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A Guide to Financing Strategies for Hospitals

*With Special Consideration
for Smaller Hospitals*

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A GUIDE TO FINANCING STRATEGIES FOR HOSPITALS

With Special Consideration for Smaller Hospitals

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Executive Summary

Given economic and industry trends related to the worldwide financial markets, the nation's economy, and U.S. health care reform, access to external capital has become more important than ever for hospitals nationwide.

Reform and market changes are accelerating hospitals' need for capital to fund physician employment and integration, information technology (IT), facility modernization and expansion, and other initiatives. Successful health care organizations will need to make substantial capital investments in each of these areas. Scale and market essentiality will be factors critical to success.

For most hospitals, operating cash flow alone will not support the higher level of required capital spending. Recent improvements in median hospital profitability and liquidity positions have been encouraging but are likely not sustainable given the downward revenue/expenditure pressures associated with bending the nation's health care cost curve. Hospitals will need to borrow capital. Competitiveness will depend on having reliable access to debt at reasonable cost, terms, and risk. Small hospitals without sufficient capital capacity and access will need to secure capital/merger partners in order to assure continuing provision of services in their communities.

The problem related to capital access is this: Given constrained national liquidity since mid-2008, most hospitals have experienced more limited capital access, fewer borrowing options, higher cost of capital, more restrictive terms, less flexibility, and higher risks related to available borrowing options. This is especially true for smaller hospitals, which have almost always experienced a more difficult time accessing capital than larger organizations.

This guide offers seven strategies that can help hospitals achieve the best possible capital access. Key "take aways," recommended action items, and implications for smaller organizations are highlighted. While the guide provides considerations related specifically to smaller organizations, such as rural hospitals, critical access hospitals, or stand-alone community hospitals, the strategies are applicable to all health care organizations, including multihospital systems, regional systems, and hospitals that are part of a larger system.

I. Understand Your Strategic Financial Position and Maintain Credit Strength

Take Aways

Over the next decade, as market changes occur and health reform regulations emerge, the quantification of impacts and risks will be more important than ever for hospitals. Every hospital should assess the expected impact of health reform and market forces on an ongoing basis and develop appropriate response strategies. Preparedness for change by organizations at all credit levels is by itself a competitive advantage.

Action Items

1. Using objective market and financial data, accurately assess the hospital's current strategic and financial position, where it needs to go, and if it has the resources to get there.
2. Through sound financial management, do everything possible to preserve the strength of the hospital's credit position.

Implications for Smaller Hospitals

The challenge for many small hospitals is whether they have the scale and financial resources needed to secure a public credit rating. If they do, the next question is whether the public rating they secure is high enough to be helpful to their capital formation effort. A public rating usually is helpful, but it is not always necessary. Many of the strategies described throughout this guide involve the use of credit intermediaries, such as banks, the FHA, or other alternatives, which do not necessarily require a public rating for access to that financing alternative.

Whether a hospital obtains a public rating or not, the basic principles behind a strong credit position apply to every organization. Understanding credit metrics and incorporating them into ongoing financial management efforts will improve any hospital's ability to approach a range of appropriate lenders from a position of relative strength.

As such, the need for objective strategic and financial planning is heightened for smaller organizations. Disciplined evaluation and study will enable the board and management to assess whether the available access to capital is strong enough to support the organization's strategic needs. Once the financial plan is established, continued rigor and discipline will be required to achieve the targeted levels of performance.

2. Identify and Evaluate the Full Range of Financing Options

Take Aways

The capital markets have returned to a more normal level of functioning in 2010, allowing access to external debt by organizations at most credit levels. Transactions continue to get done across the credit spectrum, at times requiring different structuring and provisions, but smaller and lower-grade credits should always assume that they will experience a more challenging process. Tax-exempt fixed-rate bonds are currently the product of choice, as hospitals move risks related to variable-rate debt off the table, but many alternatives are available to health care borrowers. Bank lending capacity has increased. Market volatility remains high and warrants close executive attention.

Action Items

1. Assess the full range of financing options, including nontraditional sources.
2. Recognize that fixed-rate bonds are the least risky debt structure available to hospitals, but they are often the most costly form of debt.
3. Be aware of the changing accounting treatment of leases (on balance sheet, like debt).
4. Ensure that leasing is not used as a means to finance projects to circumvent the hospital's capital decision-making process.
5. Scrub the hospital's existing portfolio of businesses; divest non-core assets.

Implications for Smaller Hospitals

Due to a lower scale of borrowing and credit strength, smaller hospitals typically do not have the complete range of financing options available to larger organizations. But there are public and private borrowing alternatives available if smaller hospitals are willing to invest the needed time to gain capital access. Access to direct bank lending has opened up for organizations of all credit strength. Small community hospitals may have to commit to an exclusive banking arrangement in order to secure funding.

Given industry, economic, and market trends, small organizations without significant credit strength should not continue to own businesses or operate programs that are not affordable or core to their missions. Divestiture of such assets will be key to survival.

3. Consider Sources of Local and State Support

Take Aways

Local and state support can significantly lower a hospital's cost of capital and contribute to capital funding.

Action Items

1. Explore sources of local and state support.
2. Pursue philanthropic support, as appropriate.

Implications for Smaller Hospitals

Smaller hospitals can benefit from pursuing all capital options, including philanthropic donations and local and state support for specific projects. Communities with small hospitals typically are highly invested in retaining their local access to health care and hospital-related jobs. Some municipalities and districts might be able to afford direct or indirect support of the hospital; given current fiscal constraints, others may not have such means.

4. Consider Partnership as a Broad Strategic Capital Option

Take Aways

The need for significant capital to fund new-era requirements will increase the potential benefits of strategic partnerships between health care organizations. Partnering options range from loose affiliations with a high degree of local control to fully integrated asset sales/mergers/acquisitions with a lower degree of local control. Hospital management teams and boards nationwide are identifying and securing partnerships appropriate to support the organization's long-term strategic and financial needs.

Action Items

1. Consider and pursue partnership options, as appropriate; early movers in consolidating markets will have a strategic advantage.
2. Ensure use of a structured process for making well-informed partnership decisions.

Implications for Smaller Hospitals

Marketplace pressures under the emerging new business model and health reform will challenge organizations to a much greater extent than in the past. Many stand-alone hospitals and small health systems, even strong ones, are recognizing that they do not have the strategic and financial resources required to achieve the capabilities associated with success in the new era. These competencies include close integration with physicians, information technology sophistication, balanced service distribution, and strong payor relationships.

Proactive hospital boards and management teams are asking challenging questions about whether their organizations can best serve their missions "as is," or if partnership with other providers would provide their communities with the best-possible services and access going forward. Many small hospitals and health systems are exploring and securing strategic partnerships with other not-for-profit and for-profit organizations. In specific markets, small hospitals may not be able to take a "wait-and-see" approach because competitors are consolidating their market. Early movers may be rewarded.

5. Evaluate and Select the Best Financing Strategy

Take Aways

To choose the right capital markets financing vehicle(s) for the hospital, many factors should be weighed, including issuance costs, all-in borrowing rate, covenants, interest rate risk, and other factors. Flexibility of selected options is critical, but so is a fundamental understanding of the underlying benefits and risks of each instrument. If a hospital's financial leaders and the board members on its finance committee don't understand and cannot explain the financing approach, the hospital should not pursue it.

Action Items

1. Evaluate each debt instrument using the 11 criteria outlined in this section.
2. Ensure that the debt vehicle selected provides as much flexibility as possible and involves the lowest overall cost and risk level, given the hospital's overall asset and liability portfolios.
3. Stick to the basics: Don't select debt products that the hospital's financial leaders and the board members on its finance committee don't understand.

Implications for Smaller Hospitals

Smaller hospitals often have less flexibility in the provisions and terms of debt vehicles, but they should weigh the relevant factors outlined in this section. Covenants related to liquidity can be particularly problematic and should be fully understood prior to a transaction.

6. Involve the Right Professionals

Take Aways

Selecting the right team of experts to identify, pursue, and secure capital options is critical. For tax-exempt bond transactions, a multidisciplinary team, which brings depth and breadth of expertise and independent viewpoints, is recommended.

Action Items

1. Use a multidisciplinary team for tax-exempt bond transactions; ensure that team members have both national and local experience.
2. Understand the role of financing team members who represent the interests of both the borrower and lenders/investors/issuers.
3. Ensure that the financing team can provide independent financial advice.

Implications for Smaller Hospitals

Small hospitals that access the municipal bond market can follow all of the guidance in this section. Hospitals without access to the tax-exempt market will also need to obtain independent, objective advice about, and assistance with, financing transactions, whether through bank, government, or other programs. Advisors with national and local experience can provide the needed assistance.

7. Stay Closely Connected

Take Aways

The hospital's management team and board, as appropriate, must remain actively engaged throughout the debt financing and/or partnership exploration and transaction processes. The leadership team ultimately is responsible for understanding the implications of capital financing decisions and for pursuing appropriate strategies.

Action Items

1. Ensure that the hospital's management team and board remain actively engaged throughout the debt financing and/or partnership exploration and transaction processes.
2. Ensure that financial and other advisors explore the full range of available capital options.

Implications for Smaller Hospitals

It is particularly important for management teams of smaller hospitals to be closely involved with financing strategies that include funding from state or local governments or from philanthropic sources. Maintaining strong relationships with these sources can help maximize the capital received and manage its structure and timing.

