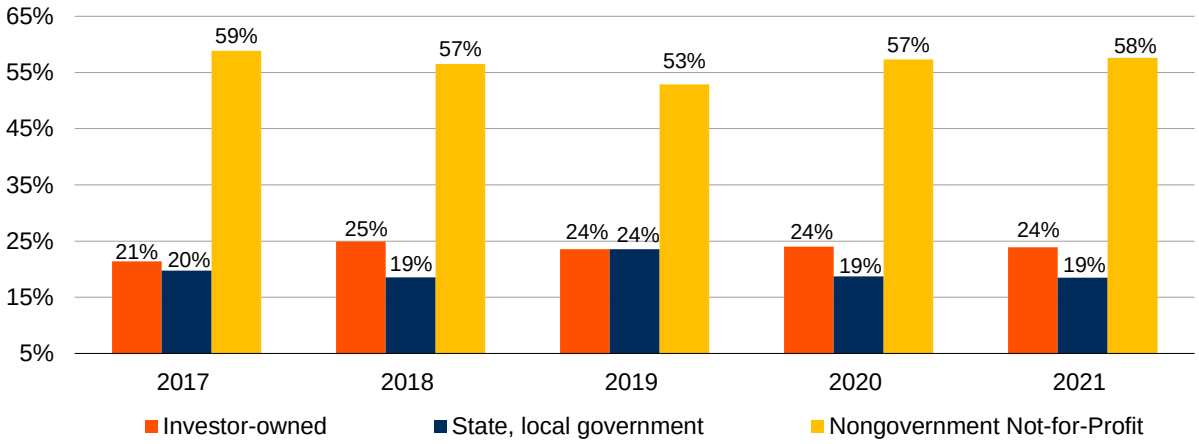
up to a daily maximum of $5,500. Over the course of a year, this would equate to a minimum of $109,500 and a maximum of $2,007,500 per hospital that does not comply.

By January 1, 2022, the following information must be made publicly available: 1) negotiated rates for all covered items and services between the plan and in-networks providers; 2) historical payments and billed charges from out-of-network providers; and 3) in-network negotiated rates and historical net prices for all covered prescription drugs at the pharmacy location level. Insurers must make this pricing information and personalized cost-sharing estimates (*i.e.*, deductible payments, co-pays, and coinsurance) available to enrollees on an online consumer-usable tool for 500 “shoppable” services by January 1, 2023, and then for the remainder of all covered serviced and items by January 1, 2024. The 500 common “shoppable” services are identified in the rule by HHS, the Department of Labor, and the Department of the Treasury.

The potential positive implications of making prices public are that the health care systems will face pressure to lower prices to compete for consumers shopping for health services, and insurers will face greater pressure to negotiate discounts. On the other hand, as health care systems and provider groups are made aware of what other providers are charging for the same care, providers could try to negotiate higher rates to match their competitors, especially in more highly concentrated markets. Studies show that existing price transparency tools are not associated with decreases in spending.

HOW THE INDUSTRY OPERATES

HOSPITAL OWNERSHIP*
(percent of U.S. community hospitals)



*Latest available data.
Source: American Hospital Association.

The delivery of health care services in the U.S. centers on the large and primarily tax-exempt facilities known as acute care hospitals. These facilities have evolved through the years and currently offer a full range of medical services in both inpatient and outpatient settings. According to 2021 data from the American Hospital Association (AHA), there were 5,157 community hospitals in operation in the U.S. as of FY 21. Approximately 24% of these facilities were investor-owned, while 76% operated under tax-exempt status (a category that includes state and local government as well as non-government not-for-profit hospitals).

Other kinds of health care facilities include psychiatric hospitals, rehabilitation facilities (both standalone units and those attached to a larger facility), freestanding ambulatory surgery centers (ASCs), clinics, nursing homes, and home health care agencies. For the purposes of this discussion, we focus primarily on the acute care hospital sector, which forms the core of the U.S. health care delivery system and is likely to remain so for the foreseeable future. Although the federal government does not directly regulate the U.S. hospital industry, it contributes a large portion of industry revenues. It also controls the rates at which it reimburses facilities, whose pricing power is limited. This position gives the government enormous influence on quality standards and even treatment options. For instance, it can encourage facilities to perform outpatient procedures by increasing reimbursement rates while lowering rates for inpatient care.

Managed Care Plans

A managed care plan is a type of health insurance plan that has contracts with hospitals, health care providers (HCPs), and medical facilities to provide care for members at a reduced price. The plan includes health management organizations, preferred provider organizations (PPOs), and point-of-service (POS), the first two being the most popular type of managed care organizations (MCOs) in the U.S.

All areas of the Health Care sector have felt the impact of managed care, but perhaps no single industry has been more affected than the hospital group. As pressures from the government and large corporate payers to reduce the cost of health care have intensified, the hospital industry has consolidated dramatically in recent years, with many nonprofit chains or individual nonprofit hospitals being acquired

and/or entering into joint venture arrangements with for-profit chains. By forming alliances, hospitals leverage their buying power in order to lower supply and other operating costs. The associated margin improvements, along with a more diverse array of service offerings, let them compete effectively for managed care business.

Industry consolidation has also strengthened the bargaining power of the hospitals. In many areas, particularly in small towns and rural areas, merged hospital companies become the “only game in town,” leaving MCOs with almost no choice but to pay the price increases that these hospitals request. Such increases, however, are partly influenced by Medicare and Medicaid payment rates, and possibly held in check by public relations concerns.

The Role of the Government

Because the U.S. federal government is responsible for financing health care services for elderly and poor citizens through Medicare and Medicaid, the federal government is a major force in shaping a health care system.

According to CMS data, U.S. health care expenditures are projected to rise around 57% from 2021 to 2030, implying a CAGR of 5.1%. National health spending is expected to grow in line with GDP over this period, with health care’s share of GDP forecasted to be 19.6% in 2030 vs. 19.7% in 2020 (latest available).

PERSONAL HEALTH CARE EXPENDITURES
(in $, billions)

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Hospital care	1,123	1,194	1,270	1,342	1,435	1,516	1,601	1,696	1,792	1,890	2,002	2,114	2,210
Professional services	979	1,022	1,069	1,144	1,201	1,272	1,347	1,424	1,503	1,582	1,664	1,751	1,827
Physician and clinical services	737	768	810	850	903	959	1,016	1,077	1,140	1,202	1,268	1,337	1,398
Other professional services	105	111	117	128	132	140	149	157	165	174	183	192	200
Dental services	138	143	142	166	166	173	182	191	199	206	214	222	230
Home health care	191	196	209	220	232	244	257	271	285	300	316	334	352
Nursing and continuing care facilities	106	113	124	122	129	139	149	160	172	184	198	213	226
Retail outlet sales	168	174	197	182	188	198	208	218	228	239	250	262	273
Prescription drugs	456	476	489	510	535	560	589	619	650	683	718	754	792
Medical products	324	338	348	365	380	398	419	440	462	486	511	539	567
Durable medical equipment	132	138	141	146	155	162	170	179	188	197	206	216	225
Non-durable medical products	54	57	55	57	60	63	66	70	73	77	81	84	88
Other personal health care	78	81	86	89	95	100	104	110	115	120	126	131	137
Total Expenditures	46	47	48	53	56	59	61	65	68	72	76	81	85

Source: Centers for Medicare and Medicaid Services.

These figures may increase further in the coming years as the baby boomer generation enters the Medicare program. Baby boomers are the approximately 75 million Americans born between 1946 and 1964. The CMS Office of the Actuary predicts that government sources will fund about 46% of the projected domestic health care expenditures by 2024, down from 51% in 2020 (latest available) due to the pandemic, but well above the 35% level in 2011.

Medicare

As part of the Social Security Amendments Act of 1965, Medicare legislation established a program of health insurance to complement the retirement, survivor, and disability insurance benefits provided under other titles of the Social Security Act.

Medicare is the largest public payer of health care. Medicare health expenditures represented approximately 3.0% of GDP in 2022, according to the Congressional Budget Office. This compares to 3.9% of GDP in 2021. Medicare expenditures are projected to reach 6.2% of GDP in 2046 and 6.5% of GDP in 2096, according to the 2023 Medicare Trustees Report. Using an alternative model where health care costs rise more than expected, the report projects Medicare health expenditures could represent 6.4% of GDP in 2047 and 8.3% of GDP in 2097. The increase in expenditures is driven primarily by trends in disposable personal income, increases in prices for medical goods and services, and shifts in enrollment from private health insurance to Medicare that result from the continued aging of the baby boomer generation into Medicare eligibility.

Medicare is a federally funded program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons, and persons with end-stage renal disease. The program consists of four parts: hospital insurance, also known as Part A; supplemental medical insurance (Part B); Medicare Advantage (Part C); and the prescription drug benefit (Part D). According to the 2023 Medicare Trustees Report, the number of people covered by Medicare was 65 million in 2022. This number is projected to grow to 87 million by 2050 and 110.2 million by 2097.

◆ **Part A.** This usually is provided automatically to persons 65 years of age or over and to most persons who are disabled for at least 24 months and are entitled to Social Security or Railroad Retirement benefits. Part A covers inpatient care in skilled nursing facilities and hospitals. Hospice and home health care are also covered by Part A. The FY 23 budget for the U.S. Department of Health and Human Services (HHS) called for around $211.7 billion in expenditures for Part A compared to $214.2 billion for FY 22.

