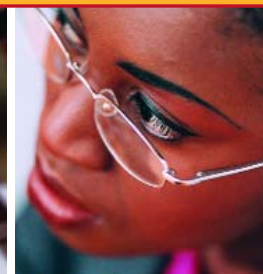


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How Are Hospitals Financing the Future?

Access to Capital in Health Care Today

**Financing the Future Report 1:
How Are Hospitals Financing the Future?
Access to Capital in Health Care Today**

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Research conducted by HFMA and
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How Are Hospitals Financing the Future? Access to Capital in Health Care Today

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financing the future

Report 1:

How Are Hospitals Financing the Future? Access to Capital in Health Care Today

Key Findings

The amount of capital accessed from traditional sources has dropped.

- Between 2001 and 2002, the total amount of capital accessed from tax-exempt and taxable bonds, equity issues, bank loans, philanthropy, and equipment leases dropped 29 percent—from \$51.4 billion in 2001 to \$36.5 billion in 2002.
- However, hospitals are accessing other types of capital, although volume is more difficult to measure. For example, sales of medical office buildings were up 22 percent in 2002, in part fueled by an increasing number of hospitals selling assets to deleverage their balance sheets.

The mix of capital sources has changed between 1997 and 2001.

- The proportion of *bank loans* decreased from 36 percent (\$19.7 billion) in 1997 to 7 percent (\$2.7 billion) in 2002.
- The proportion of *tax-exempt bond financing* increased from 39 percent to 54 percent (although the dollar volume decreased, from \$21.2 billion to \$19.8 billion).
- The proportion of *leasing* increased from 7 percent (\$3.7 billion) in 1997 to 16 percent (\$5.8 billion) in 2002.

There is a widening gap between hospitals identified as having broad access to capital and those identified as having limited access to capital.

- Between 1997 and 2001, the percentage of hospitals with broad access to capital declined, from 42 percent to 36 percent of the total hospitals reporting. But the percentage of limited-capital-access hospitals rose

even more sharply, nearly doubling from 11 percent to 19 percent.

- More limited-capital-access hospitals were urban, while more broad-access hospitals were rural than was expected based on the total population.
- There is a clear geographical split between hospitals with broad and limited access to capital. None of the top 15 states in terms of percentage of broad-access hospitals is in the top 15 for percentage of limited-access hospitals.
- Utilization played a key role in determining financial success between 1997 and 2001. On average, broad-capital-access hospitals had a 23 percent higher average daily census (ADC) than limited-capital-access hospitals. ADC in limited-access hospitals declined by 12 percent.
- Operating margins declined for both broad-capital-access and limited-capital-access hospitals between 1997 and 2001, but by a much more significant amount for limited-capital-access hospitals.

Capital is available, even to hospitals with a shaky financial profile.

- Suppliers of capital scrutinize profitability, liquidity, and capital structure; however, they also assess the “story” behind the numbers—market conditions, hospital leadership—and the strategic goals of the capital project.
- Hospitals with poor financial profiles are more highly leveraged than hospitals with excellent financial profiles, indicating that the poor-performing hospitals have been acquiring capital.

1. Setting the Scene



Almost 40 percent of patients admitted to Blythedale Children's Hospital in Valhalla, N.Y., are referred from intensive care units. For Larry Levine, Blythedale's president and CEO, the hospital's mission of

helping these very sick children is the top priority. Yet recently, deciding just how to accomplish this goal has become increasingly difficult.

Levine, like many hospital executives, performs a constant budgetary juggling act that includes keeping pace with advances in medical technology, maintaining and replacing aging equipment and facilities, and responding to information technology breakthroughs to ensure greater operational efficiency. Further complicating the issue is that the number of Medicaid and uninsured patients, and subsequent budgetary strains, keeps growing. Malpractice premiums are soaring as well.

And as if these challenges weren't enough, many revenue streams these days have slowed to a trickle. Government payments are not covering costs, and the weakened economy no longer offers the cushion of investment income. Even hospitals that find banks willing to lend them money must still consider how much debt they're truly willing—and able—to take on.

Interest rates are at a 40-year low, but rates have become a double-edged sword. Money is cheap to borrow, but falling rates mean that hospitals are earning less money on their own investments, which makes investment income a less feasible source of capital.