Concluding Comments

The stakes are high. Whether hospitals are strong or not so strong, their executives cannot afford to take a wait-and-see approach to capital access. To ensure capital options in the new health care environment, leadership teams must understand available options for accessing external capital. Doing this requires that they be committed to building an in-depth understanding of their current strategic and financial position, preserving the strength of their credit position, identifying and evaluating the broadest-possible funding sources, securing the best-fit options through involving the right experts, and staying closely connected to their capital position by monitoring existing funding and new opportunities. Winning organizations will take a proactive approach.

A GUIDE TO FINANCING STRATEGIES FOR HOSPITALS

With Special Consideration for Smaller Hospitals

Introduction

Health care is a very capital-intensive business and access to debt financing keeps hospitals in business. Few hospitals today can generate enough cash flow from their operations and reserves to fund short- and long-term strategic investments in people, programs, facilities, and technology. Most hospitals must access external debt on a periodic basis to assure the provision of continued health care services in their communities. The ability to issue and support debt is not a “nice-to-have” capability; it is essential to the viability of nearly all U.S. hospitals and health systems.

Health care organizations have been struggling to keep up with a demand for capital that has been higher than at any point in past decades. Aging facilities, increasingly competitive markets, and new equipment and technology have been creating ever-higher capital spending requirements. Debt financing in numerous forms, “relatively easy” to obtain up until recent years, has been helping organizations to fund important strategic initiatives.

At this point in history, access to external capital has become more important than ever for hospitals nationwide. Health care reform and related and unrelated market changes are accelerating hospitals’ capital needs related to physician employment and integration, information technology (IT), facility modernization and expansion, and other initiatives.

Successful health care organizations will need to make substantial capital investments in each of these areas. The emerging value-based care delivery and payment system requires new and expensive organizational competencies, including care management capabilities, sophisticated IT, and highly integrated physician arrangements. For most hospitals, operating performance alone will not support the higher level of capital spending required to achieve such competencies. Competitiveness will depend on having reliable access to debt at reasonable cost, terms, and risk as a key option available to management.

The problem is this: Fundamental changes in the capital and credit markets following the 2008 credit crisis have reduced overall market liquidity and increased investor scrutiny of all potential investment opportunities. Health care bonds and loans were no exception. Given constrained national liquidity since mid-2008, most hospitals have experienced more limited capital access, fewer borrowing options, higher cost of capital, more restrictive terms, less flexibility, and higher risks related to available borrowing options. This is especially true for smaller hospitals, which almost always have experienced a more difficult time accessing capital than larger organizations. Hospitals further down the “credit curve” (more on this follows) have been similarly affected.

Presented here are seven strategies that can help these hospitals to achieve the best possible access to capital. Our focus is on all smaller organizations—whether rural hospitals, critical access hospitals, or stand-alone community hospitals—as distinct from multi-hospital systems, regional systems, or hospitals that are part of a larger system. While the strategies provided here are not unique to hospitals of a particular size, smaller hospitals cannot afford to neglect any one of these. “All cylinders must be firing simultaneously” for maximum capital access at minimum cost and acceptable risk.

Strategy I. Understand Your Strategic Financial Position and Maintain Credit Strength

Strategic Financial Position

Given the new financial and industry realities, a hospital leadership team needs to have an accurate picture of its organization's current strategic and financial position. This includes analysis of the hospital's market and competitive positions, key market demand/volume trends, programs/service line strengths and weaknesses, facility development needs, financial and capital position, and current and likely future debt capacity given its current financial trajectory.

The strategic and economic underpinning of financial projections completed as recently as six months ago most likely have changed and must be reevaluated. Every hospital should assess the expected impact of health reform and market forces on an ongoing and regular basis. Over the next decade, as market changes occur and regulations emerge, the quantification of impacts and risks will be more important than ever for health care providers. Modeling at this time should include, at a minimum:

- Projected volume of business, including volume created through the expansion of Medicaid and the new state insurance exchanges
- Capacity to accommodate this volume, along with potential shifts in care sites and inpatient and outpatient locations/services
- The financial implications of payment rate and payor mix changes resulting from the newly insured
- The operating impacts and capital requirements associated with expanded hospital-physician organizations and relationships
- The capital and operating costs related to IT
- The capital needs for other strategic initiatives and routine operating requirements

Access to the external capital required to fund strategic plans is contingent on an organization's financial performance. Does your organization have a clear understanding of its current strategic and financial position, where it needs to go, and if it has the resources to get there?

Credit Position

A strong credit position, frequently measured by a strong bond rating (see Sidebar), helps to optimize access to capital. During difficult times, hospitals with stronger credit profiles (higher bond ratings) have had more flexible borrowing alternatives resulting in access to lower-cost restructuring opportunities. This effect has been material and has accelerated the growing credit-quality gap with strong health care credits getting stronger and weak credits getting weaker, as noted by the agencies that rate health care debt.¹

Bond Ratings

A bond rating is a credit agency's assessment of the ability and willingness of an issuer (i.e., "borrower") of debt to make full and timely payments of principal and interest on its debt over the course of its maturity. Each of the three agencies that rate health care debt uses a slightly different rating system, as shown below (from high rating to low rating for investment-grade debt). Each agency offers noninvestment grade ratings (below BBB-/Baa3) as well. Ratings are borrower-specific, meaning that they are assigned by the credit agencies based on an evaluation of factors affecting the borrower rather than a specific debt issuance.

Fitch Ratings	AA, AA-, A+, A, A-, BBB+, BBB, BBB-
Moody's Investors Service	Aaa, Aa1, Aa2, Aa3, A1, A2, A3, Baa1, Baa2, Baa3
Standard & Poor's	AA+, AA, AA-, A+, A, A-, BBB+, BBB, BBB-

Sources: Moody's Investors Service, New York, NY; Standard & Poor's, New York, NY; Fitch Ratings, New York, NY.

The challenge for many small hospitals is whether they have the scale and financial resources needed to secure a public rating. If they do, the next question is whether the public rating they secure is high enough to be helpful to their capital formation effort. A public rating usually is helpful, but it is not always necessary. Many of the strategies described throughout this paper involve the use of credit intermediaries, such as banks, the FHA, or other alternatives, which do not necessarily require a public rating for access to that financing alternative.

Whether a hospital obtains a public rating or not, the basic principles behind a strong credit position apply to every organization. Understanding credit metrics and incorporating them into ongoing financial management efforts will improve any hospital's ability to approach a range of appropriate lenders from a position of relative strength.

Benefits of a Strong Position. Benefits enjoyed by organizations with strong credit profiles, defined as “A” category or above, include the following:

Access to both Taxable and Tax-Exempt Public Debt. Public taxable debt, not readily accessible to organizations with lower credit ratings, may be required for certain programs or services that don't qualify for tax-exempt debt. Organizations with a strong credit rating may want to access taxable debt to fund investments such as medical office buildings or joint-venture ambulatory facilities. Typically, public debt alternatives will represent the lowest cost alternative, so having the size and credit position needed to access this option can represent an important business advantage.

Improved Distribution. Maintenance of a stronger credit position also creates an expanded pool of potential lenders, which drives improved pricing and terms and typically reduces the time and effort required to raise the debt capital. Many large investor groups, funds, and insurance corporations that normally buy tax-exempt hospital bonds are precluded from buying debt with ratings below the “A” category; further, banks and other lenders typically reduce the amount of credit they will make available to weaker credits. Hence, the pool of potential investors for “BBB” bonds, for example, is much smaller than it is for higher-rated bonds.

Lower Cost of Capital. Higher-rated organizations consistently pay less for debt capital than do lower-rated organizations. The difference between the two, known as the “spread,” has narrowed, then widened, and then narrowed again in recent years, but it has remained significant at almost all points in time (Figure 1). Public market health care spreads were narrow through mid-2007, when there was high market liquidity and investor confidence; conversely, in a time of limited liquidity, due to investment losses and risk sensitivity, such as what occurred in 2008 and 2009, credit spreads were much wider. Overall, however, hospitals with “AA” and “A” category credit can access lower-cost capital than hospitals with “BBB” and non-investment grade ratings.

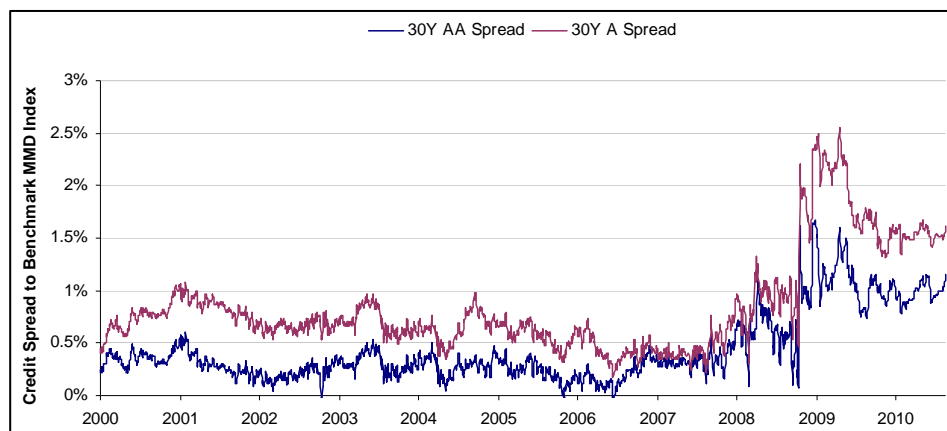


Figure 1. Health Care Credit Spreads: “AA” and “A” Credit Spreads Over MMD “AAA” Benchmark Index
Source: Kaufman, Hall & Associates, Inc.