◆ **Part B.** This is medical insurance to pay for medically necessary services and supplies provided by Medicare. Most people pay a premium to receive this coverage. Part B covers outpatient care, doctors' services, physical or occupational therapists, and additional home health care. Nearly all persons enrolled in Part A also enrolled in Part B, which primarily covers physician-based medical services. Part B costs have been rising rapidly and are expected to continue to do so at an annual rate of 6.8% through 2028, according to the 2023 Medicare Trustees Report. The HHS estimation of spending for FY 23 is $227.7 billion for Part B compared to $221.2 billion for FY 22.

◆ **Part C.** This program – also referred to as Medicare Advantage – is offered by private companies that are approved by Medicare. These plans are required to provide all Medicare-covered benefits but are permitted to vary the benefit design as long as the core benefit package is comparable. The most common benefit of such plans is reduced cost sharing for benefits through lower insurance premiums. According to an August 2022 report, around 28.4 million, or about 48% of Medicare enrollees, are enrolled in a Medicare Advantage (MA) plan, according to the Kaiser Family Foundation. The HHS estimation of spending for FY 23 is $459 billion for Part C compared to $433 billion for FY 22.

◆ **Part D.** This program – part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) – offers prescription drug coverage to beneficiaries. Part D benefits began on January 1, 2006, and are available to anybody entitled to Medicare Part A or enrolled in Medicare Part B. Beneficiaries choose among several private plans or Medicare-approved managed care organization (MCO) or health maintenance organization (HMO) plans; the beneficiaries are charged an extra premium each month to join one of these plans. Part D is expected to experience a 4.7% annual increase in

expenditures through 2028, according to the 2023 Medicare Trustees Report. The HHS estimation of spending for FY 23 is $124.5 billion for Part D compared to $127.5 billion for FY 22.

Prospective Payment System

Congress adopted a prospective payment system (PPS) in the 1980s to stymie the upward spiral of overall health care expenditures – specifically the fast-growing hospital component of total spending. PPS replaced a cost-based reimbursement method for hospitals, which incentivized increased capital spending and expansion. PPS impacts how hospitals are reimbursed and remains the system used for Medicare reimbursement.

The PPS established fixed payments that hospitals receive for each patient based on an assigned diagnosis-related group (DRG). Under this system, hospitals are reimbursed for Medicare patients' treatments according to the estimated intensity of hospital resources required to furnish care for each principal diagnosis rather than the hospital's individual cost experience. DRG rates are based on a statistically normal distribution of severity; hospitals receive additional payments for patients who fall outside of this normal distribution (called "outliers").

Individual DRG rates have been set for each hospital participating in the Medicare program. Rates are calculated separately for urban and rural hospitals and then are further adjusted to take into consideration geographic differences in wage levels, indirect costs of patient care for hospitals with teaching programs, and costs related to treating a disproportionately large share of low-income patients. Under the PPS, hospitals can retain payments that exceed their actual costs, but they also must absorb costs in excess of such payments. This revised reimbursement methodology has encouraged hospitals to operate more efficiently.

How Medicare Is Funded

Medicare Part A is financed through mandatory payroll deductions. These deductions include Federal Insurance Contributions Act (FICA) taxes of 1.5% of taxable earnings paid by employees (and another 1.5% paid by employers), and a 2.9% tax from self-employed persons who pay into the hospital insurance trust fund. Part A also carries a patient deductible before benefits are covered. Part B funds come from payment of premiums, which are usually deducted from monthly Social Security benefit checks of those who are voluntarily enrolled, and through significant contributions from the general revenues of the U.S. Treasury. Part D is funded by a combination of federal general revenues and beneficiaries' contributions. Assistance is provided to qualifying low-income individuals. Part D is also financed from the increase in monthly premiums for Part B beneficiaries.

Medicare funding levels for physicians are tied to the sustainable growth rate formula devised in 1997 by Congress to tie Medicare reimbursement levels to the overall economy. However, Medicare has consistently paid physicians more than it intended, accruing a substantial liability. The 2023 Medicare Trustees Report expressed concerns about the viability of the Medicare hospital insurance trust fund and projected that the hospital insurance could run out of funds by 2028.

Medicaid

Medicaid is a program designed to provide medical assistance to eligible needy persons. Medicaid is jointly funded by the federal and state governments but is administered by individual states operating within federal guidelines.

The federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares a state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed for a smaller share of their costs. By law, the FMAP cannot be lower than 50% or higher than 83%.

Medicaid operates as a vendor payment program, with states paying health care facilities directly. Participating providers must accept the Medicaid reimbursement level as payment in full. Each state has broad discretion in determining the reimbursement methodology and resulting rate for services as long as such rates are within federally imposed upper limits and restrictions. There are three exceptions: first, for institutional services, payment may not exceed amounts that would be paid under Medicare payment rates. Second, different limits apply for "disproportionate share" hospitals – hospitals that accept Medicaid or uninsured patients. However, most hospitals accept such patients, whom they bill according to a sliding scale of charges. Third, rates for hospice care services cannot be lower than Medicare rates.

The 50 U.S. states, the District of Columbia, and Puerto Rico all offer some form of managed Medicaid programs, such as an accountable care organization. Each state designates a single agency that is responsible for its Medicaid program operations. The federal government sets broad national guidelines, under which individual states establish their own eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment for such services; and administer their own programs. Because of this structure, Medicaid programs vary considerably from state to state, as well as within each state over time.

Most state Medicaid payments are made under a prospective payment system or under programs that negotiate payment levels with individual hospitals. In general, Medicaid reimbursement is substantially less than a hospital's cost of service, so this business segment creates a drag on a facility's overall profit margins.

Owing to both federal and state budget deficits, the federal government and most states constantly consider ways to reduce the level of Medicaid funding – for example, by cutting payments to providers – while still maintaining the list of Medicaid benefits that are covered. Therefore, Medicaid revenues for those participating in the program are likely to fall in coming years.

ACA Expands Medicaid Eligibility

Under the Affordable Care Act (ACA), Medicaid eligibility was expanded to cover all non-Medicare-eligible individuals under age 65 with incomes of less than 138% of the federal poverty level, depending on the number of persons in the household. States were able, if they so desired, to expand coverage beginning April 2010. For most states, all newly eligible adults are guaranteed a basic benefit package equal to those provided via the exchanges. As of March 27, 2023, 40 states, as well as the District of Columbia, have expanded their Medicaid programs, and 10 states have not adopted the expansion, according to the Kaiser Family Foundation.

Regulation

State and federal governments and related agencies are involved in overseeing numerous operational areas of health care facilities – especially those receiving Medicare and Medicaid funds. Foremost among them are building safety, personnel training, and management practices; conducting patient diagnosis and treatment; determining the need for new facilities; and detecting fraud and abuse.

Licensure, Certification, and Accreditation

Facilities are subject to review by governmental and other authorities to ensure continued compliance with the various standards necessary for licensing and accreditation. In order for a facility to participate in the Medicare and Medicaid programs, it must be certified by Medicare or be accredited by the Joint Commission on Accreditation of Health Care Organizations, an independent peer-review organization (PRO) that evaluates and accredits U.S HCPs and programs.

The construction of a health care facility is subject to federal, state, and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, fire protection, and rate setting. Compliance with building codes and environmental protection laws is also enforced.

Utilization Review

To ensure the efficient use of facilities and services, federal regulations require that facilities providing services to Medicare and Medicaid patients be reviewed by a federally funded PRO. These organizations review the appropriateness of patient admissions and charges, the quality of care provided, the appropriateness of cases of extraordinary length of stay or cost, and the validity of DRG classifications. PROs have the authority to deny payment for services provided. They also may assess fines and recommend to HHS that any provider in substantial noncompliance with these standards be excluded from participating in the programs.

HOW TO VALUE A COMPANY IN THIS INDUSTRY

When evaluating a company in the Health Care Facilities sub-industry, it is important to consider the company's fundamental strengths and weaknesses, its business strategy, its competitive advantages, and the broad industry-level forces at play. Key variables influencing a company's financial health and future prospects vary significantly from sub-industry to sub-industry.

What is the outlook for the managed care business? The managed care business matters to all companies in the Health Care Facilities sub-industry because managed care organizations (MCOs) tend to be payers for most health care services. Lately, managed care companies have been focused on cost containment, as mounting health care costs have been a key concern for the public and the federal government.

At times of significant MCO premium rate hikes, employers tend to initiate benefit design changes and buydowns (*i.e.*, revisions in benefit plans that lower costs, such as instituting higher member co-payments to reduce the employer's premiums). MCOs are usually aggressive in their negotiations with health care facilities, trying to push lower payment rates.

Despite the challenges and increased financial risk associated with managed care contracts, these contracts can generate significant value for health care facilities. Although MCOs typically pay less on a per-patient basis, the admission volumes that MCOs generate for hospitals – both inpatient and outpatient – can expand net patient revenues substantially.

What are the company's primary competitive advantages? For most companies in the Health Care Facilities sub-industry, size has become one of the key factors driving both revenue growth and operating margin expansion. Given the overcapacity of hospital beds in many areas of the U.S., much of the recent growth in hospital revenues has been driven by selective acquisition strategies, particularly on a geographic basis. In many instances, the purpose is to dominate local markets by buying the largest regional facilities and eliminating excess bed capacity. In addition, for-profit operators often look to acquire not-for-profit facilities that are not operating at optimal efficiency. The increasing scale and influence of MCOs in the U.S. have been a driving force behind consolidation, according to CFRA.