Hospital leaders are drawn to the healthcare field because they embrace the mission of improving the lives of the people in their communities. So despite mounting pressures, hospital leaders such as Larry Levine still look at the future with optimism. They are eager to meet rising demand for health care, eager to

take advantage of breakthroughs in healthcare delivery and technology—in short, eager to seize a unique growth opportunity in health care. But seizing that opportunity requires capital.

Financing the Future

Financing the Future is a year-long project that will give healthcare professionals the perspective and tools necessary to meet the capital challenges of today and tomorrow. Led by the Healthcare Financial Management Association (HFMA) in partnership with GE Healthcare Financial Services, with research conducted by HFMA and PricewaterhouseCoopers, *Financing the Future* is bringing together key stakeholders in the industry to quantify capital need and access, identify best practices for capital planning, provide tools for determining capital need, recommend innovative techniques for capital access, and suggest areas for policy change.

This Report

This report, the first in a series of six, focuses on access to capital: *what* are the sources, *who* has access, *how* do you get access, and steps for the future. Included are such helpful tools as a matrix of various capital sources and their uses, an explanation of a bond deal, and financial and other criteria for capital access. The report also features new research findings that illuminate the challenge of accessing capital in a period of intense financial pressure, as well as factors within hospital leaders' control to make their organizations more attractive to capital sources.

But this report is only a first step. Subsequent reports will focus on the current and future demand for capital, on the future supply of capital, on the future strategies for providers, and on implications for policy—all with the aim of helping the healthcare industry seize the opportunity to finance the future.

2. What Are the Sources of Capital?



Hospitals' capital needs are revealed by careful planning—a strategic plan that identifies short- and long-term goals, a financial plan that operationalizes those goals, and a capital plan that defines what capital

projects are necessary to fulfill the strategic goals and how to maintain the appropriate financial performance and structure to carry out the capital projects.

Hospitals have a wide range of capital sources to tap, both external and internal. But those sources are changing. The total amount of capital accessed from traditional sources has dropped in recent years, and the mix of sources used has shifted dramatically. Both changes are the result of the pressing need for capital combined with hospitals' diminishing financial condition.

External sources of capital include proceeds generated from outside transactions, including bond issuances, equity offerings, bank loans, capitalized leases or equipment pools, sales of real estate or other illiquid assets, and philanthropy. Because 85 percent of hospitals nationwide are not-for-profit entities (voluntary, religiously affiliated, or governmental), the traditional source of funding for major projects has been tax-exempt bonds.

Internal sources of capital include operating and non-operating cash flow, investment reserves, and divesting or monetizing assets. Falling profit margins have limited hospitals' ability to finance future projects with internal funding from operations. And falling interest rates and equity values have dampened returns on investment portfolios. The median return on investments for hospitals dropped 82 percent to 1.47 percent between 1999 and 2001 because of the stock market.

This drop is especially powerful when compared to returns of between 6 percent and 10 percent in the mid- to late-1990s.¹

Some types of capital are more appropriate for certain uses than others, some are only available to certain types of hospitals, and each carries its own level of risk. The sources of capital available depend directly on hospitals' ability to repay what was borrowed and fund the lender's required return while satisfying its risk appetite.

For example, tax-exempt bonds are typically used for large infrastructure projects, new buildings, and extensive renovations. Revenue bond monies are backed by revenue from operations and require the organization to maintain the revenue stream.

For another example, capital leases are traditionally used for large equipment acquisitions, such as imaging and laboratory diagnostic equipment. A capital lease may be advantageous to organizations that use equipment that employs frequently changing technology. Individual capital lease terms are directly negotiated and typically require a 36- to 84-month lease term.

The appendix of this report describes a wide range of capital sources, along with potential uses, methods of access, risks, and trends in use for each. These options will be discussed in greater detail in a forthcoming *Financing the Future* report examining the supply of capital.