Less Restrictive Bond Covenants. Bond documents include covenants, which are the financial compliance requirements that the borrower must meet on an annual, and sometimes quarterly, basis. For example, bond covenants frequently define the minimum number of days cash on hand or debt service coverage ratio that the borrowing organization must maintain. If the organization does not meet the covenants, the bonds governed by the covenants will be in “technical default,” which has associated consequences. Covenants can limit an organization’s financial flexibility, for example its ability to respond quickly to an acquisition opportunity that would reduce to below required levels, at least temporarily, liquidity indicators, such as days cash on hand. Lower-rated organizations are held to more stringent covenant standards, which limit their financial and perhaps operating flexibility.

Ability to Be Market Consolidators. A solid credit rating also can provide a major strategic and financial advantage. Market consolidators are always creditworthy organizations. In the current health care environment, strong organizations are consolidating markets by acquiring or merging with weaker competitors that are often no longer able to compete because of a lack of access to cost-effective capital. Because these organizations can offer excess capital capacity and lower capital costs, organizations with the highest credit ratings are attractive partners to those with lower ratings. Nevertheless, smaller hospitals that have strong credit positions will be less dilutive, or perhaps will even be accretive, to the credit position of larger potential partners. Whether as “consolidator” or “consolidate,” bringing a strong credit profile to a partnering discussion will favorably impact the organization’s ability to secure the best possible transaction for its community.

Credit Position Conclusions. Hospitals’ trustees and management teams of smaller hospitals should do everything possible to preserve the strength of their organization’s credit rating. In the long run, hospitals are only as strong as their own credit position. This is a “domino environment.” A weak or deteriorating position can trigger more restrictive bond and bank document covenants, limit flexibility and access to different types of financing, and increase cost of capital. This results in decreased debt capacity and more difficult access to debt capital, which ultimately threatens independence. Executives must avoid knocking over the first domino.

Take Aways

Over the next decade, as market changes occur and health reform regulations are defined, the quantification of impacts and risks will be more important than ever for hospitals. Every hospital should assess the expected impact of health reform and market forces on an ongoing basis and develop appropriate response strategies. Preparedness for change by organizations at all credit levels is by itself a competitive advantage.

Action Items

1. Using objective market and financial data, accurately assess the hospital’s current strategic and financial position, where it needs to go, and if it has the resources to get there.
2. Through sound financial management, do everything possible to preserve the strength of the hospital’s credit position.

Implications for Smaller Hospitals

The challenge for many small hospitals is whether they have the scale and financial resources needed to secure a public credit rating. If they do, the next question is whether the public rating they secure is high enough to be helpful to their capital formation effort. A public rating usually is helpful, but it is not always necessary. Many of the strategies described throughout this guide involve the use of credit intermediaries, such as banks, the FHA, or other alternatives, which do not necessarily require a public rating for access to that financing alternative.

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As such, the need for objective strategic and financial planning is heightened for smaller organizations. Disciplined evaluation and study will enable the board and management to assess whether the available access to capital is strong enough to support the organization's strategic needs. Once the financial plan is established, continued rigor and discipline will be required to achieve the targeted levels of performance.

Strategy 2. Identify and Evaluate the Full Range of Financing Options

Hospitals should look at all traditional and nontraditional financing options available in today's public and private capital markets. This is especially true for small hospitals that often do not have as wide a range of options as larger hospitals. A description of eight options follows, including municipal bonds, direct bank loans, FHA Section 242 credit enhancement, leasing, USDA Rural Development Program, New Market Tax Credit Program, debt restructuring, and asset sales. Certain of these products—particularly public market alternatives—may not be available to smaller hospitals. Nevertheless, each option is worth understanding and tracking as executives begin contemplating capital formation strategies.

Municipal Bonds

Debt capital comes in a variety of forms, but bonds issued in the public, municipal markets are a major capital financing vehicle for not-for-profit hospitals and health systems. During the last decades, municipal bonds have funded the bulk of large hospital facility and technology improvements nationwide. In 2009, hospitals issued nearly \$44 billion of tax-exempt bonds, including both new-money and refunding issuances. According to Thomson Reuters' *Municipal Market Analysis*, this sum represents nearly 11 percent of total bonds issued in the municipal market, a category that includes state and local governments, public transportation, power/utilities, airports, and universities.

Recent Market Functioning. The tax-exempt municipal market has gone through an extraordinarily challenging period in recent years. Since the Lehman Brothers bankruptcy filing in September 2008, which basically shut down the market for fixed-rate health care bonds, the market has returned to a functioning state and is again being accessed by organizations at most credit levels. However, market volatility remains high and warrants close executive attention.

For most of the period from 2009 to the present, larger and higher-grade credits have had the “best” market access. Credit spreads for this group improved over this time period, but most importantly, there has been consistently strong investor support. Deals continue to get done across the credit spectrum, at times requiring different structuring, but the level of participation by institutional and retail investors for smaller and lower-rated credits has been less consistent. Smaller and lower-grade credits should always assume that they will experience a more challenging borrowing process.

How They Work. A public bond offering is structured such that the hospital, through a “conduit issuer,” sells bonds to an underwriter, typically an investment bank, that then resells the debt to any party—individuals or institutions—interested in owning the bonds. Hospital borrowers must follow certain rules to qualify their bonds as a public offering, such as securing the required legal opinions about the

use of the capital and providing adequate disclosure to potential investors regarding the credit and bond structure.

Fixed-Rate Bonds. These bonds are the most commonly issued debt by not-for-profit hospitals and systems, and they represent the least risky debt structure available for borrowers. Fixed-rate debt essentially transfers all market risks to the investors and, as a result, typically represents the most costly form of tax-exempt or taxable debt.

The interest rate paid on a fixed-rate bond does not change during its lifetime. Even though each maturity of an issued bond may have a different interest rate, the investor purchasing the bond receives a fixed rate of return for the entire period during which the bonds are outstanding. Fixed-rate bonds are also considered *committed capital*, because as long as the hospital borrower meets its principal and interest payment obligations on a timely basis and complies with covenant requirements, the rates and repayment structure remain fixed until the bond matures, except at the option of the borrower.

Fixed-rate debt generally provides investors with call protection for a number of years, which means that for a period of time (typically 10 years), the hospital borrower can not “call” or buy back the bonds from the bondholder. At the end of the “no call” period, if interest rates have declined, the hospital borrower might wish to call the bonds and replace them with lower interest-paying obligations through issuance of new *refunding bonds*.

Variable-Rate Bonds. Variable-rate or floating-rate bonds or notes have rates that are reset daily, weekly, or monthly. The interest rate paid by the borrower fluctuates with each rate reset based on an interest rate index that reflects current, but changing market conditions. Variable-rate demand bonds (VRDBs), the primary variable-rate product available to hospitals at this time, are *put bonds*, meaning they can be put, or redeemed by bondholders for their full face amount on every reset date. VRDBs are considered *uncommitted capital* due to this put feature and the fact that the credit enhancement and liquidity support required to issue these bonds does not typically extend for their full life but must be renewed numerous times during their lifetime. Put differently, VRDBs carry certain “event risks” that might create an unexpected and accelerated repayment obligation, which could severely strain cash resources.

The biggest challenge attached to VRDBs is securing the credit and liquidity support from a highly rated bank. This is needed to convince investors that they will be able to get out of their position at any time. Such support typically takes the form of a direct pay letter of credit (LOC), under which the bank stands between the hospital and investors. Smaller hospitals may have particular difficulty securing this form of bank support from the “right” large banks, which may lead them to the direct issuance option described later.

Historically, variable-rate debt has provided borrowers on average with lower “all-in” costs of capital than fixed-rate debt. The all-in borrowing rate represents the total cost of capital, including interest and fees involved with initiating and maintaining the financing. However, access to variable-rate debt through the municipal markets has generally become limited to organizations with stronger credit ratings. This is due both to the fact that purchasers of VRDBs are typically institutional investors with minimum rating requirements and to the more limited appetite of the banks providing credit enhancement and liquidity.

Direct Bank Loans

Since Federal money started flowing through the Troubled Asset Relief Program in 2009, banks have been expanding their direct loan programs to tax-exempt health care organizations. The American Recovery and Reinvestment Act (ARRA) has also contributed to this upward lending trend. ARRA

raised the eligibility limit for tax-exempt bank-qualified bonds to \$30 million from \$10 million, and placed the limit with borrowers rather than issuing authorities. “Bank qualified debt allows small governments and authorities (which represent health care borrowers) to directly place their debt with banks . . . which are then able to deduct a percentage of the carrying costs for purchasing these bonds. This allows small governments (and other borrowers) to pay lower borrowing costs for their debt,” (Source: The American Hospital Association letter to Max Baucus and Charles Grassley, dated May 7, 2010). Whether this \$30 million eligibility limit will be extended beyond its December 31, 2010 expiration date is unknown as of the publication date of this guide.

With recent signals of economic recovery and continued federal incentives, direct lending capacity has further increased. This is particularly true among those banks that historically offered letters of credit (LOCs) to support VRDB programs that have been converted by hospitals to fixed-rate debt. Some banks, in fact, may now have more appetite for direct loans than for LOC renewals. Most regional and national banks are participating, and even local banks are looking to lend in order to retain commercial banking relationships with area hospitals.

