Hospital Corporation of America (A)

In January 1982, Hospital Corporation of America (HCA) faced a complex financial situation. Following a major acquisition in 1981, HCA's ratio of debt to total capital was approaching 70%, well in excess of its well-established target ratio of 60%. Interest coverage had dropped below its target of 3.0 to 2.4, the lowest level experienced since HCA was founded in 1968. Although some investors justified, even welcomed, HCA's more aggressive use of leverage, others were concerned. HCA's capital structure could cost the company its A bond rating. Mounting interest expense on the debt could also result in a decline in HCA's first-quarter earnings per share relative to that for a year ago. If it did, it would be the first such quarter-to-quarter decline in earnings per share in HCA's 13-year history. In light of these developments, HCA's management had to decide what, if anything, should be done about its capital structure and what specific steps should be taken in the near future to achieve the desired mix of debt and equity.

Early Development

Hospital Corporation of America was a proprietary hospital management company. It was founded in Nashville, Tennessee, by two physicians, Thomas F. Frist, Sr., and Thomas F. Frist, Jr., and by Jack C. Massey, a former pharmacist and former owner of Kentucky Fried Chicken. Beginning with only a single 150-bed hospital in 1968, HCA grew to become the nation's largest hospital management company. By 1981, HCA owned or managed 349 hospitals in the United States and overseas and had net operating revenues of $2.1 billion. Since its founding, revenues and earnings had grown at an annual rate of 32.2% and 32.6%, respectively. Pretax profit margins, averaging 9%, were the highest and most consistent among the major proprietary hospital chains. Recent financial statements and a 10-year summary of HCA's operations are presented in Exhibits 1–4.

The Proprietary Hospital Industry

Proprietary hospital management companies—that is, corporations that own and manage chains of hospitals on a for-profit basis—were a relatively new phenomenon in the $118 billion U.S. hospital-care business. The enactment of entitlement programs such as Medicare and Medicaid in 1965 stimulated demand for hospital services and virtually eliminated the tremendous bad-debt burden (i.e., weak accounts receivable) that had traditionally plagued the hospital industry. This created a valuable opportunity for private investors to build or acquire hospitals and operate them profitably. Tight control over costs, and efficiencies in such areas as staffing, purchasing, and hospital design, enabled hospital management companies to offer high-quality services at reasonable cost while achieving attractive profit margins.

With the ability to sell equity and other financial securities not generally available to nonprofit hospitals, proprietary hospital management companies expanded rapidly in the 1970s. While the number of hospitals operating in the United States actually declined steadily between 1975 and 1980 from a high of 7,200, the proprietary hospital

chains expanded the number of hospitals under their control at a 12.5% annual rate. By 1980, 38 proprietary hospital chains owned or operated 12.4% of the 6,965 hospitals and 7.9% of the 1.37 million licensed hospital beds in the United States. The five largest hospital chains controlled 632 hospitals and 87,502 beds in 1981. A comparison of the major hospital chains is provided in Exhibit 5.

It was expected that revenue growth of the hospital management companies as a group would be approximately 13–14% annually throughout the 1980s. The five major chains, however, were expected to grow at an annual rate of 25% during the first half of the decade. Although still rapid, this expected rate of growth was less than the 35% annual rate they experienced between 1975 and 1980. Shrinkage in the number of attractive acquisitions, along with high costs for construction and acquisition, accounted for the expected slowdown.

Past Growth

HCA's growth during the 1970s was achieved both through acquisition of existing hospitals and construction of new units. Between 1968 and 1981, HCA constructed 70 new and replacement facilities and acquired or leased the rest of its hospitals. Each year HCA evaluated many potential acquisitions and areas for construction and was rather selective in the facilities it acquired. Criteria for selection included the target community's need for health care services, the quality of the target hospital's medical staff and personnel, the population growth pattern in the area served, the facility's suitability for future expansion, and the hospital's overall financial position. Most of HCA's domestic hospitals were located in the Southeast and in the rapidly expanding "sunbelt" area of the United States (see Exhibit 6). This geographic preference reflected, in part, a more favorable regulatory environment in these parts of the United States and, in part, more favorable demographic trends. Roughly 40% of HCA's U.S. facilities were the only hospitals in their areas.

Some of HCA's unit growth had been achieved through the acquisition of other proprietary hospital management companies. A run on other proprietary chains was triggered in 1978 when Humana, Inc. merged with American Medicorp, then the third-largest chain. Following that acquisition, ten other hospital management companies were acquired by the five majors by 1981. HCA accounted for four of these acquisitions. Its most recent one occurred on August 26, 1981, when it purchased Hospital Affiliates International from INA Corporation, an insurance company, for $425 million cash and common stock valued at $190 million. This acquisition provided HCA with 57 additional owned hospitals and 78 more hospitals under management contract.[1] With revenues of $704 million and earnings of $29 million in 1980, Hospital Affiliates had been the nation's fifth-largest hospital management chain.