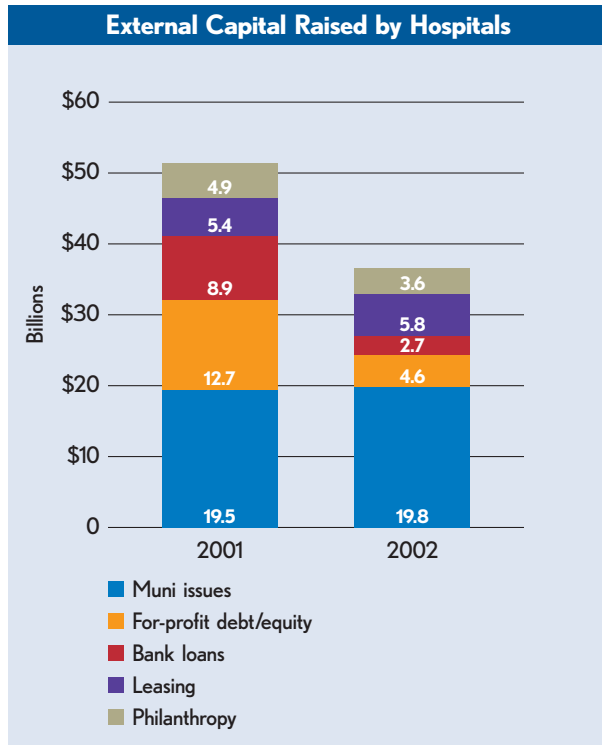
Changes in Capital Sources

Between 2001 and 2002, the total amount of capital accessed from tax-exempt and taxable bonds, equity issues, bank loans, philanthropy, and equipment leases dropped 29 percent—from \$51.4 billion in 2001 to \$36.5 billion in 2002.² (See *Exhibit 1*.) That drop amounted to \$15 billion in less capital for hospitals.

¹ Shifting Investment and Debt Portfolios of Hospitals and Health Care Systems, FitchRatings, May 1, 2003

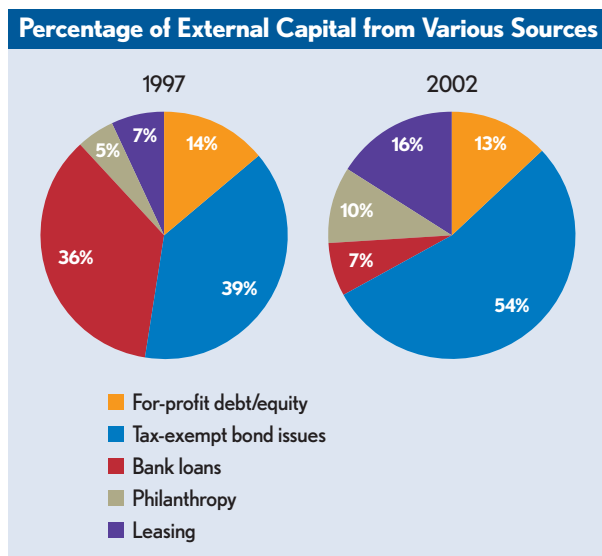
² Banc of America Securities, CMS Acute Care Hospitals report, July 2003; Association for Healthcare Philanthropy

Exhibit 1



Source: Banc of America Securities, CMS Acute Care Hospitals report, July 2003; Association for Healthcare Philanthropy; Equipment Leasing Association.

Exhibit 2



Source: Banc of America Securities, CMS Acute Care Hospitals report, July 2003; Association for Healthcare Philanthropy; Equipment Leasing Association.

If the capital raised is limited to only new tax-exempt bond issues—no refinancings—the drop is even larger: 33 percent between 2001 and 2002. That’s because nearly one-fourth of tax-exempt hospital bonds issued in 2002 were refinancings of existing debt due primarily to historically low interest rates.

This drop in total capital is attributable mainly to drops in for-profit debt/equity issues and bank loans. For-profit debt/equity issues fell from \$12.7 billion in 2001 to \$4.6 billion in 2002.

Capital from bank loans dropped 70 percent—from \$8.9 billion to \$2.7 billion—between 2001 and 2002. Finally, capital from philanthropy slumped 26 percent to \$3.6 billion.

Recent years have also seen a significant shift in the mix of capital sources. (See Exhibit 2.) Between 1997 and 2002:

- The proportion of *tax-exempt bond financing* increased from 39 percent to 54 percent, but the dollar value decreased (from \$21.2 billion to \$19.8 billion).
- The proportion of *bank loans* decreased from 36 percent (\$19.7 billion) to 7 percent (\$2.7 billion).
- The proportion of *leasing* increased from 7 percent (\$3.7 billion) to 16 percent (\$5.8 billion).
- The proportion of *philanthropy* increased from 5 percent (\$2.7 billion) to 10 percent (\$3.6 billion).

Causes and Effects of Capital Shifts

Various factors have influenced the shift in capital accessed. The increase in tax-exempt bonds can be attributed to drops in other sources of capital and to low interest rates. The significant drop in bank loans likely arises from a combination of bank consolidation, the diminishing financial health of hospitals, and a handful of high-profile bankruptcies.