Implications for Borrowers. Unlike municipal bonds, direct bank loans do not require a public rating for the underlying credit, can be implemented with the broadest range of banks, and can frequently be completed on a faster timetable than is true for many public market alternatives. Direct loans can also offer hospitals a useful tool to gain floating-rate exposure without some of the risks attached to public market structures, most notably the ongoing put risk associated with VRDBs. *Put risk* is the risk that bonds can be “put” back to the hospital by the lender/investor, requiring that the loan be repaid. Due to put risk, VRDBs require liquidity support from a bank. The rating agencies closely monitor the amount of put risk an organization incurs due to the inherent risks associated with renewal and pricing of the liquidity and credit support.

Conversely, most direct loans do not have an ongoing put, but they frequently have a “hard put” at the end of the initial term. Even if the principal is amortized, the vast majority of it will still be due at the end of the loan’s term. This “bullet” payment represents a significant risk, and borrowers should be careful to manage the potential impact of such requirements on liquidity balances. One means of partially mitigating this risk is by securing a “term out” provision; in this case, residual debt that cannot be renewed or refinanced would be converted into a term loan that is repaid over some period of time (i.e., one to five years). This improves the hospital’s risk position—providing some room to secure other financing—but does not eliminate it; banks will be very careful about managing the full duration of their exposure against a particular credit (debt plus term out).

Direct loans can yield reduced costs of capital for hospitals that may not have access to other financing products that offer lower costs. However, with lower costs often come additional restrictions and legal covenants that can range from expanded coverage of existing public debt covenants to lender review and approval for every financial decision.

Structure. Direct loans can be either tax-exempt or taxable. Tax-exempt loans are issued through a conduit agency (e.g., an authority or city) and funded by the bank; taxable debt is issued directly by the bank with no need for a conduit issuer.

Loan amounts have been ranging from \$10 to \$50 million per bank, although there have been some as big as \$100 to \$150 million. Amortization periods can range up to 30 years, as is typical with publically issued municipal bonds, but typically have much shorter terms, ranging from three to ten years. Direct loans may provide hospitals with “committed” funding for a period of time; however, as noted earlier, at the end of the loan term, the loan must be renewed (and repriced), refinanced, or perhaps termed out, if renewal or

refinancing are not alternatives. This rolling term or renewal risk will likely represent the most significant issue in the structure and must be managed closely.

Direct loan covenants may be more stringent than with traditional fixed-rate municipal bond financings. Banks may request certain covenants that differ from those in the organization's Master Trust Indenture (MTI), such as higher ratios (often, specifically, the debt service coverage ratio). Terms generally can be negotiated in order to try to align the loan as closely as possible with the organization's MTI.

Rates. Taxable variable-rate loans are typically priced at a spread to one-month London Interbank Offered Rate (LIBOR), which reflects taxable interest rates. Rates and spreads to LIBOR that are offered will be highly dependent upon a hospital's credit, the hospital-bank relationship, and the term of the facility. Banks are offering lower rates and spreads to hospitals with established relationships—again, to keep the hospital's business.

If the loan is tax exempt, either the one-month LIBOR base rate is multiplied by a percentage representing the bank's "tax factor" (at this point, in the 64 to 74 percent range) plus a spread, or the loan is priced at a spread to the Securities Industry and Financial Markets Association (SIFMA) index.

For hospitals of all sizes and levels of capital access, direct loans can offer a useful tool to obtain floating-rate exposure without certain of the risks attached to public market structures. The direct loan structure creates rollover/renewal risk at maturity but does not create public market pricing exposure to the bank's credit or week-to-week put risk. The spread to the benchmark index is purely based on the hospital's credit. Importantly, there is no deviation in that spread if the bank's rating deteriorates during the loan period.

"Drawable" Option. Bank-issued loans can be set up as tax-exempt drawable loans, which can offer cost savings to hospital borrowers funding new construction projects. Normally when borrowing in the public market, hospitals raise all of the needed capital in a single offering and then put the money in a construction or project fund that is reinvested. Due to market conditions at this point in time, hospitals may be borrowing at a capital cost in excess of 5 percent, for example, but receiving only 0.5 percent interest on the reinvested funds. This "negative arbitrage" can represent a significant amount of money over a multiyear construction program.

With drawable tax-exempt loans, the conduit issuer issues the whole amount, but the bank allows the hospital borrower to draw on the loan, as needed. The fee for this flexibility might be 25 basis points on the undrawn balance, but this approach effectively limits the hospital's negative arbitrage to the bank's "unused" fee. During construction periods that extend over multiple years, it may be cheaper for a hospital to use a drawable direct bank loan than it would be to issue VRDBs. Clearly the question is how the reductions in negative arbitrage compare to the incremental fee; in some situations, the savings could be attractive.

The tax-related issues that must be addressed are considerable, but surmountable, so direct bank loans represent an important form of variable-rate debt for hospitals and health systems. Certain banks are aggressively marketing such loans in order to build their presence in the health care market. Because public disclosure is not required for bank loans, it is impossible to gauge the actual number of transactions, but the volume nationwide is likely significant. Loans are being offered to organizations across the credit spectrum, including some unrated hospitals. Increased competition among banks for the tax-exempt business is boosting the attractiveness of loan offerings.

Federal Housing Administration (FHA) Section 242 Mortgage Insurance Program

The Office of Healthcare Programs within the U.S. Department of Housing and Urban Development (HUD) administers the Section 242 program. Chartered in 1968 to provide mortgage insurance for hospitals and health systems, the program provides credit enhancement commitments (insurance against losses) for health facility replacement, remodeling, expansion—including purchase of existing facilities, modernization, and equipment. The program has grown in size and geographic reach in past years; the FHA currently has about 100 loans in 43 states in its portfolio, reflecting more than \$8 billion in commitments to all types of healthcare organizations (see Sidebar).

Section 242 Program Participants

- Hospitals in 43 states and territories
- Acute care hospitals
- Critical access hospitals
- Large urban teaching hospitals
- System-affiliated hospitals
- For-profit, not-for-profit, and government-owned hospitals

Traditional Applications. The Section 242 program has historically provided lower-rated or non-rated credits with access to the capital markets at attractive interest rates by providing credit enhancement through the form of mortgage insurance. Among other requirements, applicants must have a minimum of a positive three-year average operating margin, debt service coverage greater than 1.25 times, and Certificate of Need (CON) approval, where required. The program is well suited for hospitals that have expansion/replacement projects that are large relative to their balance sheets and that have sufficient time to secure a mortgage insurance commitment from HUD. Once considered an “option of last resort,” many hospitals are taking a second look at the Section 242 program.

Broader Funding Applications. Recently, HUD has expanded the program through Section 223f transactions that allow funds to be used by hospitals for refinancing of non-FHA-insured debt. This program expansion is intended to help hospitals that have experienced increased borrowing costs as a result of the demise of bond insurance, downgrades of commercial banks, and the disappearance of other financing alternatives.

Several recent transactions have involved innovative uses of the FHA program and its capital commitments. For example, one organization constructed a new hospital in a suburban growth market by creating a subsidiary to complete a \$300+ million tax-exempt Section 242 financing. As a result, the parent system is not legally obligated on the new hospital project’s HUD financing, but did provide support to various components of the financing structure. Therefore, in a default situation, HUD’s recourse would not extend to the parent, but would be limited to the suburban facility actually carrying the mortgage insurance. While this legal protection may be effective, this “off balance sheet” approach may not extend to either accounting treatment or rating agency credit evaluation.

How the Program Works. HUD is a real estate lender, so the FHA Section 242 program offers credit enhancement in the form of mortgage insurance. Because HUD requires “first lien-holder status,” mortgage of *all* real property owned by the hospital is required for Section 242 commitments. Consequently, all of the hospital’s outstanding debt must generally be refinanced into the Section 242 program. Hospitals wishing to secure Section 242 financing must meet minimum financial requirements and satisfy other specific conditions.

For organizations that meet the criteria, the program offers significant leverage—up to 90 percent loan-to-value—for borrowers that need to fund large projects relative to the size of their existing balance sheet or stand alone debt capacity. “Value” includes construction costs, including equipment, capitalized

interest, and financing costs, an allowance to make the project operational (up to 2 percent of construction cost for working capital), and the appraised value of property, plant, and equipment. Mortgage terms extend up to 25 years, plus the construction period.

Standard FHA financial and reporting covenants are similar to those found in most lower-rated bond transactions. The application/approval process is extensive, often taking up to 12 months to complete, and can be more costly than a standard tax-exempt debt issuance. One unique cost related to FHA financing is the need for a financial feasibility study performed by an approved consultant.

Borrowers are able to access the tax-exempt bond market at interest rate levels equivalent to the high “A” to low “AA” rating categories. All-in cost of capital typically includes an additional one to two percent more for the fees and other expenses involved. An all-in comparative analysis typically demonstrates that the HUD structure generates appreciable savings relative to a conventional bond financing for lower-rated credits; market access improves significantly for hospitals that have weaker credit and large projects to finance.

Affordability. Hospitals should be diligent in their evaluation of whether or not they can afford the project for which they’re pursuing a Section 242 mortgage, *however* available the financing. Leveraging the organization through borrowing that further undermines the organization’s balance sheet will increase operating strains during the life of the bonds and total risk. Unanticipated events could compromise the organization’s financial position and should be considered.

Leasing

As is true in other sectors, leasing represents a major form of capital formation for investment in equipment and real estate by not-for-profit hospitals and health systems. To date, two types of leases have been common in health care: capital and operating leases. A *capital lease* is a leasing arrangement in which the lessee seeks a long-term commitment to use the asset with or without the eventual opportunity to purchase the asset. An *operating lease* is a lease with no transfer of ownership interest or title between lessor and lessee. The lessee makes “rent payments,” which are recorded as an operating expense as they occur.