Sources of Capital

HCA's operations generated substantial cash that could be used for reinvestment. However, its ambitious construction and acquisition program also required substantial financing from external sources.

[1]Proprietary hospital management companies frequently managed hospitals for others on a contractual-fee basis. Such management contracts did not require much in the way of capital investment, but neither did they provide as much revenue as owned and operated facilities. They were valuable, however, as a source of potential acquisition candidates and as a means for scouting potential new areas for expansion. In 1981, HCA operated hospitals under management contracts in 38 states throughout the United States.

Generally, external financing during HCA's early growth period followed a simple pattern: Revolving bank credits were used to fund hospitals under construction, while industrial revenue bonds and privately placed long-term mortgage loans from insurance companies were used to fund completed hospitals and acquisitions. Other sources of capital were difficult to tap at first because of the newness of the proprietary hospital industry, the small size and short track record of HCA itself, and the generally poor image that many investors had of hospital management companies at that time.

However, as the hospital management industry matured and HCA's strong performance became recognized, other types of financing were used beginning in the mid-1970s. In 1975, HCA issued $33 million of 15-year first-mortgage bonds, the first public bond offering undertaken by a hospital management company. Standard and Poor's initially rated the bonds BBB and later upgraded them to A.[2] In an effort to tap sources of funds overseas, HCA also issued $25 million of Eurodollar notes in 1978. In another first for the industry, the company sold $47 million of commercial paper in 1980. The issue was rated A-2 by Standard and Poor's and P-2 by Moody's.

In 1981, HCA added $89 million of debt to its balance sheet. Most of this debt was to mature in less than 7 years, and a substantial portion of it bore fluctuating interest rates that were tied to the prime rate or the London Interbank Offered Rate[3] (a complete schedule of HCA's debt is shown in Exhibit 7). Of this, $425 million was in the form of a revolving bank credit that was used to finance the purchase of Hospital Affiliates. This sudden increase in the level of debt on HCA's books made HCA the highest-leveraged company in the United States with an A bond rating.

HCA had also issued common stock on a number of occasions. It had a public offering of new equity each year from 1969 to 1971 as it built its capital base. Since 1971, HCA had only two public offerings of stock: one in 1976 and the other in 1979, when it sold 2.2 million common shares, receiving net proceeds of $85.8 million, the largest stock deal done that year by an industrial company. HCA also issued new common shares in connection with some of its acquisitions.

HCA's management hoped not to have to issue new equity any more frequently than every other year. Nonetheless, they were very careful to maintain close contact with the equity market. They did so through frequent presentations to security analysts and clear and complete disclosure of information in HCA's financial reports.

Future Growth

One of HCA's principal objectives was to realize at least 13% annual growth in earnings per share after removing the effects of inflation. As a practical matter, however, HCA sought annual growth in the 25–30% range (including the effects of inflation) for the foreseeable future. This aggressive rate was sought for several reasons. One was

[2]Moody's refused to rate the bonds, claiming that HCA's substantial investment in hospital construction meant that it was actually a real estate company. Because enterprises such as real estate investment trusts (REITs) and hotel chains were performing so poorly at this time, Moody's chose not to rate real estate companies at all. The rating agency eventually changed its mind and gave an A to HCA's $23 million industrial revenue bond issue in 1979.

[3]The London Interbank Offered Rate is the interest rate offered for dollar deposits in the London market. It serves as a benchmark interest rate for dollar loans in Europe, much as the prime rate serves as a benchmark for some loans in the United States.

competition from other management companies in the acquisition of hospitals. As Bill McInnes, vice president of finance for HCA, noted:

> There is a feeling here that we must be prepared to strike while the iron is hot. There are only 7,000 hospitals out there and we can't expect to have them all. With, perhaps, three to five good years [of growth by acquisition] left, we will have to move along in an expeditious manner to get our fair share.

Management also recognized that HCA's expected growth rate was a major factor influencing the price of the company's equity. "This is a company in which people check the stock price two or three times a day," Mr. McInnes said.[4] "No one wants to see what will happen [to the stock price] if the growth rate starts to unwind." Management's attention to growth and its impact on equity prices was undoubtedly heightened by security analyst reports on HCA, many of which were predicting 1982 earnings per share of $3.00—a 35% increase over 1981.

Management expected growth to continue in the same basic directions that it had taken since the company's founding—through acquisition, construction of new hospitals, expansion of services, and the signing of new management contracts. Some indication had been given that the company was likely to expand into new areas, but only into other health services such as home health care and outpatient surgery.