The geographic expansion trend has been particularly keen within rural markets, where local residents traditionally traveled to the larger hospitals located in urban areas for the treatment of difficult conditions. By dominating the local markets and boosting capital expenditures at the remaining hospital base, acquiring companies are able to upgrade the facilities and attract local physicians, thereby enhancing their ability to serve the local community. In an effort to encourage facilities to serve less populated markets, the government has made reimbursement rates higher for rural areas, offering an additional incentive for selective geographic expansion.

While political and social pressures tend to restrict the power of MCOs to demand lower rates, hospitals must grapple with a restrictive rate environment. Operating margin erosion is primarily stemmed through the reduction of supply and other costs, mainly through economies of scale. In addition, most of the successful hospital operators are offsetting soft inpatient admission trends by expanding their outpatient service offerings.

Financial Analysis

A number of items on the income statement and balance sheet are important in the analysis of a company in the Health Care Facilities and Health Care Services sub-industries. Given the diversity in terms of geography, sources of revenue, scope of operations, and methods of growth, these items must be evaluated on a company-by-company basis.

Revenues. Health care facility operators generate the bulk of operating revenue growth by driving up patient admissions and boosting surgical procedure volumes. These revenues are further affected by reimbursement rate trends by both government and private payers. In general, hospitals operating primarily in large, highly competitive urban markets generate a significant portion of revenues from managed care customers, as MCO penetration in these markets far surpasses that of rural markets.

One can look to the MCOs to gauge whether premium trends are moving up or down. Premium trends help provide a sense of how much pricing pressure will be placed on health care facilities and how much pricing flexibility these facilities may have. In rural markets, it is common for a high proportion of patient revenue to be generated from either private pay or Medicare sources, as these markets are largely untapped by MCOs.

In addition to a review of organic revenue growth, one should also examine revenue trends on a same-facility basis to analyze operating trends for the facilities that have been owned and under company management for at least one year. If management has expanded its market penetration through an aggressive acquisition program, the performance of existing facilities can show whether the top-line growth is sustainable. It also provides some clues about management's ability to consummate and integrate acquisitions.

Another important aspect is the mix of how coverage for care is being paid, often referred to as the "quality mix" or "payer mix." If the payer mix has shifted materially, what is the reason? The proportion of patient care is often primarily comprised of Medicare, Medicaid, and private pay. Private pay tends to be the most lucrative on a per-patient basis, while Medicaid is the least. During times of state budget deficits, a higher mix of Medicaid patients could signal a problem as states may seek to save money by cutting Medicaid reimbursements.

Another aspect to consider for health care facilities is the ratio of inpatient to outpatient procedures. Outpatient procedures are increasingly viewed as the preferred treatment option by both commercial and government payers because they tend to be less expensive. Examining these issues is important in determining the sustainability of revenues.

Other items related to revenue analysis are operating statistics such as admissions, surgery volumes, length of stay, and total patient days. It is important to look at these numbers both on a company-wide and same-facility basis. When measured against national industry averages and competitors' results, these statistics can help one determine the relative strength of a company.

Uncompensated care. Uncompensated care is care provided by hospitals for which they do not expect to collect compensation – it is classified either as bad debt or charity care. Bad debt (also known as the provision for doubtful accounts) is most often expressed as a percentage of net revenues that a health care company has received, but for which it will not eventually receive full payment. Bad debt typically arises from low-income patients who are without insurance and whose incomes do not allow them to qualify as indigent. Legally, hospitals are required to treat patients until they are medically stable, regardless of their ability to pay. Thus, hospitals inevitably end up treating some people who cannot or will not pay their bills.

Closely linked to bad debt is the amount of charity care that a hospital provides. Charity care differs from bad debt, in that when patients meet a certain criterion (*e.g.*, income is below 150% of the government-determined poverty level), the care is written off as charity care with no expectation of future payment. As such, when care is provided as charity care, it has the impact of decreasing both revenues and bad debt, as neither revenues nor the associated bad debt are recorded for the services provided on financial statements.

Watch Out! *Management can manipulate revenues and earnings by changing estimates related to both its provision for charity care and bad debt expense. Bad debt expense can be a significant item for any type of health care facility while charity care relates primarily to hospitals. Unfortunately, the adoption of ASC 606 (new revenue recognition standards) in the first quarter of 2018 has resulted in a significant reduction in information regarding estimates for bad debt expense and related valuation accounts.*

Investors should review bad debt and charity care policies. Have they been changed in ways that will affect comparability with historical results or financial performance? In addition, since bad debt and charity care policies can vary over time within a particular organization as well as between organizations, it is important to track the trend in uncompensated care over time (usually as a percentage of total revenues), both within an organization and versus its peers. Unfortunately, the adoption of ASC 606 (a recent update to revenue recognition standards) in the first quarter of 2018 has resulted in a significant reduction in information regarding estimates for bad debt expense and related valuation accounts.

Operating margins. How does the company compare with others in its industry segment? For example, a company that manages facilities in rural areas, where there is less MCO-related pressure on utilization and pricing, may have higher operating margins than a company with a large presence in urban areas.

To gauge core operating trends, an investor usually will focus on earnings before interest and taxes (EBIT). For health care facilities companies, an investor may look at earnings before interest, taxes, depreciation, and amortization or EBITDA. The exclusion of non-cash charges (depreciation and amortization), interest expense, and taxes presents a clearer picture of operating cash flow and can provide an understanding of a company's ability to maintain capital expenditures, pursue acquisitions, pay down debt, or fund other corporate programs.

Watch Out! *All health care providers, but specifically hospitals and other facilities, can have high insurance costs related to product liability, workers' compensation, and health care benefit costs, and some portion of these insurance costs may be self-insured. Companies that provide self-insurance are required to estimate and accrue costs related to the above noted items. To the extent that these accruals are subject to management discretion, they may be manipulated to achieve a financial performance target.*

Labor. Health care facilities are highly labor-intensive, with salaries and benefits often consuming 40% of gross revenues (before bad debt expense) on average. It is important to analyze the trend in wages as a percentage of operating revenues. Of course, as managed care and other cost pressures vary among geographic regions, the impetus to cut staffing will vary as well.

Hospital salary and wage costs are not necessarily higher in rural areas than in large urban markets, as competition for skilled health workers in urban areas is still keen. Moreover, urban areas normally have a higher cost of living than rural markets. Even so, because the supply of nurses and qualified physicians in rural markets is very tight, companies must offer higher packages to recruit and retain these employees. Note, too, that a greater portion of revenue is generated from government sources in rural areas, where pricing and service utilization pressures are less severe.

Supplies. Due to rapidly advancing medical technology, supply costs consume an increasing proportion of hospital revenues, despite initiatives to improve supply-chain efficiency. Thus, the trend in supply costs (as a percentage of operating revenues) is a significant measure for analysts to track.

High-cost supplies – such as external defibrillators, magnetic resonance and computed tomography imaging machines, and high-resolution ultrasound equipment – have significantly boosted costs, placing a great deal of pressure on hospital operating budgets. The recent introduction of drug-coated stents and advances in orthopedics have added to the list of lifesaving but costly medical technology.

SG&A expenses. The remaining expense items on an income statement relate to selling, general, and administrative (SG&A) spending. SG&A expenses include expenses for functions such as marketing, billings, collections, database maintenance, customer service, malpractice, and other insurance costs.

EPS. It's useful to know whether a company has a strong track record of meeting its earnings per share (EPS) targets and whether the rate of revenue growth is in line with earnings growth. Comparing these growth rates can reveal whether an MCO is sacrificing profits to expand membership.

Watch Out! *Many companies in the Health Care Providers & Services industry are fixed asset intensive, making depreciation a significant expense for most of these companies. Since depreciation is based on estimates of asset lives, management can manipulate these estimates to manage earnings. Specifically, extending the depreciable life of an asset will boost a company's earnings while shortening depreciable lives will decrease earnings.*

Watch Out! *Companies record special charges for unusual or infrequent items, e.g., restructuring charges. Such charges are often excluded from non-GAAP earnings, and therefore provide dishonest management with the ability to enhance analysts' perception of a company's profitability through aggressive use of these special charges. Significant and/or recurring use of special charges is a red flag that a company may be using special charges to flatter non-GAAP results.*

The Impact of Acquisitions

It is important to know whether sales and earnings growth is acquisition-driven or internally (organically) driven. Internal growth shows that a company can effectively manage and innovate within its existing geographic territory and facilities. If growth is acquisition-driven, it is important to examine relevant statistics on a "same-store" basis. Growth generated via acquisitions often masks underlying performance trends in revenue growth and margins.

Watch Out! *A company can manipulate earnings by using the adjustment to fair market value of a target company's assets and liabilities in an acquisition to understate assets and overstate liabilities, thereby allocating a greater portion of the purchase price to goodwill.*

Behind the Balance Sheet

Balance Sheet Integrity

While the income statement shows financials over periods of time, the balance sheet is a snapshot of a company's financial position at a specific moment. This picture can be useful in determining the stability and soundness of a firm.

Debt-to-capitalization ratio. This is the ratio of a company's total debt to its total capitalization, which is commonly equal to the sum of interest-bearing debt and shareholder's equity. Debt can typically be found on the balance sheet as short-term debt, under current liabilities, and as long-term debt, under non-current liabilities. Many analysts tend to use the ratio of long-term debt-to-total capital. Companies with a lower debt-to-capitalization ratio typically have more financial flexibility as they can usually borrow at lower rates and they are usually less burdened by existing interest and principal payments.