Use of leases as an alternative source of capital beyond traditional bank loans and bond financings is entirely appropriate and effective in *many* cases, especially for smaller hospitals that have limited or no access to public market alternatives. This may be especially true of short-lived assets for which long-term financing may be inappropriate. However, hospital executives should be well aware of two “exploding” uses of leases and accounting changes on the near horizon that will likely significantly alter the leasing landscape.

Capital Crunch-Related Leasing. During times when organizations have to constrain or curtail their capital expenditures, leasing may look like an attractive way to move forward with projects that cannot otherwise be financed through bonds or bank loans due to limited capital and credit capacity.

Executives should ensure that leasing is not used as a means to finance projects without proper vetting through the organization’s capital decision-making process, which should define and enforce capital expenditure limits. Projects circumventing the process create an “end run” problem that is present in many hospitals and health systems. The challenging financial conditions in recent years likely exacerbated this problem in many organizations. Smaller hospitals should be particularly attuned to leasing used as an end run on the capital process.

Physician Strategies. Physician acquisition or partnership strategies, which many hospitals and health systems are pursuing aggressively at this time, may also result in significantly increased organizational lease obligations. These leases are often characterized by short amortization and relatively high total costs when compared to traditional tax-exempt debt. Many leases have difficult termination and renewal provisions, especially long-term real estate leases.

Depending upon the size of the hospital or health system, physician leases can have a large income and balance sheet impact, either individually or in aggregate. For larger organizations with significant physician-related initiatives, lease commitments may exceed traditional tax-exempt debt.

Accounting Treatment of Leases. The International Accounting Standards Board (IASB) and Financial Accounting Standards Board (FASB) have jointly developed a new approach to lease accounting. The approach requires lessees to capitalize operating leases in a manner similar to the current treatment of capital leases. Expected to be effective by mid-2011, operating leases will need to be recognized on the balance sheet, essentially as debt, which will eliminate the “off balance sheet” benefits of operating leases.

Because this new standard will increase reported debt on the balance sheet, many hospitals may experience weakened leverage ratios. This could cause some organizations to fail certain debt covenant tests in their bond/loan agreements. These ratios include debt to cash flow, maximum annual debt service coverage, cash to debt, and debt to capitalization. The shorter life may also have, in and of itself, a material impact on the maximum annual debt service.

Perhaps more importantly, this accounting change clarifies leases for what they are: an alternative form of financing that should be compared to all other available options to discern the best financing tactic at any moment in time. Leasing is a broad-based market that can accommodate smaller projects on a fairly efficient basis; for this and other reasons, it may represent an excellent alternative for smaller hospitals. However, it is likely not the only alternative and given shifting accounting and rating considerations, it is essential that financial executives have clear control over leasing review and decision-making processes within their organization.

Rating Agency View. Since the early 2000s, the three rating agencies have disregarded the distinction between operating and capital leases, treating operating leases as a debt equivalent. In various publications over recent years, Moody’s Investors Service articulated this view, indicating that although noncancelable operating leases are *off* balance sheet (at this time) for accounting purposes, such leases are *on* credit. In assessing debt capacity and credit quality, Moody’s incorporates such leases as part of an organization’s comprehensive debt program, “when material.” To date, however, none of the not-for-profit health care rating groups have incorporated operating leases in their published medians.

“A red flag goes up when leases comprise a material amount of total debt; materiality will be different for different organizations, depending on rating category, debt capacity, and structure, as well as financial performance” note Moody’s Lisa Goldstein, Senior Vice President—Team Leader, and Beth Wexler, Senior Credit Officer.² Moody’s asks the organization’s management to explain its philosophy for using operating leases instead of a more permanent debt financing, such as long-term bonds or capital leases.

Each rating agency handles leasing calculations in different ways, but because the rating agencies already treat capital and operating leases as *on* balance sheet, the new accounting standards will better align the accounting and rating agency treatment of leases.

Management Questions to Evaluate Lease Use

Lease-use philosophy

- What is management's philosophy and history related to use of capital and operating leases?
- What assets are being leased?
- Why lease versus buy? Are other funding sources being considered, such as long-term bonds or capital leases, instead of operating leases?
- Did the organization enter into the lease as a way to manage and protect against obsolescence? What is the history of managing this issue?
- If the lease were to be fully on balance sheet and incorporated with the rating debt metrics, would the organization reconsider its use?

Lease management and documentation

- What is the approval process for leases? Are lease decisions consistently made within the capital allocation process?
- Who is responsible for leases?
- How are leases documented? Is a single overall summary document maintained and reported on by type of lease (capital or operating), use (equipment or real estate), and level of commitments over time?
- Are all leases fully tracked, including those with joint ventures and affiliated entities?

Lease structure and terms

- How are the leases being structured? Are there criteria related to the asset's useful life that govern the use of leases? Who bears the residual value?
 - Are the leases cancelable or noncancelable? Are they typically renewed at maturity? What happens at the end of the lease term regarding the leased assets?
 - What secures the lease and what is the recourse to the leaseholder? Are the leases parity to the Master Trust Indenture debt with cross-default provisions?
 - Are real estate operating leases, in turn, subleased to others (within or external to the health care system)?
 - Are equipment operating leases done through a master leasing agreement? Are the terms standardized? Does the organization use its leverage to gain better overall terms?
-

Concluding Comments about Leases. As mentioned earlier, leased assets *must* be considered within the context of the organization's capital formation options and capital allocation process and be subject to organizational capital constraints. Clearly, leases can offer an attractive way for a hospital or health system to finance an asset and preserve cash under the right circumstances.

For organizations with access to a range of financing alternatives, lease use should be carefully scrutinized and controlled (see Sidebar for relevant evaluation questions). The off-balance-sheet treatment of leases is no longer an available benefit, but there may be other benefits that should be considered. For example, an organization entering a new but uncertain market with an outpatient presence might wish to lease a facility rather than own it. This provides an easier exit strategy if the organization decides that it no longer wishes to have a presence in that market. Most importantly, going forward the use of leasing for qualified projects should be carefully weighed against other funding alternatives in the tax-exempt, public and private markets.

USDA Rural Development Community Facilities Program³

The USDA Rural Development Community Facilities Program makes and guarantees loans to develop "essential community facilities," which include clinics, ambulatory care centers, hospitals, rehabilitation centers, and nursing homes, in rural areas and towns with populations of up to 20,000. These loans may be used to construct, enlarge, or improve health care facilities, including the cost to acquire land, pay professional fees, and purchase equipment required for operations.

Refinancing existing debt may be considered an eligible direct or guaranteed loan purpose if the debt being refinanced is a secondary part of the loan, is associated with the project facility, and if the applicant's creditors are unwilling to extend or modify terms in order for the new loan to be feasible.

The Community Facilities Program is similar to the FHA Section 242 financing program in that it can provide credit enhancement to specifically defined borrowers. It can guarantee loans made and serviced by lenders such as banks, savings and loans, mortgage companies that are part of bank holding companies, banks of the Farm Credit

System, or insurance companies regulated by the National Association of Insurance Commissioners. The Community Facilities Program may guarantee up to 90 percent of any loss of interest or principal on the loan. However, unlike the FHA program, the Community Facilities Program can also make direct loans to applicants who are unable to obtain commercial credit.

Rates and Terms. For the direct loan program there are three levels of interest rates available (poverty, intermediate, and market) each on a fixed basis. The poverty rate is currently set at 4.5 percent. The market rate is indexed to a rate determined by the U.S. Treasury Department. The intermediate rate is set halfway between the market and the poverty rates. Eligibility for these different interest rates is determined by the median household income (MHI) of the area being served by the borrower and the type of project being financed. The intermediate and market interest rates are adjusted quarterly.

For the guaranteed loan program, the interest rate charged is the lender's customary interest rate for similar projects. The interest rates for guaranteed loans may be fixed or variable and are determined by the lender and borrower, subject to review and approval. Loan repayment terms may not exceed the applicant authority (under State law or organizational structure), the useful life of the facility, or a maximum 40 years.

Security Requirements. Bonds or notes pledging taxes, assessments, or revenues will be accepted as security if they meet statutory requirements. Where state laws permit, a mortgage may be taken on real and personal property. Tax-exempt notes or bonds may be issued to secure direct loans but cannot be used for guaranteed loans.

Similar to the FHA Section 242 program, the standard Community Facilities Program financial and reporting covenants are consistent with most lower-rated bond transactions. The application/approval process is quite extensive but requires less time than the FHA process to complete. Nonetheless, it can be more costly than a standard tax-exempt debt issuance, including the need for an external financial feasibility study.

Applications for the Community Facilities Program are handled by USDA Rural Development field offices. For more information, access the USDA Rural Development Community Facilities Program website www.rurdev.usda.gov/HCF_CF.html.

New Market Tax Credit Program

Although appropriate for a much smaller universe of hospital borrowers, this product deserves brief mention, as a number of hospitals are using it to achieve positive financing outcomes. Signed into law as part of the Community Renewal Tax Relief Act of 2000 (Omnibus H.R. 4577), the New Markets Tax Credit program (NMTC) seeks to encourage private investment in low-income U.S. communities that historically have had poor access to capital. The program provides a 39 percent credit against federal income taxes over a seven-year period for investors (e.g., banks, insurance companies, and investment funds) that make "qualified equity investments" in "community development entities" (CDEs). The CDEs act as intermediary vehicles for the provision of loans and investments to eligible businesses under the NMTC program.