As far as future growth by acquisition was concerned, it seemed likely that a somewhat different tack would be taken. Partly for antitrust reasons, many analysts and industry participants believed that the acquisition of other hospital management companies had nearly run its course as a major source of new growth for the large chains in the 1980s. Thereafter, it was believed, growth by acquisition would have to occur primarily through the purchase of nonprofit county, municipal, and religious-order hospitals. Many such hospitals had old buildings in need of renovation, obsolete equipment, and unsophisticated management systems. Because of the unwillingness or inability of their present owners to raise taxes or issue new debt to continue operations, it was likely that many of these units would be put up for sale.

HCA appeared to be well positioned to make inroads into this market. Interestingly, this position had as much to do with HCA's quality image as its financial strength. Among the major hospital management companies, HCA was considered one of the most attractive by which to be acquired because of its industry leadership position, its decentralized management style, and the high quality of its corporate management. Its list of directors read like a page from *Who's Who in Finance and Industry.* The board was chaired by Donald MacNaughton, former chairman and chief executive officer of Prudential Insurance Co. of America, and included other prominent business leaders such as Robert Anderson, chairman and CEO of Rockwell International Corp; Frank Borman, chairman, president, and CEO of Eastern Air Lines; Owen Butler, chairman of Procter & Gamble Co.; John de Butts, retired chairman and CEO of American Telephone and Telegraph; and Irving Shapiro, chairman of the finance committee of E. I. du Pont de Nemours and Co.

HCA's quality image was important when approaching nonprofit hospitals because of the misgivings that some of their owners often had about selling to a profit-oriented management company. Many nonprofit hospitals were directed by politicians, public agents, and other public figures, who sometimes balked at the thought of profits being earned on the care of sick people or who incorrectly believed that past abuses associated with nursing home companies also characterized the proprietary hospital management business. HCA's quality image was often the critical factor in overcoming the doubts of such trustees and convincing them to sell to HCA.

[4]Officers and directors of HCA as a group owned 3.6 million shares of HCA's common stock and 1.8 million options on HCA's common shares.

Other Goals

Besides its growth objective, HCA had several other explicitly stated goals and guidelines. A very important one was its 60% target ratio of debt to total capital. This target was in line with the degree of leverage more or less expected by the rating agencies for an A-rated hospital management company. Its origin, however, was somewhat informal. Typically, debt was used to finance real estate development projects on a 75% loan-to-value basis. In HCA's early years management reasoned that, since 15% of its expenditures on hospital projects were for equipment rather than property or plant, it would be conservative and use only 60% debt financing for its hospital construction. Ultimately, this ratio became the standard for the entire proprietary hospital management industry. However, insofar as many hospitals in the 1980s were built and operated on a standalone basis with as much as 90% debt financing, a case could be made on comparative grounds for a higher debt ratio for a healthy hospital management company. In fact, several of HCA's managers expressed the belief that HCA could comfortably accommodate as much as 75–85% debt in its capital structure if it so desired.

Return on total capital was expected to be a minimum of 11% after taxes, and return on equity was expected to be at least 17% after taxes. Although very important goals, these target rates of return could be difficult to maintain during periods of rapid growth, especially if that growth were achieved largely through acquisition. The reason was that growth by acquisition often meant the takeover of hospitals that needed to be turned around. This process could take several years and result in the squeezing of profit margins in the meantime.

HCA's other goals included a dividend payout of 15% of net income and the maintenance or improvement of net profit margins as a percent of operating revenues. Sam Brooks, senior vice president of finance and chief financial officer of HCA, had also expressed his desire to keep the average interest cost for all HCA's debt at 15% or lower in the foreseeable future.

Regulatory Change and the Outlook for the Future

The future of the hospital management industry appeared bright in several respects. In the near term, continued growth in revenues and earnings seemed assured as nonprofit hospitals became available for acquisition. In the long run, as growth by acquisition and new construction subsided, the natural expansion and aging of the population could be relied upon to increase occupancy rates, thus providing still further growth. Moreover, because of the high *operating* leverage created by hospitals' fixed costs, much of the growth in revenues due to higher occupancy rates could be expected to translate directly into higher earnings. The provision of additional services and a concentration on further cost containment rather than on geographic expansion could further add to growth in earnings in the long run.

The future was not without its risks, however. The federal government had been exploring ways to reduce hospital and medical costs in order to cut federal expenses for Medicare, VA hospitals, and other government-backed health care programs. Various types of industry deregulation tended to be favored in the political climate of the early 1980s as a means of improving production efficiency and increasing consumer welfare.