Watch Out! *Some companies engage in supplier financing arrangements (aka reverse factoring). There are several variations of these programs, but basically, a company arranges for a financial institution to pay its suppliers and the company repays the financial institution later. This effectively lengthens the supplier payment terms and thus improves working capital which can result in overstated cashflows and understated leverage ratios.*

GLOSSARY

Acute care—Hospital care focused on patients whose physical or mental condition requires immediate intervention and constant medical attention, equipment, and personnel.

Benefit design—The complex process of determining levels of coverage and types of services to be included in a health plan, at specified rates of reimbursement.

Capitation—A compensation method under which a health maintenance organization (HMO) pays doctors and other health care facilities a fixed monthly fee for performing a range of services for each HMO member under their care, regardless of the actual level of service usage.

Co-payment—A nominal, flat fee that a plan member pays when he or she receives services or drugs. Co-payments are generally aimed at covering administrative costs.

Cost sharing—A method of reimbursement that holds a patient partially responsible for the payment of medical services or therapies. Cost sharing is used as a cost containment strategy as it restrains consumer demand for certain medical care.

Diagnosis-related groups (DRGs)—Under Medicare guidelines, DRGs comprise 495 different classes of illnesses, each with a separate reimbursement schedule. Established in 1983 by amendments to the Social Security Act, the DRG system is used by the Centers for Medicare & Medicaid Services (CMS) to standardize payments for Medicare patients and is intended to spur providers to manage patient care more efficiently.

Fee-for-service (FFS)—A traditional method of payment for healthcare services where a given payment is made for specific services rendered, in contrast to capitation, DRG, or per diem discounted rates. Expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones.

Gross patient revenue—Revenues from services rendered to patients, including those received from or on behalf of individual patients.

Health maintenance organization (HMO)—A health plan that both pays for and provides (or arranges to provide) access to a comprehensive range of medical services. To belong to an HMO, members pay a fixed monthly premium that does not vary based on the level of service utilization.

Individual mandate/individual health insurance mandate—A legal requirement that citizens in a particular jurisdiction (state, country, etc.) purchase health insurance coverage; those who do not do so would face fines, penalties, or other legal ramifications.

Managed care organization (MCO)—A system of provider networks implementing a method of delivering and paying for health care. Managed care plans include HMOs, preferred provider organizations (PPOs), point-of-service (POS) plans, and similar coordinated plan networks.

Medicaid—A health benefit program for low-income U.S. residents who are aged, blind, disabled, or members of families with dependent children. The program also pays nursing home costs for indigent elderly patients. Although state and federal governments jointly fund Medicaid, each state sets eligibility standards.

Medicare—A federally funded U.S. national health insurance program for people aged 65 and older, as well as for all disabled persons.

Net patient revenue—Gross patient revenue, less deductions for contractual adjustments, bad debts, charity, and so forth.

Net total revenue—Net patient revenue plus all other revenue, including contributions, endowment revenue, government grants, and all other payments not made on behalf of individual patients.

Outpatient visits—Visits by patients who are not lodged in a hospital while receiving medical, dental, or other services. Each appearance to a hospital unit counts as one outpatient visit. A visit consists of one or more “occasions of service”; each test, examination, or procedure rendered to an outpatient counts as one occasion of service.

Participating provider—Any provider that is licensed to operate in a given state and has entered into a contract with an insurer. Usually refers to providers who are a part of a network.

Per diem rates—A form of payment for services in which the provider receives a daily fee without regard to actual charges incurred. Such rates are usually flat and all-inclusive, but they may vary by level of care, such as medical, surgical, intensive care, skilled care, psychiatric, and so on.

Point-of-service (POS)—A managed care plan in which members may receive services from facilities both inside and outside the plan's network. When members seek treatment outside the network, they are more likely to have to pay for some of the treatment out-of-pocket.

Preferred provider organization (PPO)—A health care organization that pays almost completely for services obtained from its network of preferred facilities but pays only partially for services obtained from out-of-network facilities.

Primary care—Routine health care provided in a doctor's office or health center. Such care focuses on prevention or early detection of health problems through regular physicals tests, mammograms, and other basic procedures.

Prospective payment system (PPS)—A payment method under Medicare that establishes rates, prices, or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference between established revenues and actual costs. PPS is used to pay hospitals for inpatient hospital services based on the DRG classification system and for acute care, and it is adjusted for differences in area wages, teaching activity, care to the poor, and other factors. Also covers extra costs associated with atypical patients (outliers) in each DRG.

Provider—A healthcare facility or practitioner.

Rehabilitation outpatient services—Outpatient programs providing health-related therapy and social and/or vocational services to help disabled persons attain their maximum functional capacity.

Skilled nursing facility (SNF)—A facility that provides residents with routine long-term care, including daily dietary, social, and recreational services and a full range of pharmaceutical services and medical supplies. As defined by Medicare, SNF is a licensed institution that provides full-time nursing care and is usually exempt from DRG or PPS payment restrictions. Often located within hospitals, SNFs are sometimes sited in rehab facilities or nursing homes.

Stark Law—The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

INDUSTRY REFERENCES

PERIODICALS

360Dx
360dx.com
An independent online news organization based in New York serving the global community of scientists, technology professionals, and executives since 1997.

The Wall Street Journal
wsj.com
An American business-focused, English-language international daily newspaper based in New York City.

RESEARCH AND CONSULTING FIRMS

Action Economics
actioneconomics.com
A research firm that provides in-depth analysis of economic data and projections.

Center on Budget and Policy Priorities
cbpp.org
A nonpartisan research and policy institute that pursues federal and state policies designed both to reduce poverty and inequality and to restore fiscal responsibility in equitable and effective ways.

Employee Benefit Research Institute
ebri.org
A nonprofit, nonpartisan organization devoted to developing sound employee benefits programs and enhancing public policies through objective research.

IQVIA
iqvia.com
A consulting firm that specializes in health care analysis, services, and solutions.

National Institute for Health Care Management
nihcm.org
A nonprofit, nonpartisan group that conducts research on health care issues.

TRADE ASSOCIATIONS

Academy of Managed Care Pharmacy
amcp.org
A nonprofit professional organization representing managed care pharmacies and pharmacists, which provides information on managed care pharmacy benefit trends and contracting arrangements with pharmaceutical companies.

America's Health Insurance Plans
ahip.org
A trade association representing more than 300 member companies that provide health insurance coverage to more than 200 million Americans.

American Hospital Association
aha.org
Represents hospitals and individuals working in the health care field; an industry advocate, active in the development of national health care policy and in legislative and regulatory debates.

American Medical Association
ama-assn.org
Develops and promotes standards in medical practice, research, and education, and advocates on behalf of patients and physicians.

Association of American Medical Colleges
aamc.org
A nonprofit organization dedicated to transforming health through medical education, health care, medical research, and community collaborations.

GOVERNMENT AGENCIES

Centers for Medicare & Medicaid Services
cms.gov
A division of the U.S. Department of Health & Human Services that oversees the administration of the Medicare and Medicaid programs and sets compensation rates for participating providers. It publishes Health Care Financing Review, an annual summary and analysis of Medicare and Medicaid programs and the national health care system. It also publishes Medicare and Medicaid Statistical Supplement, which contains statistics on hospital utilization rates, number of uninsured people, service categories, HMO enrollment, etc.

Congressional Budget Office
cbo.gov
A nonpartisan federal agency that produces independent analyses of budgetary and economic issues to support the Congressional budget process.

Federal Reserve Economic Data
fred.stlouisfed.org/
A database maintained by the Research division of the Federal Reserve Bank of St. Louis that has more than 500,000 economic time series from 87 sources.

U.S. Bureau of Economic Analysis
bea.gov
An agency that provides U.S. macroeconomic data and industry statistics.

U.S. Census Bureau
census.gov
An agency that provides data about developments in the U.S. population and economy.

U.S. Department of Health & Human Services
hhs.gov
A Cabinet-level federal agency that is the U.S. government's principal overseer of health-related issues. Among other things, the department funds medical research, works to control infectious diseases, provides immunization services, ensures food and drug safety, and administers Medicare and Medicaid.

ONLINE RESOURCES

Kaiser Family Foundation
kff.org
A nonprofit foundation dedicated to studying and reporting on the U.S. health care system; publishes reports on government programs, medical spending trends, and various policy initiatives.

Morgan Lewis
morganlewis.com
A multinational law firm that provides high-quality litigation, corporate, labor and employment, and intellectual property services to clients across industry sectors and regions around the world.

Tenet Healthcare
tenethealth.com
A multinational investor-owned health care services company based in Dallas, Texas, United States.