Eligibility. Entities eligible to receive NMTC financing from CDEs include corporations, partnerships, or non-profit organizations located in low-income communities. The legislation defines such communities as census tracts with a poverty rate of at least 20 percent or a median family income not exceeding 80 percent of the statewide or metropolitan area median family income. In addition, entities eligible to

receive NMTC financing must be active in low-income communities, as defined by specific criteria, such as having:

- Fifty percent or more of gross income derived from an eligible census tract; and
- Forty percent or more of services performed, and tangible property derived from, an eligible census tract.

Funding Examples. NMTC proceeds have financed a variety of projects in distressed U.S. communities for organizations such as manufacturers, alternative energy companies, charter schools, and health care providers. Hospital borrowers have accessed the NMTC program primarily to finance the purchase, construction, or renovation of projects that will provide long-term benefits to low-income communities. Examples include a children’s hospital in a low-income community on the West Coast that recently received \$30 million in NMTC funding for facility improvements and a Boston hospital that used \$20 million of NMTC funding to restore its historic medical center.

The NMTC program has been found to be an attractive financing option because NMTC loans typically have below-market interest rates (typically one to three percent below market), lower fees, and more flexible loan terms (e.g., longer amortizations and interest-only payment periods). Health care borrowers should be aware, though, of the generally increased amount of time and effort that is required to complete a financing through the NMTC program. In addition, extension of the NMTC program through 2011 is currently subject to Congressional authorization, which is expected this fall. For more information, see www.cdfifund.gov.

Debt Restructuring

Hospitals under significant financial strain, with little liquidity and high debt burden, may want to consider restructuring their existing debt portfolio. Reducing or eliminating tax-exempt bond debt and other securities can offer liquidity from immediate cash payouts and remove securities that may limit the organization’s capital position and its ability to undertake new investments.⁴

When hospitals are experiencing financial distress and are in danger of default on debt and insolvency, “investors and lenders are often prepared (and may expect) to restructure their debt, including cashing out at a discount, reducing principal and interest, stretching maturities and changing payment terms. In certain cases, these restructuring efforts may also include the compromise of some or the entire initial debt obligation,” note two experts.⁴

For example, a 550-bed hospital in upstate New York used debt restructuring as one strategy to achieve a turnaround within two years of filing for bankruptcy protection with debts of \$90+ million. The hospital negotiated a five-year deferral of debt from secured creditors, which was expected to save the hospital \$12 million during that period.⁵ Hospitals should consult with their financial advisor and legal counsel to identify whether debt restructuring can and should be pursued.

Asset Sales

Health care leaders should be asking hard questions about their existing portfolio of hospitals, businesses, services lines, and real estate to ensure that they have the right portfolio for changing competitive conditions. Divestiture of non-core assets may represent a significant capital-raising opportunity for many hospitals and health systems, and a means to focus the organization on core mission activities.

Non-Core Businesses. Businesses accumulated by hospitals and health systems during the past decades, such as long-term care facilities, home health and hospice agencies, managed care plans, joint-ventured

ambulatory surgery centers, and others may no longer be affordable or core to the organization. Businesses that are not core to the mission could be divested in order to fund core strategies.

The type of sales process selected for those non-core assets or businesses can significantly impact the monetary value of the divestiture and other benefits and considerations (see Sidebar), so hospitals will want to seek the advice of a financial advisor and legal counsel.

Types of Sales Processes

	<i>Exclusive Negotiations</i>	<i>Limited Sale</i>	<i>Controlled Sale</i>	<i>Public Auction</i>
Buyer universe	One	2 to 4	5 to 15	Many
Comfort with strategic decision to divest	Low	Low	High	High
Maintain confidentiality	High	High	Medium	Low
Risk of not closing a transaction	High	Medium	Low	Low
Maximize monetary value	Low	Medium	High	High
Maximize non-monetary value	Low	Medium	High	High
Controlling time line	Low	Low	High	High
Controlling transaction structure and documents	Low	Low	High	High
Ensure fairness/adequacy of value	Low	Medium	High	High
Time commitment from management	Low	High	Low	Low
Fairness of information disclosure	High	Low	High	High
Fiduciary responsibility	Medium	Medium	High	High

Source: Kaufman, Hall & Associates, Inc.

Real Estate. The starting point for consideration of real estate as a source of capital is a thorough assessment of an organization's existing real estate holdings. The assessment should include a close look at the current operational value of each building or land holding, its future strategic value, and the potential financial value, using appropriate criteria or metrics for each.

For the most part, hospitals will want to continue owning properties with high values across all three factors, as well as properties with high strategic value (even if they have lower operational and financial values). Generally, assets with high financial value, but lower operational and/or strategic value, should be considered as monetization opportunities. Real estate assets with low values across all three categories are more of a challenge and may represent a redevelopment opportunity. A more thorough "sell or hold" evaluation is recommended for real estate assets with mixed results.

Often real estate monetization related to buildings involves a sale/leaseback transaction, where the hospital commits to a long-term lease for a portion of the buildings it has sold. Proceeds from the sale of buildings are returned to the hospital's balance sheet, which improves liquidity and key credit rating ratios—most importantly, days cash on hand and cash to debt. However, the hospital will lose rental income and incur new occupancy expenses for the portion of space leased by the hospital. The question is whether the balance sheet benefit outweighs the incremental operating costs.

As mentioned earlier, executives must fully understand the implications of such transactions, including financial issues related to the implied cost of capital in the leaseback transaction as compared to the hospital's overall cost of capital. Strategic issues, such as ongoing control, are also important. Through long-term ground lease control provisions, it is possible to monetize certain real estate assets while still maintaining a degree of strategic control, such as restriction on competitive activities and the right to lease space.

Take Aways

The capital markets have returned to a more normal level of functioning in 2010, allowing access to external debt by organizations at all credit levels. Transactions continue to get done across the credit spectrum, at times requiring different structuring and provisions. Tax-exempt fixed-rate bonds are currently the product of choice, as hospitals move risks related to variable-rate debt off the table, but many alternatives are available to health care borrowers. Bank lending capacity has increased. Market volatility remains high and warrants close executive attention.

Action Items

1. Assess the full range of financing options, including nontraditional sources.
2. Recognize that fixed-rate bonds are the least risky debt structure available to hospitals, but they are often the most costly form of debt.
3. Be aware of the changing accounting treatment of leases (on balance sheet, like debt).
4. Ensure that leasing is not used as a means to finance projects to circumvent the hospital's capital decision-making process.
5. Scrub the hospital's existing portfolio of businesses; divest non-core assets.

Implications for Smaller Hospitals

Due to a lower scale of borrowing and credit strength, smaller hospitals typically do not have the complete range of financing options available to larger organizations. But there are public and private borrowing alternatives available if smaller hospitals are willing to invest the needed time to gain capital access. Access to direct bank lending has opened up for organizations of all credit strength. Small community hospitals may have to commit to an exclusive banking arrangement in order to secure funding.

Given industry, economic, and market trends, small organizations without significant credit strength should not continue to own businesses or operate programs that are not affordable or core to their missions. Divestiture of such assets will be key to survival.

Strategy 3. Consider Sources of Local and State Support

Due to their economic and strategic interest to rural and small communities, local hospitals may be able to secure significant support from local government authorities, businesses, and residents. For example, city officials in a town in Oklahoma pledged more than \$3 million to help a regional medical center complete its new 62-bed, \$61 million facility. Additionally, the State waived the state sales tax for materials in construction as part of its effort to defray the cost for existing industries that are helping health care in the State.

Other means of support to explore that can significantly lower a hospital's cost of capital might include:

- Obtaining the city or county's agreement to support the debt service on issued bonds, should the hospital default.
- Introducing a "millage pledge" as part of a ballot initiative (This involves a promise by the taxpayers themselves to support the bonds either directly or through an underlying guarantee of the debt service payments.)
- Utilization of enterprise or redevelopment zone financing.
- Assistance with FHA financing.

Philanthropy can represent an important piece of the capital pie but certainly should not be the foundation upon which significant capital projects are built. Should the hospital want to conduct a capital campaign or other fundraising initiative, working with local businesses or individuals to generate contributions will likely be a material source of philanthropy.

Take Aways

Local and state support can significantly lower a hospital's cost of capital and contribute to capital funding.

Action Items

1. Explore sources of local and state support.
2. Pursue philanthropic support, as appropriate.

Implications for Smaller Hospitals

Smaller hospitals can benefit from pursuing all capital options, including philanthropic donations and local and state support for specific projects. Communities with small hospitals typically are highly invested in retaining their local access to health care and hospital-related jobs. Some municipalities and districts might be able to afford direct or indirect support of the hospital; given current fiscal constraints, others may not have such means.

Strategy 4. Consider Partnership as a Broad Strategic Capital Option

Hospital leaders should consider *all* strategic options for obtaining the capital required to meet continued needs of their communities. Beyond traditional and nontraditional options available through the capital markets and asset divestiture, as described earlier, hospitals can and should consider partnering with other organizations (or physicians) that can bring capital to the table to fund specific strategic initiatives or the organization's ongoing operations.

The need for significant capital to fund new-era requirements will increase the need for such partnerships. Due to accelerating health care industry and economic trends, many hospitals and small health systems are exploring strategic partnerships with other organizations. Hospital merger and acquisition activity includes all types of partnerships between not-for-profit and/or for-profit players.

Through analysis of the hospital's current strategic and financial position, as described in Strategy 1, hospital executives should have a clear understanding of their hospitals' relative market strength and available capital capacity. The assessment must continuously be updated as market definitions change quickly. For example, regionalization, involving acquisition by systems of hospitals across state lines, is occurring with increasing frequency nationwide.