Regulatory reform of health care could have potentially far-reaching implications for the hospital management companies. For example, under the present regulatory system, hospital expansion was controlled by local health planning agencies through "certificates of need." New hospital projects would be granted such a certificate only

if it could be demonstrated that there existed a genuine need for the new services or expanded capacity being contemplated. Although a bureaucratic headache, this requirement restricted new hospital construction and, in the process, tended to provide existing hospitals with protected franchises. Were certificates of need eliminated, as had been proposed, this form of protection would be removed. This might stimulate rapid expansion by competing hospitals, possibly resulting in the duplication of services, excess bed capacity, and lower occupancy rates than might otherwise be expected. The average occupancy rate for all U.S. hospitals was only 75% in 1979, down from 83% in 1969.

Of equal concern were various proposals to reform the nation's system of health care insurance so that consumers would become more price sensitive and hospitals more cost conscious. Because 90% of all Americans were covered by some form of health insurance, the bulk of hospital revenues came from third-party payers. Consequently, the demand for hospital services by the ultimate consumer was relatively price insensitive. It had been estimated that hospitals could vary prices by as much as 20% up or down without a material effect on patient utilization.[5]

Similarly, because most hospitals receive a substantial part of their reimbursements from government-backed programs such as Medicare and Medicaid, incentives to control costs were diminished. The reason was that such reimbursement programs were "cost-based." That is, hospitals were reimbursed for their costs of providing services to covered patients. Costs allowable under Medicare/Medicaid programs included depreciation and interest but excluded costs of research, losses on bad debts, and expenses for charitable cases. In addition, Medicare allowed a return on equity (excluding nonpatient-related assets and liabilities) at a rate equal to 150% of the average annual interest rate on certain debt obligations of the Federal Hospital Insurance Trust Fund. The pretax return on equity allowed was 12.3% in 1978, 13.7% in 1979, 16.5% in 1980, and 20.0% in 1981.

One of the effects of this system of insurance in the United States was to provide hospitals with relatively stable revenue streams that were largely insulated from economic cycles, inflation, and other economywide risks. Another was that hospitals tended to compete with one another on the basis of quality and breadth of services, reputation of medical staffs, and advertising rather than on the basis of low prices. Proposals to make consumers bear a greater proportion of their hospital expenses out of their own pockets and to change Medicare and Medicaid to something other than cost-based reimbursement systems could change these characteristics significantly. Some of the proposals being considered included treating health insurance premiums paid by employers as taxable income to employees, increasing the level of out-of-pocket expenses borne by Medicare/Medicaid patients, turning the Medicare program into a voucher system that provided fixed benefits independent of costs, eliminating return-on-equity provisions in Medicare and Medicaid reimbursements, and revising the Medicare/Medicaid programs so that they were *prospective* reimbursement systems. Under a system of prospective reimbursement, hospitals would be paid on the basis of "prospectively" set rates rather than actually realized costs. If a hospital provided services at a lower cost than the established rates, it could earn a profit; if not, it would realize a loss.

Most industry analysts predicted that some form of prospective reimbursement would be implemented some time in the 1980s. What was unclear was the exact composition of hospital costs that would be covered by such a system. One possibility would be a system in which capital costs would be prospectively set along with other costs of providing services. If this were to occur, hospitals would no longer be able to count on recouping the full amount of their allowable interest expense from the federal government. Another possibility was that interest expenses would continue to be paid retrospectively, but the return-on-equity provisions would be dropped altogether. This outcome would place even greater pressure on the private-patient side of a hospital's business to provide an adequate rate on capital. Whatever type of prospective reimbursement system was adopted, it seemed probable that the virtual elimination of losses and the subsidizing of capital costs heretofore provided by the cost-based reimbursement system would be reduced. This would instill greater volatility in hospital revenues and earnings.

[5]Todd B. Richter, "The Hospital Management Industry: Survival of the Fittest," *Industry Trend Analysis* (Morgan Stanley & Co., Inc., Investment Research), September 30, 1982, p. 11.

Financial Decisions

HCA's growth objective implied capital expenditure outlays of $575 million in 1982. This level could be expected to expand by 20% a year for the next several years. Given these increasing capital requirements, its debt repayment schedule (see Exhibit 7), the future prospects of the hospital care industry, and HCA's other goals, senior management had to determine how best to prepare financially for HCA's future.

The first issue that had to be addressed in this process was HCA'S target capital structure. Was its long-standing 60% target ratio of debt to total capital too high, too low, or about right? The rating agencies had made it clear that HCA would have to return to its 60–40 capital structure if it were to retain its A bond rating. In a meeting with the rating agencies, prearranged for the day after the acquisition of Hospital Affiliates was announced, Sam Brooks was "given the distinct impression that we had roughly until the end of the summer of 1982 to do something about our debt ratio." Loss of its A bond rating could make access to the debt markets more difficult for HCA. Historical data on debt issued with various credit ratings are presented in Exhibit 8.