COMPARATIVE COMPANY ANALYSIS

				Operating Revenues															
				Million $							CAGR (%)			Index Basis (2012=100)					
Ticker	Company		Yr. End	2022	2021	2020	2019	2018	2017	2016	10-Yr.	5-Yr.	1-Yr.	2022	2021	2020	2019	2018	2017
HEALTH CARE SERVICES																			
ADUS	§ ADDUS HOMECARE CORPORATION		DEC	951.1	864.5	764.8	648.8	516.6	416.5	393.6	14.6	18.0	10.0	242	220	194	165	131	106
AMED	† AMEDISYS, INC.		DEC	2,223.2	2,214.1	2,071.5	1,955.6	1,662.6	1,511.3	1,419.3	4.6	8.0	0.4	157	156	146	138	117	106
AMN	§ AMN HEALTHCARE SERVICES, INC.		DEC	5,243.2	3,984.2	2,393.7	2,222.1	2,136.1	1,988.5	1,902.2	18.6	21.4	31.6	276	209	126	117	112	105
CHE	† CHEMED CORPORATION		DEC	2,135.0	2,139.3	2,079.6	1,938.6	1,782.6	1,666.7	1,576.9	4.1	5.1	-0.2	135	136	132	123	113	106
CI	[] THE CIGNA GROUP		DEC	180,021.0	174,274.0	160,550.0	153,743.0	48,569.0	42,043.0	40,007.0	20.0	33.8	3.3	450	436	401	384	121	105
CRVL	§ CORVEL CORPORATION	#	MAR	0.0	646.2	552.6	592.2	595.7	558.4	518.7	4.6	4.5	16.9	0	125	107	114	115	108
CCRN	§ CROSS COUNTRY HEALTHCARE, INC.		DEC	2,806.6	1,676.7	836.4	822.2	816.5	865.0	833.5	20.3	26.5	67.4	337	201	100	99	98	104
CVS	[] CVS HEALTH CORPORATION		DEC	321,629.0	290,912.0	267,908.0	255,765.0	193,919.0	184,765.0	177,526.0	10.1	11.7	10.6	181	164	151	144	109	104
DVA	[] DAVITA INC.		DEC	11,609.9	11,618.8	11,550.6	11,388.5	11,412.2	10,883.7	10,695.8	3.6	1.3	-0.1	109	109	108	106	107	102
LH	[] LABORATORY CORPORATION OF AMERICA HOLDINGS		DEC	14,876.8	16,120.9	13,978.5	11,554.8	11,333.4	10,308.0	9,552.9	10.1	7.6	-7.7	156	169	146	121	119	108
MD	§ PEDIATRIX MEDICAL GROUP, INC.		DEC	1,972.0	1,911.2	1,734.0	1,779.8	1,723.1	3,253.4	3,183.2	0.8	-9.5	3.2	62	60	54	56	54	102
DGX	[] QUEST DIAGNOSTICS INCORPORATED		DEC	9,883.0	10,788.0	9,437.0	7,726.0	7,531.0	7,402.0	7,214.0	3.0	6.0	-8.4	137	150	131	107	104	103
RDNT	§ RADNET, INC.		DEC	1,430.1	1,324.2	1,098.1	1,154.2	975.1	922.2	884.5	8.3	9.2	8.0	162	150	124	130	110	104
HEALTH CARE FACILITIES																			
ACHC	† ACADIA HEALTHCARE COMPANY, INC.		DEC	2,610.4	2,314.4	2,089.9	2,008.4	1,904.7	2,836.3	2,810.9	20.4	-1.6	12.8	93	82	74	71	68	101
CYH	§ COMMUNITY HEALTH SYSTEMS, INC.		DEC	12,211.0	12,368.0	11,789.0	13,210.0	14,155.0	15,353.0	18,438.0	-0.5	-4.5	-1.3	66	67	64	72	77	83
EHC	† ENCOMPASS HEALTH CORPORATION		DEC	4,348.6	4,014.9	3,566.3	4,605.0	4,277.3	3,913.9	3,642.6	7.4	2.1	8.3	119	110	98	126	117	107
HCA	[] HCA HEALTHCARE, INC.		DEC	60,233.0	58,752.0	51,533.0	51,336.0	46,677.0	43,614.0	41,490.0	6.2	6.7	2.5	145	142	124	124	113	105
SEM	§ SELECT MEDICAL HOLDINGS CORPORATION		DEC	6,333.5	6,204.5	5,531.7	5,453.9	5,081.3	4,365.2	4,217.5	8.1	7.7	2.1	150	147	131	129	120	104
THC	† TENET HEALTHCARE CORPORATION		DEC	19,390.0	19,703.0	17,809.0	18,479.0	18,313.0	19,179.0	19,621.0	7.8	0.2	-1.6	99	100	91	94	93	98
ENSG	§ THE ENSIGN GROUP, INC.		DEC	3,025.5	2,627.5	2,402.6	2,036.5	1,754.6	1,598.3	1,654.9	13.9	13.6	15.1	183	159	145	123	106	97
PNTG	§ THE PENNANT GROUP, INC.		DEC	473.2	439.7	391.0	338.5	286.1	251.0	217.2	NA	13.5	7.6	218	202	180	156	132	116
USPH	§ U.S. PHYSICAL THERAPY, INC.		DEC	547.6	489.7	418.3	477.1	449.3	410.4	352.5	8.4	5.9	11.8	155	139	119	135	127	116
UHS	[] UNIVERSAL HEALTH SERVICES, INC.		DEC	13,399.4	12,642.1	11,558.9	11,378.3	10,772.3	10,409.9	9,766.2	6.8	5.2	6.0	137	129	118	117	110	107

Note: Data as originally reported. CAGR-Compound annual growth rate.
[]Company included in the S&P 500. †Company included in the S&P MidCap 400. §Company included in the S&P SmallCap 600. #Of the following calendar year.
Souce: S&P Capital IQ.

Net Income

Ticker		Company		Yr. End	Million $ 2022	2021	2020	2019	2018	2017	2016	CAGR (%) 10-Yr.	5-Yr.	1-Yr.	Index Basis (2012=100) 2022	2021	2020	2019	2018	2017
HEALTH CARE SERVICES																				
ADUS	§	ADDUS HOMECARE CORPORATION		DEC	46.0	45.1	33.1	25.2	16.4	12.0	12.2	19.7	30.9	2.0	378	371	272	208	135	98
AMED	†	AMEDISYS, INC.		DEC	118.6	209.1	183.6	126.8	119.3	30.3	37.3	NA	31.4	-43.3	318	561	493	340	320	81
AMN	§	AMN HEALTHCARE SERVICES, INC.		DEC	444.1	327.4	70.7	114.0	141.7	132.6	105.8	38.5	27.4	35.6	420	309	67	108	134	125
CHE	†	CHEMED CORPORATION		DEC	249.6	268.6	319.5	219.9	205.5	98.2	108.7	10.8	20.5	-7.0	230	247	294	202	189	90
CI	[]	THE CIGNA GROUP		DEC	6,668.0	5,365.0	8,458.0	5,104.0	2,637.0	2,237.0	1,867.0	15.2	24.4	24.3	357	287	453	273	141	120
CRVL	§	CORVEL CORPORATION	#	MAR	0.0	66.4	46.4	47.4	46.7	35.7	29.5	9.6	17.6	43.3	0	225	157	161	158	121
CCRN	§	CROSS COUNTRY HEALTHCARE, INC.		DEC	188.5	132.0	-13.0	-57.7	-17.0	37.5	8.0	NA	38.1	42.8	2366	1657	-163	-724	-213	471
CVS	[]	CVS HEALTH CORPORATION		DEC	4,149.0	7,910.0	7,179.0	6,634.0	-594.0	6,622.0	5,317.0	0.7	-8.9	-47.5	78	149	135	125	-11	125
DVA	[]	DAVITA INC.		DEC	560.4	978.5	773.6	811.0	159.4	663.6	879.9	0.4	-3.3	-42.7	64	111	88	92	18	75
LH	[]	LABORATORY CORPORATION OF AMERICA HOLDINGS		DEC	1,279.1	2,377.3	1,556.1	823.8	883.7	1,227.1	711.8	8.2	0.8	-46.2	180	334	219	116	124	172
MD	§	PEDIATRIX MEDICAL GROUP, INC.		DEC	66.3	131.0	-796.5	-1,497.7	268.6	320.4	324.9	-12.1	-27.0	-49.3	20	40	-245	-461	83	99
DGX	[]	QUEST DIAGNOSTICS INCORPORATED		DEC	946.0	1,995.0	1,431.0	858.0	736.0	772.0	645.0	5.5	4.1	-52.6	147	309	222	133	114	120
RDNT	§	RADNET, INC.		DEC	10.7	24.7	-14.8	14.8	32.2	0.1	7.2	-15.9	188.8	-56.9	147	342	-205	204	446	1
HEALTH CARE FACILITIES																				
ACHC	†	ACADIA HEALTHCARE COMPANY, INC.		DEC	273.1	190.6	-672.1	108.9	-175.8	199.8	6.1	29.6	6.4	43.3	4446	3103	NM	1773	NM	3253
CYH	§	COMMUNITY HEALTH SYSTEMS, INC.		DEC	46.0	230.0	511.0	-675.0	-788.0	-2,459.0	-1,721.0	-16.1	NM	-80.0	-3	-13	-30	39	46	143
EHC	†	ENCOMPASS HEALTH CORPORATION		DEC	271.0	412.2	284.2	358.7	292.3	271.1	247.6	3.9	0.0	-34.3	109	166	115	145	118	109
HCA	[]	HCA HEALTHCARE, INC.		DEC	5,643.0	6,956.0	3,754.0	3,505.0	3,787.0	2,216.0	2,890.0	13.4	20.6	-18.9	195	241	130	121	131	77
SEM	§	SELECT MEDICAL HOLDINGS CORPORATION		DEC	159.0	402.2	259.0	148.4	137.8	177.2	115.4	0.7	-2.1	-60.5	138	349	224	129	119	154
THC	†	TENET HEALTHCARE CORPORATION		DEC	411.0	914.0	399.0	-215.0	104.0	-704.0	-192.0	10.5	NM	-55.0	-214	-476	-208	112	-54	367
ENSG	§	THE ENSIGN GROUP, INC.		DEC	224.7	194.7	170.5	110.5	92.4	40.5	50.0	18.7	40.9	15.4	449	389	341	221	185	81
PNTG	§	THE PENNANT GROUP, INC.		DEC	6.6	2.7	15.7	2.5	15.7	9.9	7.9	NA	-7.6	146.4	84	34	200	32	199	125
USPH	§	U.S. PHYSICAL THERAPY, INC.		DEC	32.2	40.8	35.2	40.0	34.9	22.3	20.6	6.0	7.6	-21.2	156	199	171	195	170	108
UHS	[]	UNIVERSAL HEALTH SERVICES, INC.		DEC	675.6	991.6	944.0	814.9	779.7	752.3	702.4	4.3	-2.1	-31.9	96	141	134	116	111	107

Note: Data as originally reported. CAGR-Compound annual growth rate.
[]Company included in the S&P 500. †Company included in the S&P MidCap 400. §Company included in the S&P SmallCap 600. #Of the following calendar year.
Souce: S&P Capital IQ.