Partnership structures vary in level of integration and control, from loosely coupled strategic affiliations to comprehensive asset mergers (Figure 2). Criteria for consideration of partnerships at all levels include synergy of mission, organizational culture, market position, and financial and operational positions. A small hospital will likely be looking for a partner to help move its strategic agenda forward. The partner could be another hospital, a health system, or a group of physicians that can enable the hospital to offer new services or improve the breadth and quality of existing services. The partner would need to have a stronger financial position, depth and breadth of management and other resources, and ability to leverage economies of scale.

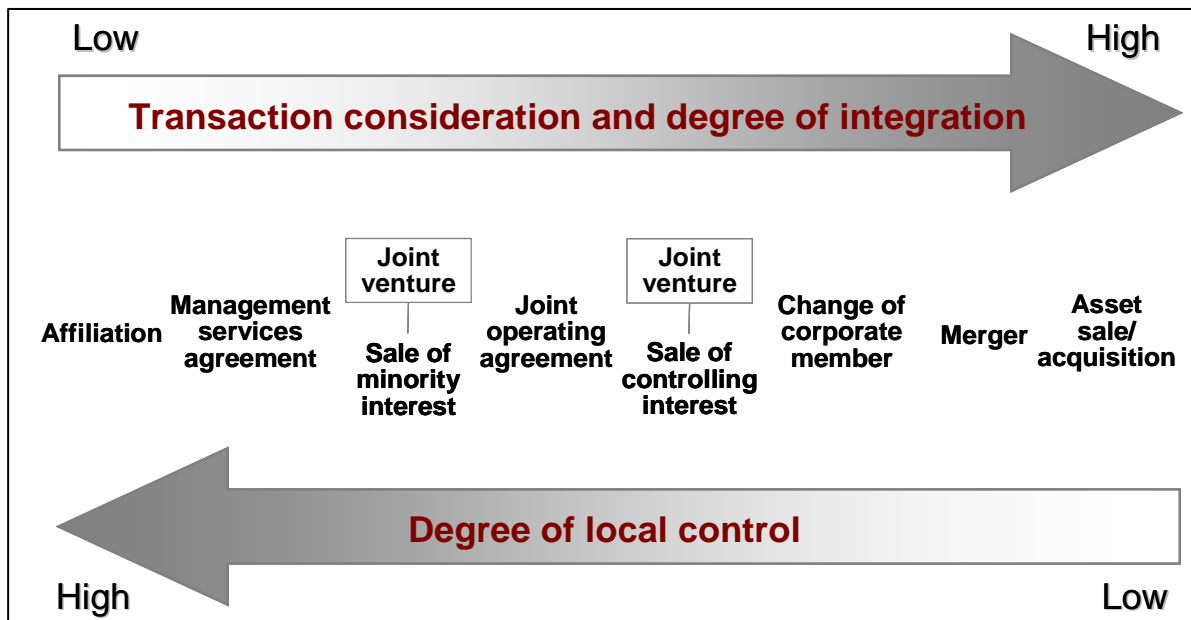


Figure 2. Range of Partnering Options
Source: Kaufman, Hall & Associates, Inc.

Partnership exploration and implementation can be exceedingly challenging on many different levels, particularly when a hospital *requires* a partner for future success. Hospitals can achieve best-fit partnerships by: clearly defining partnership objectives; identifying the broadest-possible strategic partnership options; evaluating the opportunities and risk associated with each; determining which option(s) would best enable the organization to fulfill its objectives while maintaining an acceptable level of risk; and purposefully pursuing this option. Options clearly are more numerous when an organization’s core position is solid. The Sidebar outlines four options often available to small hospitals.

Take Aways
The need for significant capital to fund new-era requirements will increase the potential benefits of strategic partnerships between health care organizations. Partnering options range from loose affiliations with a high degree of local control to fully integrated asset sales/mergers/acquisitions with a lower degree of local control. Hospital management teams and boards nationwide are identifying and securing partnerships appropriate to support the organization’s long-term strategic and financial needs.

Broad Strategic Options Available to Small Hospitals

1. Proceed as an independent provider; key considerations include whether the organization can meet defined future success requirements on its own.
2. Affiliate with a larger not-for-profit health system; key considerations include an evaluation of which objectives would and would not be addressed through affiliation.
3. Merge with a not-for-profit health system; key considerations include the role and function of local governance.
4. Divest assets to a for-profit health system and use the sale proceeds to establish a health care foundation; key considerations include the kinds of commitments that could be negotiated related to capital investment, retention of programs/services, quality of care, retention of staff, and more.

Action Items

1. Consider and pursue partnership options, as appropriate; early movers in consolidating markets will have a strategic advantage.
2. Ensure use of a structured process for making well-informed partnership decisions.

Implications for Smaller Hospitals

Marketplace pressures under the emerging new business model and health reform will challenge organizations to a much greater extent than in the past. Many stand-alone hospitals and small health systems, even strong ones, are recognizing that they do not have the strategic and financial resources required to achieve the capabilities associated with success in the new era. These competencies include close integration with physicians, information technology sophistication, balanced service distribution, and strong payor relationships.

Strategy 5. Evaluate and Select the Best Financing Strategy

Hospitals that can achieve their goals by obtaining capital via traditional capital market sources should ensure that they have clearly defined borrowing goals and then keep those goals in mind throughout the process. All capital decisions must support the organization's strategic plan, provide as much flexibility as possible given existing and pending laws or restrictions, involve the lowest overall cost for the risk of the asset and liability portfolios, and allow for future financing needs.

Evaluation Criteria

The following 11 factors should be weighed when considering each potential debt instrument:

All-In Borrowing Rate. The all-in borrowing rate represents the total cost of capital, including interest and ongoing fees involved with maintaining the financing. Historically, all-in rates have on average been lower with variable-rate debt than with fixed-rate debt, and also lower with traditional bond offerings than with nontraditional offerings.

Costs of Issuance. Tax-exempt bonds typically have higher costs of issuance than do taxable bonds, but in either case, organizations should carefully evaluate these costs. Tax law permits tax-exempt borrowers to finance costs of issuing bonds in an amount up to 2 percent of the principal issued. Such financing can cover any expenses incurred in preparing and implementing the plan of finance.

Use of Proceeds. The tax status of the financing option is determined both by the tax status of the entity for which the financing is being sought and the use of the proceeds. For example, if a tax-exempt hospital wants to use financing proceeds to build a medical office building in which independent physicians will practice, the transaction will likely need to be taxable so that the benefits of tax exemption are not provided to the individual physicians. Hospitals should seek guidance from legal counsel in this area.

Credit Position. The creditworthiness of an organization largely determines its access to financing vehicles. Publicly offered variable-rate bonds typically require either a letter of credit from a commercial bank or bond insurance with a line of credit.

Document Structure and Underlying Security Requirements. The weaker the credit, the more security is required. With some financing vehicles, such requirements can limit an organization's ability to issue debt in the future.

Covenants. There are two basic categories of covenants—maintenance and incurrence. *Maintenance covenants* are routine requirements that the borrower must meet on an annual and sometimes quarterly basis. Examples include the liquidity covenant (i.e., days cash on hand) and the debt service coverage ratio. *Incurrence covenants* are special requirements that must be met to undertake a particular action, such as sale or disposition of property. Organizations should always seek the least restrictive covenants possible.

Principal Amortization. The amortization schedule for the financing vehicle is critical to cash flow and maintenance covenants.

Interest-Rate Risk. When incurring fixed-rate debt, the borrower is insulated from interest rate fluctuations. Variable-rate debt, characterized by periodic resets of the interest rate, exposes the borrower to risk related to changing rates. The best course is to achieve a mix of fixed-rate and variable-rate debt that minimizes interest-rate risk.

Average Useful Life Versus Average Maturity. Tax-exempt financing rules require that projects eligible for tax exemption be specifically delineated in the documents that support the borrowing. The weighted economic maturity of the bonds cannot currently exceed 120 percent of the weighted average project asset life to be financed. Organizations should check with bond counsel to certify the tax-exempt eligibility of each project and the weighted average life of the financing.

Disclosure Requirements. Tax-exempt vehicles require organizations to provide prompt, accurate, complete, and continuing disclosure of certain financial and utilization information.

Prepayment Penalties and Unwind Provisions. Different financing vehicles have differing premiums or prepayment penalties associated with an early redemption date.

Selection Principles

By weighing each financing option against these 11 factors, organizations can narrow the field of options to the most appropriate financing alternatives. The best strategy in choosing a financing structure is to stick to the basics, looking toward more complicated vehicles only if they would provide known and measurable benefits. Complex financing vehicles may carry greater risk or terms that could limit an organization's current and future flexibility.

Take Aways

To choose the right capital markets financing vehicle(s) for the hospital, many factors should be weighed, including issuance costs, all-in borrowing rate, covenants, interest rate risk, and other factors. Flexibility of selected options is critical, but so is a fundamental understanding of the underlying benefits and risks of each instrument. If a hospital's financial leaders and the board members on its finance committee don't understand and cannot explain the financing approach, the hospital should not pursue it.

Action Items

1. Evaluate each debt instrument using the 11 criteria outlined in this section.
2. Ensure that the debt vehicle selected provides as much flexibility as possible and involves the lowest overall cost and risk level, given the hospital's overall asset and liability portfolios.
3. Stick to the basics: Don't select debt products that the hospital's financial leaders and the board members on its finance committee don't understand.

Implications for Smaller Hospitals

Smaller hospitals often have less flexibility in the provisions and terms of debt vehicles, but they should weigh the relevant factors outlined in this section. Covenants related to liquidity can be particularly problematic and should be fully understood prior to a transaction.