Others, however, saw HCA's high level of debt in a more positive light. One Wall Street analyst was quoted as saying that the acquisition of Hospital Affiliates and the debt burden that accompanied the transaction "removes the stigma, if it is one, that Hospital Corp. is too conservative. It said for a long time that it would stick to a 60–40 ratio of debt to equity . . . [This] shows they're willing to be flexible when the right move comes along."[6] Although maintaining its high degree of leverage would cost HCA its A bond rating, the loss might not be all that damaging. Du Pont, for example, lost its long-standing AAA bond rating with its acquisition of Conoco in 1981 without a dramatic rise in its cost of debt or a loss of access to the debt market.

Still others argued that even a 60% ratio of debt to total capital could be too high in light of potential changes in the regulatory environment. By increasing the risk surrounding the cash flows of the hospital management companies, such changes might necessitate a capital structure with only 50% debt or less. Reducing leverage to such a level would take time to accomplish and would require corrective action well in advance of the anticipated changes, even if one were beginning at a 60% debt level. As Bill McInnes said, "A $2½ billion capital structure can't be turned around on a dime."

[6]"Hospital Corp. to Buy INA Unit for $650 Million," *The Wall Street Journal,* April 21, 1981, p. 27.

EXHIBIT 1

Consolidated Income Statements, 1979–1981 (millions of dollars except per share data)

	1979	1980	1981
Operating revenues	$1,043	$1,429	$2,406
Contractual adj. and doubtful accounts	143	197	343
Net revenues	901	1,232	2,064
Operating expenses	726	998	1,682
Depreciation and amortization	41	53	88
Interest expense	38	50	131
Income from operations	95	130	162
Other income	1	6	22
Income before income taxes	96	136	184
Provision for income taxes			
Current	28	44	49
Deferred	14	11	24
Net income	$ 54	$ 81	$ 111
Average number of common and common equivalent shares (millions)	41	47	50
Earnings per share	$ 1.34	$ 1.73	$ 2.23

Note: Figures may not add exactly because of rounding.

EXHIBIT 2

Consolidated Balance Sheets at December 31, 1979–1981 (millions of dollars)

	1979	1980	1981
Cash and cash equivalents	$ 30	$ 29	$ 50
Accounts receivable, net	149	214	363
Supplies	29	44	65
Other current assets	10	15	18
Current assets	218	303	498
Net property, plant, and equipment	802	1,187	2,066
Investments and other assets	40	81	188
Intangible assets	18	38	207
Total assets	$1,078	$1,610	$2,958
Accounts payable	$ 38	$ 58	$ 93
Dividends payable	2	3	4
Accrued liabilities	45	80	166
Income taxes payable	56	71	61
Current maturities of long-term debt	19	26	43
Current liabilities	160	238	367
Long-term debt	427	775	1,649
Deferred income taxes	74	85	117
Other liabilities	30	43	58
Total liabilities	691	1,141	2,191
Common stock (issued 52,210,645 shares in 1981; 45,378,375 shares in 1980; 19,456,634 shares in 1979)	19	45	52
Additional paid-in capital	157	144	342
Retained earnings	210	279	374
Shareholders' equity	387	469	768
Total liabilities and shareholders' equity	$1,078	$1,610	$2,958

Note: Figures may not add exactly because of rounding.

EXHIBIT 3 Ten-Year Historical Summary, 1972–1981 (millions of dollars except per share data and percentages)