Ticker		Company		Yr. End	Return on Revenues (%)						Return on Assets (%)						Return on Equity (%)					
					2022	2021	2020	2019	2018	2017	2022	2021	2020	2019	2018	2017	2022	2021	2020	2019	2018	2017
HEALTH CARE SERVICES																						
ADUS	§	ADDUS HOMECARE CORPORATION		DEC	4.8	5.2	4.3	3.9	3.2	2.9	4.9	4.8	3.7	4.0	4.7	4.4	4.9	8.3	6.7	6.9	7.3	7.1
AMED	†	AMEDISYS, INC.		DEC	5.3	9.4	8.9	6.5	7.2	2.0	6.0	11.3	11.7	10.0	16.6	3.7	6.0	23.5	25.5	22.8	24.0	6.3
AMN	§	AMN HEALTHCARE SERVICES, INC.		DEC	8.5	8.2	3.0	5.1	6.6	6.7	15.4	10.5	3.0	5.9	9.5	10.6	15.4	33.0	9.1	16.6	23.6	26.2
CHE	†	CHEMED CORPORATION		DEC	11.7	12.6	15.4	11.3	11.5	5.9	17.3	20.0	22.3	17.3	21.1	10.7	17.3	35.2	39.3	33.4	36.3	18.4
CI	[]	THE CIGNA GROUP		DEC	3.7	3.1	5.3	3.3	5.4	5.3	4.6	3.5	5.4	3.3	1.7	3.6	4.6	11.1	17.7	11.8	9.7	16.2
CRVL	§	CORVEL CORPORATION	#	MAR	0.0	10.3	8.4	8.0	7.8	6.4	NA	16.0	10.9	11.4	14.7	13.0	NA	30.7	22.6	24.6	25.5	23.0
CCRN	§	CROSS COUNTRY HEALTHCARE, INC.		DEC	6.7	7.9	NM	NM	NM	4.3	19.9	18.0	NM	NM	NM	8.0	19.9	58.4	NM	NM	NM	19.9
CVS	[]	CVS HEALTH CORPORATION		DEC	1.3	2.7	2.7	2.6	NM	3.6	1.8	3.4	3.1	3.0	NM	7.0	1.8	10.9	10.8	10.8	NM	17.8
DVA	[]	DAVITA INC.		DEC	4.8	8.4	6.7	7.1	1.4	6.1	3.3	5.7	4.6	4.7	0.8	3.5	3.3	46.0	31.4	21.5	14.5	18.4
LH	[]	LABORATORY CORPORATION OF AMERICA HOLDINGS		DEC	8.6	14.7	11.1	7.1	7.8	11.9	6.3	11.7	7.8	4.6	5.5	7.4	6.3	24.1	18.3	11.3	12.8	20.0
MD	§	PEDIATRIX MEDICAL GROUP, INC.		DEC	3.4	6.9	NM	NM	15.6	9.8	2.8	4.8	NM	NM	4.5	5.5	2.8	13.1	NM	1.8	3.9	10.5
DGX	[]	QUEST DIAGNOSTICS INCORPORATED		DEC	9.6	18.5	15.2	11.1	9.8	10.4	7.4	14.7	10.2	6.7	6.7	7.4	7.4	30.9	23.7	16.0	15.2	16.9
RDNT	§	RADNET, INC.		DEC	0.7	1.9	NM	1.3	3.3	0.0	0.4	1.2	NM	0.9	2.9	0.0	0.4	14.7	NM	10.8	28.2	3.4
HEALTH CARE FACILITIES																						
ACHC	†	ACADIA HEALTHCARE COMPANY, INC.		DEC	10.5	8.2	NM	5.4	NM	7.0	5.5	4.0	NM	1.6	NM	3.1	5.5	9.2	6.4	2.2	2.3	8.3
CYH	§	COMMUNITY HEALTH SYSTEMS, INC.		DEC	0.4	1.9	4.3	NM	NM	NM	0.3	1.5	3.2	NM	NM	NM	0.3	NM	NM	NM	NM	NM
EHC	†	ENCOMPASS HEALTH CORPORATION		DEC	6.2	10.3	8.0	7.8	6.8	6.9	4.8	6.0	4.4	5.9	5.6	5.6	4.8	18.3	14.1	23.8	21.8	26.1
HCA	[]	HCA HEALTHCARE, INC.		DEC	9.4	11.8	7.3	6.8	8.1	5.1	10.8	13.7	7.9	7.8	9.7	6.1	10.8	352.5	377.1	NM	NM	NM
SEM	§	SELECT MEDICAL HOLDINGS CORPORATION		DEC	2.5	6.5	4.7	2.7	2.7	4.1	2.1	5.5	3.4	2.0	2.3	3.5	2.1	33.2	19.4	11.2	10.8	15.2
THC	†	TENET HEALTHCARE CORPORATION		DEC	2.1	4.6	2.2	NM	0.6	NM	1.5	3.3	1.5	NM	0.5	NM	1.5	41.3	31.8	7.9	20.2	NM
ENSG	§	THE ENSIGN GROUP, INC.		DEC	7.4	7.4	7.1	5.4	5.3	2.5	6.5	6.8	6.7	4.7	7.8	3.7	6.5	21.5	23.2	14.7	10.7	3.5
PNTG	§	THE PENNANT GROUP, INC.		DEC	1.4	0.6	4.0	0.8	5.5	3.9	1.3	0.5	3.1	0.6	16.0	11.2	1.3	2.0	18.1	4.7	26.0	0.0
USPH	§	U.S. PHYSICAL THERAPY, INC.		DEC	5.9	8.3	8.4	8.4	7.8	5.4	3.7	5.4	5.9	7.1	7.9	5.3	3.7	13.4	13.3	15.7	14.8	9.8
UHS	[]	UNIVERSAL HEALTH SERVICES, INC.		DEC	5.0	7.8	8.2	7.2	7.2	7.2	5.0	7.6	7.0	7.0	6.9	7.0	5.0	15.7	15.9	15.0	15.2	16.0

Note: Data as originally reported. CAGR-Compound annual growth rate.
[]Company included in the S&P 500. †Company included in the S&P MidCap 400. §Company included in the S&P SmallCap 600. #Of the following calendar year.
Souce: S&P Capital IQ.