Strategy 6. Involve the Right Professionals

Strategy, legal, and financial experts can help hospitals identify, pursue, and secure a full range of capital options. Professionals with national experience bring both depth and breadth of expertise to the table. Objective advice is critical.

Because issuance of bonds is the most common way not-for-profit hospitals and health systems finance major strategic investments, the focus here is on the team that participates in the bond-issuance process. However, support from relevant outside professionals is important under any external financing alternative. In all instances, a multidisciplinary team is strongly recommended; roles and expertise vary and independence of viewpoints is critical to the terms achieved by the hospital and its ultimate financing success. Figure 3 shows the participants involved in a tax-exempt bond transaction.

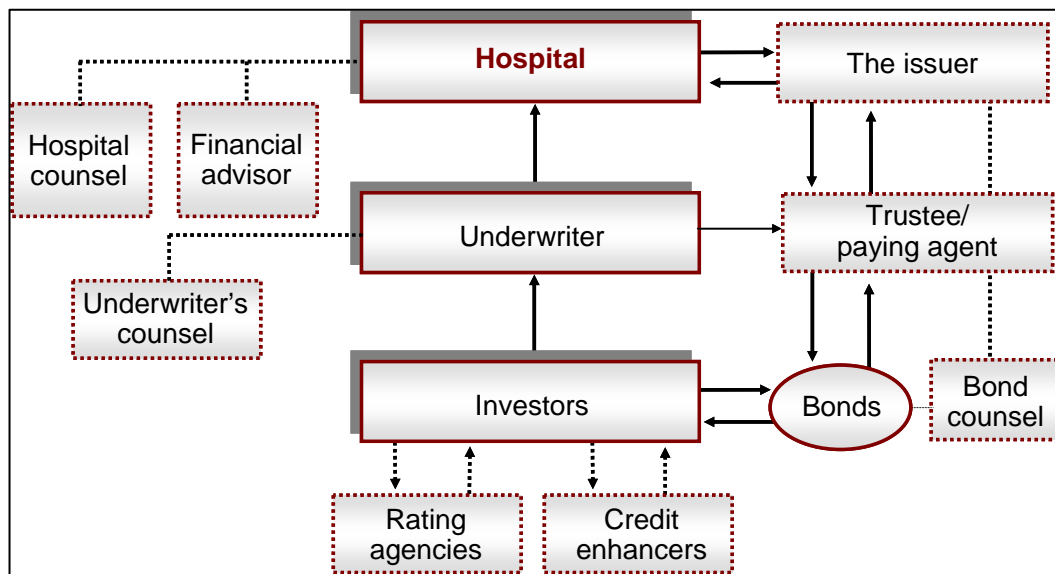


Figure 3. Participants in the Tax-Exempt Bond Financing Process
Source: Kaufman, Hall & Associates, Inc.

The Financing Team

The financing team includes individuals who represent the interest of both the borrowers and lenders/investors/issuers. A description of each follows.

The Borrower—the actual hospital or health care system “obligor” that is contractually required to repay the debt.

The Borrower’s Counsel—represents the borrower’s legal interest in the transaction and provides required corporate legal opinions.

The Borrower’s Financial Advisor—advocates for the borrower throughout the financing transaction as an independent and objective participant. Support includes counseling the borrower about final bond

and/or swap pricing terms and conditions, and guiding the borrower through the financing process described earlier.

The Issuer—the state or local government entity or “conduit” that is authorized to issue obligations that are exempt from federal income tax.

The Issuer’s Counsel—represents the issuer’s legal interest and provides required legal opinions on behalf of the issuer.

Underwriter (Investment Banker)—provides overall technical analysis and recommendations related to plan of finance decisions (working closely with the financial advisor), acts as a broker in the marketing and sale of bonds to investors, and actively participates in credit and bond insurance conversations.

Underwriter’s Counsel—represents the underwriter’s legal interest and provides required legal opinions regarding the adequacy of disclosure and the underwriter’s responsibilities.

Bond Counsel—provides the overall opinion that the bonds are tax exempt and drafts many of the basic financing transaction documents, ensuring that the bonds conform to federal and state tax code requirements, and coordinates required regulatory approvals.

Master Trustee and Bond Trustee—assumes certain fiduciary responsibilities on behalf of all master note holders under the master trust indenture. The bond trustee represents bondholders’ interests within certain parameters on a specific series of debt and coordinates payments from the borrower to the bondholders.

Auditor—typically conducts certain accounting reviews and procedures, as required by the underwriter and underwriter’s counsel, to ensure adequate disclosure of the borrower’s financial position to the investment community.

A balanced financing team can provide both national and local support. National exposure to a bond offering may be desirable because wide distribution can translate into lower interest costs. The hospital will wish to consider its legal team carefully, installing an expert bond attorney who is knowledgeable about current best practices. A local attorney who can respond to legal situations unique to the particular hospital may also be a good idea.

Role of the Financing Team

To complete a financing, the financing team evaluates the organization’s capital structure, formulates the right plan of finance, guides the organization through the ratings process, evaluates credit support options, ensures compliance with regulatory and legal due diligence requirements, drafts documents, negotiates covenants, and executes the overall financing transaction. An independent, financial advisory team can offer and apply successful strategies used by hospitals nationwide—both large and small—to accomplish these tasks.

Take Aways

Selecting the right team of experts to identify, pursue, and secure capital options is critical. For tax-exempt bond transactions, a multidisciplinary team, which brings depth and breadth of expertise and independent viewpoints, is recommended.

Action Items

1. Use a multidisciplinary team for tax-exempt bond transactions; ensure that team members have both national and local experience.
2. Understand the role of financing team members who represent the interests of both the borrower and lenders/investors/issuers.
3. Ensure that the financing team can provide independent financial advice.

Implications for Smaller Hospitals

Small hospitals that access the municipal bond market can follow all of the guidance in this section. Hospitals without access to the tax-exempt market will also need to obtain independent, objective advice about, and assistance with, financing transactions, whether through bank, government, or other programs. Advisors with national and local experience can provide the needed assistance.

Strategy 7. Stay Closely Connected

Regardless of the financing strategy selected to meet the strategic and capital needs of the hospital, the process by which that financing is implemented will require a variety of individual decisions. Financial and legal advisors with specific subject and process knowledge can provide needed expertise related to debt financing and identification and implementation of successful strategic partnership transactions. The hospital's management team and board, as appropriate, must remain actively engaged in the entire process, however; the decisions made at each step could have significant, cumulative effects on the organization's long-term strategic and financial flexibility. Advisors can help to identify such effects, but ultimately, management is responsible for understanding the implications and pursuing appropriate strategies.

For example, as a financing process moves forward, management should stay closely connected, questioning the professionals as to the full range of available alternatives related to each potential decision. No question or idea is a bad one, and management should never accept as valid a response such as "that's the way it is always done." It is particularly important for management to be closely involved with financing strategies that include funding from state or local governments or from philanthropic sources. Clearly, the maintenance of strong relationships with these sources can help maximize the capital received and manage its structure and timing.

Within the context of the organization's strategic partnership requirements, management should ensure that the advisory team fully identifies and evaluates all viable options and approaches.

Take Aways

The hospital's management team and board, as appropriate, must remain actively engaged throughout the debt financing and/or partnership exploration and transaction processes. The leadership team ultimately is responsible for understanding the implications of capital financing decisions and for pursuing appropriate strategies.

Action Items

1. Ensure that the hospital's management team and board remain actively engaged throughout the debt financing and/or partnership exploration and transaction processes.
2. Ensure that financial and other advisors explore the full range of available capital options.

Implications for Smaller Hospitals

It is particularly important for management teams of smaller hospitals to be closely involved with financing strategies that include funding from state or local governments or from philanthropic sources. Maintaining strong relationships with these sources can help maximize the capital received and manage its structure and timing.

Concluding Comments

The stakes are high. Whether hospitals are strong or not so strong, their executives cannot afford to take a wait-and-see approach to capital access. To ensure capital options in the new health care environment, leadership teams must understand available options for accessing external capital. Doing this requires that they be committed to building an in-depth understanding of their current strategic and financial position, preserving the strength of their credit position, identifying and evaluating the broadest-possible funding sources, securing the best-fit options through involving the right experts, and staying closely connected to their capital position by monitoring existing funding and new opportunities. Winning organizations will take a proactive approach.

References

1. Standard & Poor's: Tough Times Take a Toll on Credit Quality of U.S. Not-for-Profit Health Care Sector. New York, August 25, 2008.
2. Direct communication with Lisa Goldstein and Beth Wexler of Moody's Investors Service: March 2010.
3. USDA Rural Development: Community Facilities Loans and Grants. www.rurdev.usda.gov/rhs/cf/brief_cp_direct.htm (accessed October 12, 2010).
4. Kaplan, H. L., Singh, A. R.: "The Opportunity and "Duty" to Restructure Nonprofit Health Care Debt." *ABI Journal*, June 2009.
5. Financing the Future II: Report 5—Strategies for Financially Distressed Hospitals. Westchester, IL: Healthcare Financial Management Association, May 2006.

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In addition to debt financings, interest rate swaps, and many other types of derivative transactions, Mr. Jordahl's capital markets experience includes raising equity and equity-equivalent capital as well as advising on mergers, acquisitions, divestitures, joint operating agreements, fairness opinions, specific financial advisory assignments, and financial reorganizations. Mr. Jordahl received a B.A., cum laude, from Harvard College.

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