	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Summary of Operations										
Operating revenues	$ 173	$ 223	$ 298	$ 393	$ 506	$ 627	$ 797	$1,043	$1,429	$2,406
Interest expense	6	9	13	17	21	24	32	38	50	131
Income before income taxes	18	23	30	36	47	59	74	96	136	184
Net income	10	12	16	21	27	33	42	54	81	111
Average shares outstanding (millions)[a]	35	34	34	35	38	39	40	41	47	50
Earnings per share[a]	$ .30	$ .35	$ .45	$ .59	$ .71	$ .86	$ 1.05	$ 1.34	$ 1.73	$ 2.23
Cash dividends per share[a]	.02	.04	.05	.06	.09	.12	.17	.22	.27	.34
Dividend payout	6.7%	11.4%	11.1%	10.2%	12.7%	14.0%	16.2%	16.4%	15.6%	15.2%
Financial Position										
Total assets	$ 275	$ 321	$ 417	$ 508	$ 602	$ 709	$ 857	$1,078	$1,610	$2,958
Total debt	155	175	240	298	327	363	427	446	801	1,692
Shareholders' equity	91	107	121	142	186	215	252	387	469	768
Book value per share (year-end)	$ 2.69	$3.12	$3.53	$4.09	$4.89	$5.65	$ 6.57	$ 8.84	$10.33	$14.70
Average price-earnings ratio	33.7	18.1	7.3	8.0	9.2	8.6	10.9	11.8	15.9	18.5
Stock Performance										
High	$12.10	$9.90	$5.10	$7.10	$7.60	$9.00	$15.30	$19.90	$37.00	$50.70
Low	8.10	2.80	1.50	2.30	5.40	5.80	7.50	11.60	17.90	31.70
Selected Ratios										
Current ratio	1.3	1.4	1.2	1.5	1.5	1.4	1.4	1.4	1.3	1.4
Net profit margin	6.0%	5.5%	5.2%	5.3%	5.3%	5.3%	5.2%	5.2%	5.7%	4.6%
Return on beginning assets	5.3%	4.4%	4.9%	5.0%	5.3%	5.5%	5.9%	6.3%	7.5%	6.9%
Return on beginning equity	14.3%	13.4%	14.5%	17.0%	19.0%	17.9%	19.3%	21.5%	20.9%	23.7%
Asset turnover	.89	.81	.93	.94	1.00	1.04	1.12	1.22	1.33	1.50
Total debt/Total capital	63.1%	62.0%	66.4%	67.8%	63.7%	62.7%	62.9%	53.5%	63.1%	68.8%

[a] Average share figures include unexercised options. Per share earnings and dividends were computed based on average shares outstanding.

EXHIBIT 4 Key Statistics for HCA's Hospitals, 1972–1981

	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Hospitals in Operation										
Owned and leased, U.S	46	53	56	62	68	72	81	88	144	188
Managed, U.S	2	4	6	8	15	21	26	45	56	146
Owned and managed, international	—	—	—	2	2	2	5	15	18	15
Total	48	57	62	72	85	95	112	148	188	349
Bed capacity	7,304	8,507	9,280	11,648	13,458	14,465	18,036	22,543	28,204	49,866
Occupancy rate (U.S.-owned only)	na	na	70%	66%	66%	66%	65%	68%	69%	68%
Sources of Revenues by Payer										
Cost-based										
Medicare	27%	27%	29%	30%	32%	33%	35%	36%	37%	38%
Medicaid	4	3	3	4	4	4	4	3	3	5
Blue Cross	8	9	8	7	5	5	5	4	4	3
Total cost-based	39%	39%	40%	41%	41%	42%	44%	43%	44%	46%
Charge-based	61	61	60	59	59	58	56	57	56	54
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

na = not available.

EXHIBIT 5 Comparative Data on Selected Publicly Held Hospital Management Companies, 1980–1981 (millions of dollars except per share data and percentages)

	Hospital Corporation of America		Humana, Inc.		American Medical International, Inc.		National Medical Enterprises, Inc.		Lifemark	
	1980	1981	1980	1981	1980	1981	1980	1981	1980	1981
Summary of Operations										
Operating revenues	$1,429	$ 2,406	$1,392	$ 1,704	$ 766	$1,117	$ 723	$1,044	$ 203	$ 323
Interest expense	50	131	76	60	25	41	26	33	6	12
Income before income taxes	136	184	120	177	66	97	54	96	16	31
Net income	81	111	65	93	33	51	29	52	14	18
Earnings per share, primary	$ 1.73	$ 2.23	$ 1.53	$ 2.33	$ 1.23	$ 1.60	$ .91	$ 1.24	$ 1.77	$ 1.80
Cash dividends per share	27	.34	.35	.54	.38	.45	.20	.30	.33	.42
Dividend payout	15.6%	15.2%	22.9%	23.2%	30.9%	28.1%	22.0%	24.2%	18.6%	23.3%
Financial Position										
Total assets	$1,610	$ 2,958	$1,327	$ 1,502	$ 663	$ 984	$ 596	$ 867	$ 211	$ 387
Total debt	801	1,692	757	776	312	396	274	299	102	171
Preferred stock	—	—	66	64	—	—	5	5	—	—
Shareholders' equity	469	768	216	297	201	327	200	376	61	135
Book value per share	$10.33	$ 14.70	$ 5.97	$ 8.01	$ 7.36	$10.20	$ 5.47	$ 8.39	$ 7.56	$13.18
Average price-earnings ratio	15.9	18.5	11.9	16.3	18.3	16.9	8.2	15.6	16.1	10.3
Stock Performance										
High	$37.00	$ 50.70	$26.20	$ 46.38	$22.50	$32.50	$10.50	$27.25	$35.80	$28.10
Low	17.90	31.70	10.25	29.75	9.88	21.50	4.38	11.50	21.20	9.10
Bond rating[a]	A	A	NR	B+	Ba	NR	Ba	B+	Ba	BB+
Selected Ratios										
Current ratio	1.3	1.4	1.4	1.4	1.6	1.5	1.8	2.0	1.7	1.2
Net profit margin	5.7%	4.6%	4.6%	5.5%	4.3%	4.5%	4.1%	5.0%	6.9%	5.7%
Return on beginning assets	7.5%	6.9%	5.4%	7.0%	6.5%	7.7%	9.2%	8.7%	11.1%	8.7%
Return on beginning equity	20.9%	23.7%	38.1%	43.1%	21.3%	25.2%	27.0%	25.9%	40.3%	30.3%
Asset turnover	1.3	1.5	1.2	1.3	1.5	1.7	2.3	1.8	1.6	1.5
Total debt/Total capital	63.1%	68.8%	72.8%	68.2%	60.8%	54.8%	57.2%	44.0%	62.7%	55.9%
Hospitals in Operation										
Owned/managed	188	349	90	89	61	102	54[c]	57[c]	30	35
Bed capacity	28,204	49,866	16,765	16,431	6,117[b]	9,713[b]	6,593[c]	6,929[c]	3,546	4,563
Occupancy rate	69%[d]	68%[d]	58.9%	61.3%	60.6%[b]	na	na	na	na	na