Ticker	Company		Yr. End	Current Ratio						Debt/Capital Ratio (%)						Debt as a % of Net Working Capital					
				2022	2021	2020	2019	2018	2017	2022	2021	2020	2019	2018	2017	2022	2021	2020	2019	2018	2017
HEALTH CARE SERVICES																					
ADUS	§ ADDUS HOMECARE CORPORATION		DEC	1.7	2.8	2.0	3.1	2.9	2.8	17.2	27.8	27.2	11.1	6.0	18.1	143.8	106.9	134.8	32.5	15.0	38.6
AMED	† AMEDISYS, INC.		DEC	1.1	1.0	0.8	1.1	1.0	1.4	27.4	30.6	20.1	26.4	1.2	13.2	1,251.3	NM	NM	976.5	351.7	81.4
AMN	§ AMN HEALTHCARE SERVICES, INC.		DEC	1.3	1.4	1.3	1.5	1.6	1.8	44.7	42.0	51.1	45.6	40.8	36.2	357.9	221.9	774.5	338.4	251.9	153.1
CHE	† CHEMED CORPORATION		DEC	0.9	0.8	1.1	0.7	0.8	0.9	10.4	22.9	0.0	11.0	13.1	14.4	NM	NM	0.0	NM	NM	NM
CI	[] THE CIGNA GROUP		DEC	0.7	0.8	0.8	0.7	0.6	0.8	38.4	42.9	41.1	42.9	51.3	27.9	NM	NM	NM	NM	NM	NM
CRVL	§ CORVEL CORPORATION	#	MAR	0.0	1.5	1.7	1.6	1.8	1.7	NA	0.0	0.0	0.0	0.0	0.0	NA	0.0	0.0	0.0	0.0	0.0
CCRN	§ CROSS COUNTRY HEALTHCARE, INC.		DEC	2.5	2.5	2.0	2.1	2.3	2.2	24.5	37.2	26.5	30.3	26.3	28.0	36.8	57.2	62.3	72.5	71.2	80.7
CVS	[] CVS HEALTH CORPORATION		DEC	0.9	0.9	0.9	0.9	1.0	1.0	40.8	40.2	45.5	49.9	55.3	38.5	NM	NM	NM	NM	5,795.9	3,922.0
DVA	[] DAVITA INC.		DEC	1.2	1.3	1.3	1.6	1.7	2.9	79.2	78.6	72.5	68.8	61.1	60.8	1,579.0	1,134.8	1,136.4	584.9	223.3	160.6
LH	[] LABORATORY CORPORATION OF AMERICA HOLDINGS		DEC	1.5	1.9	1.7	1.1	1.5	1.3	33.6	34.5	36.4	43.3	46.1	47.9	331.0	212.6	264.7	1,779.3	626.3	1,147.0
MD	§ PEDIATRIX MEDICAL GROUP, INC.		DEC	1.0	2.0	3.5	1.4	1.3	1.2	41.3	52.5	69.9	53.6	39.0	37.6	62,390.8	239.7	156.9	912.1	1,255.7	1,931.9
DGX	[] QUEST DIAGNOSTICS INCORPORATED		DEC	1.2	1.6	1.7	1.3	0.9	1.2	40.7	38.8	38.1	41.7	40.8	44.0	1,170.9	414.4	323.0	810.4	NM	1,569.5
RDNT	§ RADNET, INC.		DEC	0.8	0.9	0.7	0.7	0.9	1.2	63.1	68.2	70.4	73.7	75.8	89.1	NM	NM	NM	NM	NM	1,308.4
HEALTH CARE FACILITIES																					
ACHC	† ACADIA HEALTHCARE COMPANY, INC.		DEC	1.3	1.2	1.9	1.2	1.1	1.2	32.0	36.4	60.3	55.0	57.2	55.3	1,158.4	1,639.8	244.3	3,949.2	9,281.4	3,403.8
CYH	§ COMMUNITY HEALTH SYSTEMS, INC.		DEC	1.4	1.5	1.6	1.5	1.5	1.7	106.9	107.3	109.6	114.1	107.8	101.2	1,271.7	1,065.1	709.1	1,159.7	1,138.8	811.8
EHC	† ENCOMPASS HEALTH CORPORATION		DEC	1.2	1.2	1.3	1.0	1.0	1.4	56.0	54.3	58.8	57.7	54.0	58.5	1,679.8	1,652.0	1,234.2	7,563.8	NM	1,231.1
HCA	[] HCA HEALTHCARE, INC.		DEC	1.4	1.4	1.4	1.4	1.3	1.6	100.2	95.8	91.3	101.7	110.0	117.9	992.6	852.7	836.2	962.9	1,213.9	860.4
SEM	§ SELECT MEDICAL HOLDINGS CORPORATION		DEC	1.1	0.9	1.1	1.3	1.4	1.5	73.9	73.0	67.2	64.2	66.2	63.7	3,315.8	NM	2,170.0	1,140.5	1,139.6	858.3
THC	† TENET HEALTHCARE CORPORATION		DEC	1.3	1.4	1.5	1.2	1.2	1.3	76.2	78.3	84.2	88.1	87.2	85.7	981.3	780.0	670.6	1,643.6	1,843.3	1,157.1
ENSG	§ THE ENSIGN GROUP, INC.		DEC	1.3	1.2	1.0	1.2	1.3	1.6	10.7	13.0	12.1	33.1	27.9	37.7	75.0	131.1	547.5	478.9	295.7	213.0
PNTG	§ THE PENNANT GROUP, INC.		DEC	1.1	1.1	0.7	0.8	1.0	1.0	33.4	31.0	7.6	20.7	0.0	0.0	1,759.2	1,221.4	-28.1	NM	0.0	0.0
USPH	§ U.S. PHYSICAL THERAPY, INC.		DEC	1.3	1.1	0.9	1.4	1.9	1.9	26.6	20.6	7.2	11.7	9.9	15.5	682.1	1,006.3	NM	202.9	103.0	151.2
UHS	[] UNIVERSAL HEALTH SERVICES, INC.		DEC	1.3	1.1	1.3	1.2	1.3	1.0	43.8	39.6	35.2	41.0	41.7	40.9	747.1	1,454.8	433.7	1,100.6	801.0	NM

Note: Data as originally reported. CAGR-Compound annual growth rate.
[]Company included in the S&P 500. †Company included in the S&P MidCap 400. §Company included in the S&P SmallCap 600. #Of the following calendar year.
Souce: S&P Capital IQ.

Ticker	Company		Yr. End	Price/Earnings Ratio (High-Low) 2022	2021	2020	2019	2018	2017	Dividend Payout Ratio (%) 2022	2021	2020	2019	2018	2017	Dividend Yield (High-Low, %) 2022	2021	2020	2019	2018	2017
HEALTH CARE SERVICES																					
ADUS	§ ADDUS HOMECARE CORPORATION		DEC	39 - 24	45 - 26	54 - 23	52 - 32	56 - 25	39 - 29	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
AMED	† AMEDISYS, INC.		DEC	49 - 22	49 - 21	52 - 24	42 - 27	39 - 14	73 - 47	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
AMN	§ AMN HEALTHCARE SERVICES, INC.		DEC	13 - 9	18 - 10	55 - 25	27 - 19	23 - 16	18 - 13	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
CHE	† CHEMED CORPORATION		DEC	32 - 26	32 - 24	27 - 18	32 - 19	26 - 19	40 - 26	8.8	8.2	6.6	9.0	9.1	17.7	0.3 - 0.3	0.4 - 0.3	0.4 - 0.2	0.4 - 0.3	0.5 - 0.3	0.5 - 0.3
CI	[] THE CIGNA GROUP		DEC	16 - 10	17 - 12	10 - 6	15 - 11	21 - 15	24 - 15	20.8	25.0	0.2	0.3	0.0	0.0	2.0 - 1.3	2.1 - 1.4	2.1 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
CRVL	§ CORVEL CORPORATION	#	MAR	56 - 27	43 - 18	37 - 20	28 - 19	32 - 22	34 - 21	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
CCRN	§ CROSS COUNTRY HEALTHCARE, INC.		DEC	7 - 3	8 - 2	NM - NM	NM - NM	NM - NM	15 - 11	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
CVS	[] CVS HEALTH CORPORATION		DEC	35 - 28	17 - 11	14 - 10	15 - 10	NM - NM	13 - 10	70.1	33.2	36.6	39.2	NM	30.9	3.5 - 2.1	2.5 - 2.0	3.0 - 2.1	3.8 - 2.6	3.8 - 2.5	3.3 - 2.4
DVA	[] DAVITA INC.		DEC	20 - 11	14 - 10	18 - 10	14 - 8	86 - 52	21 - 15	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
LH	[] LABORATORY CORPORATION OF AMERICA HOLDINGS		DEC	22 - 15	13 - 8	13 - 7	21 - 15	22 - 14	14 - 11	15.3	0.0	0.0	0.0	0.0	0.0	1.4 - 1.1	1.4 - 1.1	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
MD	§ PEDIATRIX MEDICAL GROUP, INC.		DEC	35 - 18	23 - 13	NM - NM	NM - NM	20 - 11	21 - 12	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
DGX	[] QUEST DIAGNOSTICS INCORPORATED		DEC	21 - 15	11 - 7	12 - 7	17 - 13	21 - 15	20 - 16	32.2	15.5	20.8	33.3	36.1	32.0	2.2 - 1.7	2.2 - 1.4	2.2 - 1.6	3.1 - 1.7	2.7 - 2.0	2.4 - 1.7
RDNT	§ RADNET, INC.		DEC	163 - 80	81 - 38	NM - NM	68 - 34	24 - 15	10487 - 4735	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
HEALTH CARE FACILITIES																					
ACHC	† ACADIA HEALTHCARE COMPANY, INC.		DEC	29 - 17	32 - 23	NM - NM	28 - 20	NM - NM	23 - 12	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
CYH	§ COMMUNITY HEALTH SYSTEMS, INC.		DEC	40 - 6	9 - 4	2 - 1	NM - NM	NM - NM	NM - NM	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
EHC	† ENCOMPASS HEALTH CORPORATION		DEC	27 - 17	21 - 14	30 - 17	20 - 16	28 - 17	17 - 13	36.5	27.2	39.3	30.3	34.5	33.8	1.2 - 0.9	2.4 - 1.0	2.0 - 1.3	2.2 - 1.4	1.9 - 1.4	2.0 - 1.3
HCA	[] HCA HEALTHCARE, INC.		DEC	14 - 9	12 - 7	15 - 6	15 - 11	13 - 8	15 - 12	11.6	9.0	4.1	15.7	12.9	0.0	1.0 - 0.8	1.3 - 0.7	1.2 - 0.0	2.5 - 0.0	1.4 - 1.0	1.5 - 1.0
SEM	§ SELECT MEDICAL HOLDINGS CORPORATION		DEC	25 - 17	14 - 9	15 - 6	21 - 12	21 - 15	15 - 9	40.6	12.6	0.0	0.0	0.0	0.0	2.1 - 1.6	2.3 - 1.7	1.9 - 1.2	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
THC	† TENET HEALTHCARE CORPORATION		DEC	24 - 10	9 - 5	11 - 3	NM - NM	38 - 15	NM - NM	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
ENSG	§ THE ENSIGN GROUP, INC.		DEC	24 - 17	27 - 19	24 - 8	29 - 18	27 - 12	31 - 22	5.4	5.9	6.4	9.2	10.2	21.5	0.3 - 0.2	0.3 - 0.2	0.3 - 0.2	0.8 - 0.3	0.5 - 0.3	0.8 - 0.4
PNTG	§ THE PENNANT GROUP, INC.		DEC	104 - 40	700 - 200	112 - 18	382 - 165	NA - NA	NA - NA	0.0	0.0	0.0	0.0	0.0	0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0	0.0 - 0.0
USPH	§ U.S. PHYSICAL THERAPY, INC.		DEC	58 - 33	59 - 35	54 - 19	60 - 41	98 - 54	44 - 32	66.3	46.0	11.7	36.4	33.4	45.2	2.1 - 1.5	2.2 - 1.3	1.8 - 0.0	2.7 - 0.0	1.1 - 0.8	1.1 - 0.7
UHS	[] UNIVERSAL HEALTH SERVICES, INC.		DEC	17 - 10	13 - 10	13 - 6	17 - 13	17 - 13	16 - 12	8.7	6.6	1.8	6.5	4.8	5.1	0.7 - 0.5	0.9 - 0.5	0.7 - 0.0	0.6 - 0.0	0.6 - 0.3	0.4 - 0.3

Note: Data as originally reported. CAGR-Compound annual growth rate.
[]Company included in the S&P 500. †Company included in the S&P MidCap 400. §Company included in the S&P SmallCap 600. #Of the following calendar year.
Souce: S&P Capital IQ.

Ticker	Company	Yr. End	Earnings per Share ($)						Tangible Book Value per Share ($)						Share Price (High-Low, $)											
			2022	2021	2020	2019	2018	2017	2022	2021	2020	2019	2018	2017	2022		2021		2020		2019		2018		2017	
HEALTH CARE SERVICES																										
ADUS	§ ADDUS HOMECARE CORPORATION		DEC	2.8	2.8	2.1	1.8	1.3	1.0	-1.3	0.4	-1.4	9.3	8.4	6.0	112.9	- 68.6	129.0	- 73.1	118.0	- 43.1	97.7	- 57.9	77.8	- 33.3	40.8	- 29.9
AMED	† AMEDISYS, INC.		DEC	3.6	6.3	5.5	3.8	3.6	0.9	-10.4	-11.6	-6.0	-2.6	3.4	4.4	179.9	- 79.5	325.1	- 133.6	298.5	- 132.9	168.1	- 106.7	140.9	- 49.8	65.9	- 42.1
AMN	§ AMN HEALTHCARE SERVICES, INC.		DEC	9.9	6.8	1.5	2.4	2.9	2.7	-8.8	-5.2	-13.0	-5.5	-2.7	-0.1	129.0	- 82.8	129.1	- 67.4	89.2	- 36.7	65.8	- 45.0	68.2	- 47.1	51.8	- 33.6
CHE	† CHEMED CORPORATION		DEC	16.5	16.9	19.5	13.3	12.2	5.9	7.3	-4.9	9.3	0.8	0.4	0.1	530.7	- 430.2	560.0	- 403.0	543.8	- 330.0	445.1	- 265.1	336.0	- 243.7	251.0	- 158.6
CI	[] THE CIGNA GROUP		DEC	21.3	15.7	23.0	13.4	10.5	8.8	-121.5	-109.3	-91.7	-96.2	-120.1	26.2	340.1	- 213.2	272.8	- 190.9	225.0	- 118.5	207.3	- 142.0	227.1	- 163.0	212.5	- 133.5
CRVL	§ CORVEL CORPORATION	#	MAR	0.0	3.7	2.6	2.6	2.5	1.9	0.0	15.7	15.4	6.8	6.9	5.5	211.1	- 129.2	213.4	- 97.4	106.9	- 44.7	94.0	- 60.5	70.7	- 46.5	61.2	- 36.0
CCRN	§ CROSS COUNTRY HEALTHCARE, INC.		DEC	5.0	3.5	-0.4	-1.6	-0.5	1.0	6.7	3.4	0.5	0.3	1.1	0.9	40.1	- 15.3	30.4	- 8.6	13.4	- 4.5	13.0	- 6.8	14.3	- 6.9	16.4	- 11.1
CVS	[] CVS HEALTH CORPORATION		DEC	3.1	6.0	5.5	5.1	-0.6	6.4	-24.5	-25.0	-31.5	-37.6	-44.0	-14.2	111.3	- 86.3	104.6	- 68.0	76.4	- 52.0	77.0	- 51.7	83.9	- 60.1	84.7	- 66.5
DVA	[] DAVITA INC.		DEC	5.9	8.9	6.3	5.3	0.9	3.5	-72.4	-66.5	-51.9	-38.1	-19.6	-11.1	124.8	- 65.3	136.5	- 94.4	117.7	- 62.2	75.3	- 43.4	80.7	- 48.3	72.9	- 52.5
LH	[] LABORATORY CORPORATION OF AMERICA HOLDINGS		DEC	14.0	24.4	15.9	8.4	8.6	11.8	-22.4	-15.3	-23.3	-44.6	-43.5	-46.7	314.0	- 200.3	317.2	- 200.7	218.8	- 98.0	178.4	- 122.3	190.4	- 119.4	165.2	- 128.0
MD	§ PEDIATRIX MEDICAL GROUP, INC.		DEC	0.8	1.5	-9.6	-17.8	2.9	3.5	-8.1	-7.4	-9.0	-0.1	-14.9	-20.0	28.0	- 14.4	35.7	- 20.3	27.9	- 7.4	38.9	- 19.9	63.0	- 31.7	72.1	- 40.6
DGX	[] QUEST DIAGNOSTICS INCORPORATED		DEC	8.0	15.6	10.5	6.3	5.3	5.5	-21.8	-15.3	-9.6	-15.8	-18.9	-18.8	172.5	- 120.4	174.2	- 113.4	131.8	- 73.0	109.0	- 79.9	116.5	- 79.0	113.0	- 90.1
RDNT	§ RADNET, INC.		DEC	0.2	0.5	-0.3	0.3	0.7	0.0	-7.8	-6.4	-7.0	-6.6	-6.8	-4.9	30.4	- 12.0	38.8	- 17.7	23.5	- 5.8	20.5	- 10.0	16.5	- 9.7	11.9	- 5.3
HEALTH CARE FACILITIES																										
ACHC	† ACADIA HEALTHCARE COMPANY, INC.		DEC	3.0	2.1	-7.6	1.2	-2.0	2.3	5.7	2.8	-3.1	4.0	-1.7	-3.1	89.9	- 50.1	68.7	- 48.6	51.0	- 11.1	35.4	- 25.1	45.4	- 24.3	54.3	- 26.9
CYH	§ COMMUNITY HEALTH SYSTEMS, INC.		DEC	0.4	1.8	4.4	-5.9	-7.0	-22.0	-44.5	-46.1	-49.2	-60.8	-57.7	-49.7	14.7	- 1.9	17.0	- 7.0	11.0	- 2.3	5.4	- 1.8	6.4	- 2.5	10.5	- 3.9
EHC	† ENCOMPASS HEALTH CORPORATION		DEC	2.7	4.1	2.8	3.6	2.9	2.8	-2.4	5.2	-11.7	-14.5	-12.8	-12.4	74.6	- 44.3	89.7	- 56.3	87.1	- 48.0	72.9	- 56.7	82.5	- 49.2	50.4	- 38.2
HCA	[] HCA HEALTHCARE, INC.		DEC	19.2	21.2	10.9	10.1	10.7	6.0	-44.8	-34.3	-23.6	-32.7	-37.6	-40.6	279.0	- 164.5	263.9	- 156.4	166.9	- 58.4	150.2	- 110.3	147.4	- 84.9	91.0	- 71.2
SEM	§ SELECT MEDICAL HOLDINGS CORPORATION		DEC	1.2	3.0	1.9	1.1	1.0	1.3	-21.3	-20.3	-20.1	-22.6	-21.8	-17.0	30.8	- 18.9	43.6	- 25.6	28.6	- 10.0	23.5	- 13.0	21.7	- 14.8	19.8	- 12.0
THC	† TENET HEALTHCARE CORPORATION		DEC	3.8	8.4	3.8	-2.1	1.0	-7.0	-101.8	-90.8	-97.9	-89.0	-89.1	-88.5	92.7	- 36.7	83.7	- 38.0	42.8	- 10.0	39.4	- 16.8	39.7	- 14.5	22.7	- 12.3
ENSG	§ THE ENSIGN GROUP, INC.		DEC	4.0	3.4	3.1	2.0	1.7	0.8	21.1	17.5	14.0	11.1	9.7	6.9	97.4	- 70.3	98.7	- 68.3	77.3	- 24.1	63.0	- 37.3	49.0	- 21.7	24.8	- 16.5
PNTG	§ THE PENNANT GROUP, INC.		DEC	0.2	0.1	0.5	0.1	0.6	0.4	-0.6	-0.6	-0.6	-0.1	0.0	0.0	24.2	- 8.7	69.6	- 17.5	66.6	- 9.4	36.0	- 6.2	0.0	- 0.0	0.0	- 0.0
USPH	§ U.S. PHYSICAL THERAPY, INC.		DEC	2.3	2.4	2.5	2.5	1.3	1.8	-22.1	-17.5	-9.8	-10.2	-10.0	-9.2	131.5	- 73.3	143.7	- 84.4	134.1	- 45.1	148.5	- 99.0	129.7	- 71.7	78.0	- 56.5
UHS	[] UNIVERSAL HEALTH SERVICES, INC.		DEC	9.1	11.8	11.0	9.1	8.3	7.8	27.4	26.5	27.6	17.9	16.7	10.0	158.3	- 82.5	165.0	- 116.2	148.3	- 65.2	157.8	- 114.9	139.6	- 108.6	129.7	- 95.3

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