EXHIBIT 5 Continued

Sources of Revenues by Payer								
Cost-based								
Medicare	37%	38%	39%	40%	45%	45%	42.1%	42.0%
Medicaid	3	5	5	5	7	7	12.6	12.7
Blue Cross	4	3	5	5	3	2	4.1	4.5
Total cost-based	44%	46%	49%	50%	55%	54%	58.8%	59.2%
Charge-based	56	54	51	50	45	46	41.2	40.8
Total	100%	100%	100%	100%	100%	100%	100%	100%
Growth Rates, 1976–1981								
Revenues	35.3%		41.1%		31.2%		47.0%	
Net income	32.4		54.6		46.1		52.7	
Total assets	34.2		30.0		22.7		34.3	
Hospitals in operation	30.1		6.8		13.4		18.7	
	—	—	—	—	—	—	—	—
	—	—	—	—	—	—	—	—
	—	—	—	—	—	—	—	—
	44%	42%						
	56	58						
	100%	100%						
		31.0%						
		40.9						
		39.7						
		11.7						

Note: Fiscal year ends August 31 for Humana and American Medical International; December 31 for HCA and Lifemark; May 31 for National Medical Enterprises. NR = not rated; na = not available.

[a]Excludes convertibles.
[b]For owned hospitals only.
[c]Excludes long-term care facilities (i.e., nursing homes).
[d]U.S.-owned only.

EXHIBIT 6
HCA's Hospital Locations in the United States

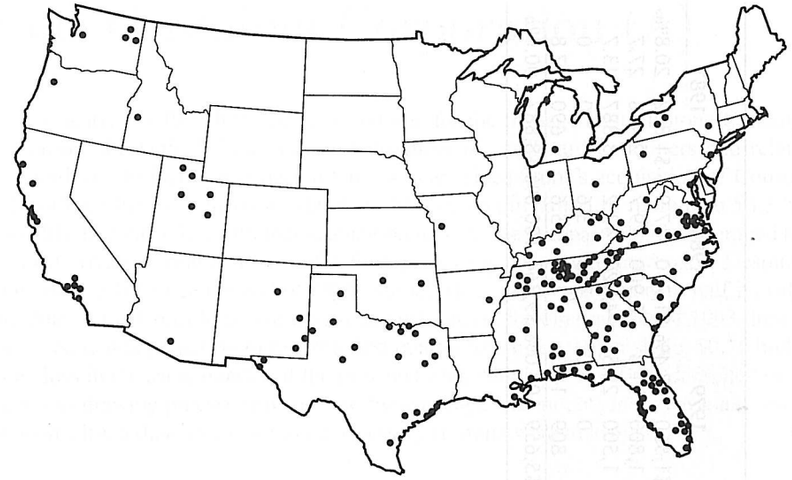

EXHIBIT 7 Schedule of Outstanding Long-Term Debt, 1979–1981 (millions of dollars)

	1979	1980	1981
Mortgage notes and bonds, 6%–16½%, due through 1998	$288	$153	$ 176
Revenue bonds, 6¼%–13½%, due through 2011	63	102	134
Notes, debentures, and capitalized leases, 7%–16½%, due through 1999	75	227	281
Revolving credit and term loan agreements at prime or LIBOR, plus ½%–¾%	—	168	515
Commercial paper and bank financing, 13¼% composite effective rate at December 31, 1981[a]	—	125	208
Convertible subordinated debentures:			
8¾%, due 1996, convertible at $43.50 per share	—	—	80
8¾%, due 2006, convertible at $41.17 per share	—	—	125
12%, due 1996, convertible at $62.30 per share	—	—	81
Guaranteed notes, 15½%, due 1988	—	—	50
Total	$427	$775	$1,649

Debt maturing in the next 5 years ($ millions):

1982	$ 34
1983	70
1984	71
1985	117
1986	163

[a]In 1980 and 1981 the company entered into revolving credit agreements with a group of banks, aggregating $160 million and $278 million, respectively. The lines were used to support commercial paper and other bank financing during these 2 years. Because of the availability of long-term financing under these agreements, the company classified the commercial paper issue under long-term debt.

EXHIBIT 8 Debt Issued in the U.S. Public Market by Industrial Corporations with Varying Credit Ratings, 1974–1981 (millions of dollars)

Source: Salomon Brothers Inc.

Credit Rating	1974		1975		1976		1977		1978		1979		1980		1981	
Aaa	$1,650	25.1%	$ 2,875	24.0%	$ 700	11.7%	$ 800	20.5%	$ 275	8.6%	$1,550	27.4%	$1,750	17.9%	$1,852	20.8%
Aa	2,415	36.7	3,310	27.7	2,030	33.8	1.125	28.9	700	21.8	1,800	31.8	2,900	29.7	2,458	27.7
A	2,060	31.3	5,355	44.7	2,205	36.8	960	24.6	1,310	40.8	1,500	26.5	4,220	43.2	3,887	43.7
Baa	440	6.7	420	3.5	1,010	16.8	445	11.4	210	6.5	0	0	345	3.6	0	0
Other	15	.2	9	.1	53	.9	567	14.6	713	22.3	809	14.3	549	5.6	690	7.8
	$6,580	100.0%	$11,969	100.0%	$5,998	100.0%	$3,897	100.0%	$3,208	100.0%	$5,659	100.0%	$9,764	100.0%	$8,887	100.0%

[c]Excludes long-term care facilities (i.e., nursing homes).
[d]U.S.-owned only.

Stone Container Corporation (A)

The first quarter of 1993 had been a trying one for the management of Stone Container Corporation, the United States's largest producer of cardboard containers and related paper products. In fact, it had been a tense 4 years since Stone's acquisition of Consolidated-Bathurst Inc. of Canada in March 1989. The accumulation of more than $3.3 billion of debt in connection with that acquisition had left the company highly leveraged relative to its rivals during a period of falling prices for paper and linerboard. Despite a strong bull market since the end of 1990, Stone's stock price was less than half its value at the time of the Consolidated-Bathurst acquisition. As the first quarter of 1993 drew to a close, Stone was preparing to report a first quarter loss of $0.91 per share, $0.76 higher than its loss in the same quarter of the previous year. Although it had not defaulted on its debt, it was drawing precariously close to the coverage and indebtedness covenants on its bank loans. Immediate steps would be necessary if Stone were to avoid default.

Company and Industry Background

In 1993, Stone Container Corporation was the paper and forest products industry's leading producer of containerboard and corrugated containers as well as kraft paper, bags, and sacks. Additionally, Stone Container held a major position in newsprint manufacturing and groundwood specialty papers. Stone Container also produced building products and wood pulp. With plants throughout the world, Stone Container employed 31,800 people. Sixty-nine percent of its sales came from the United States while Canada accounted for 16%, and Europe, 15%. Stone Container's 1992 sales totaled $5,520.7 million (see Exhibit 1). Other financial statements are provided in Exhibits 2 and 3. A ten-year historical summary of Stone's performance is provided in Exhibit 4.

The Paper and Forest Products Industry

In early 1993, the paper and forest products industry included a vast array of companies. Among them were Georgia-Pacific, the world's largest producer of paper and wood products; Scott Paper, the world's largest producer of sanitary tissue products; Weyerhauser, the world's largest private owner of softwood timber; and Stone Container, the industry leader in containerboard, corrugated containers, kraft paper, bags, and sacks. Other products made by industry participants included newsprint, packaging papers, paperboard, paper towels, lumber, logs, plywood, among many others.

Between 1986 and 1992 the paper and forest products industry grew from $61.6 billion in sales to $85.2 billion, a total increase just shy of 40%. In 1986, industry net profit was $2.85 billion. After exceeding $6 billion in 1988, industry net profits then fell to $.97 billion in 1992.[1]

[1] *Valueline,* July 23, 1993, p. 914.

Research Associate Kirk A. Goldman prepared this case under the supervision of Professor W. Carl Kester as the basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.