The increase in the proportion of leasing is likely an outgrowth of the tightening of other sources. The increase in philanthropy also arises from the lack of access to other sources; however, it should be noted that the dollar amount of philanthropy decreased between 2001 and 2002, which can be attributed to a tough economy that meant individuals had less money to donate.

The shrinking of the amount of capital accessed from traditional sources between 2001 and 2002 does not necessarily mean that hospitals are demanding less capital. The constriction of traditional sources often means a ballooning in need for and access to alternative sources. These alternative sources may include commercial finance and insurance companies, REITS, and balance-sheet management techniques.

Although measuring the precise volume of capital coming from such sources is difficult, available data shows growth in access to alternative capital sources. For example, sales of medical office buildings were up 22 percent in 2002.³ This trend is fueled, in part, by

more hospitals selling assets to raise capital and de-leverage their balance sheets. In 2002, \$961.9 million in medical office building transactions took place, up from \$791.7 million in 2001, according to Real Capital Analytics, a New York-based research and consulting firm specializing in commercial real estate.

Thus, although some “all-weather” sources of capital will likely always be with us—such as tax-exempt bonds—the mix of capital sources is changing significantly in response to global and national economic conditions, the financial health of hospitals, and the capital needs of hospitals.

3. Who Has the Best Access to Capital?



What is the profile of a hospital with broad access to capital? A hospital with limited access to capital? Are the percentages of such hospitals increasing or decreasing? Are such hospitals found in specific areas of the country? Are

they a certain size? Do they serve a certain type of patient? Do they share certain performance characteristics?

To begin answering these and other questions about capital access, we identified two sets of criteria related to the most pervasive measures of capital access—profitability, liquidity, and debt burden. (See *Exhibit 3*.)

One set of criteria describes hospitals with sterling financial profiles—high profitability, high liquidity, and limited debt burden. These hospitals would be able to fund their own capital needs or would be considered excellent credit risks to the capital markets. For the purposes of this study, hospitals that meet these criteria are termed “broad-capital-access hospitals.”

The second set of criteria fits the profile of hospitals under significant financial strain—not profitable, not liquid, and with significant debt burden. These hospitals may have access to capital, but from a more limited number of sources and at a higher cost than hospitals with a brighter financial picture. Hospitals that meet these criteria are termed “limited-capital-access hospitals.” (See *sidebar*, Identifying “Broad Capital Access” and “Limited Capital Access” Hospitals.)

Exhibit 3

Thresholds for Categorizing Hospitals by their Ability to Access Capital		
	Broad Access	Limited Access
Operating margin	more than 2.0%	less than 0.0%
Debt service coverage ratio	more than 3.50	less than 1.25
Days cash on hand – short term	N/A	less than 5
Current ratio	more than 2.0	less than 1
Debt to capitalization	0% to 35%	less than 0% or more than 70%

³ Real Capital Analytics, Brian O. Snow, research director, Sept. 16, 2003.

We then identified which hospitals between 1997 and 2001 fit these two sets of criteria, studied how the number of broad- and limited- capital- access hospitals has changed in recent years, and identified organizational and operational characteristics associated with broad and limited capital access.

Identifying “Broad Capital Access” and “Limited Capital Access” Hospitals*

Identifying factors associated with capital access required quantifying which hospitals have relatively easy access to capital and which hospitals have more limited access.

Using criteria from rating agencies, as well as interviews with capital suppliers, we identified criteria for “broad” capital access hospitals and “limited” capital access hospitals that are far enough to the extremes of financial strength and financial weakness that nearly everyone will agree that hospitals meeting those criteria truly fall into one or the other category. We then applied those criteria to hospital financial profiles between 1997 and 2001 using Solucient databases.

Each hospital in the database was given a combined “score” based on a value of +1 for each broad-access criterion and -1 for each limited-access criterion. If the combined score was greater than 2 or less than -2, a hospital was defined as broad access or limited access, respectively. The criteria for determination are shown in Exhibit 3.

The broad or limited access score is merely an indicator of overall financial position for the individual hospital and does not mean the hospitals has no access. If a hospital is a member of a system, it may have access as part of an obligated group, although it will undoubtedly have to compete within the system for capital. Similarly, various states have funding mechanisms for “safety net” hospitals that would otherwise lack access to capital.

* Analysis conducted by PricewaterhouseCoopers

Trends in Capital Access

Between 1997 and 2001, hospitals’ capital-access position became worse and “worsen.”

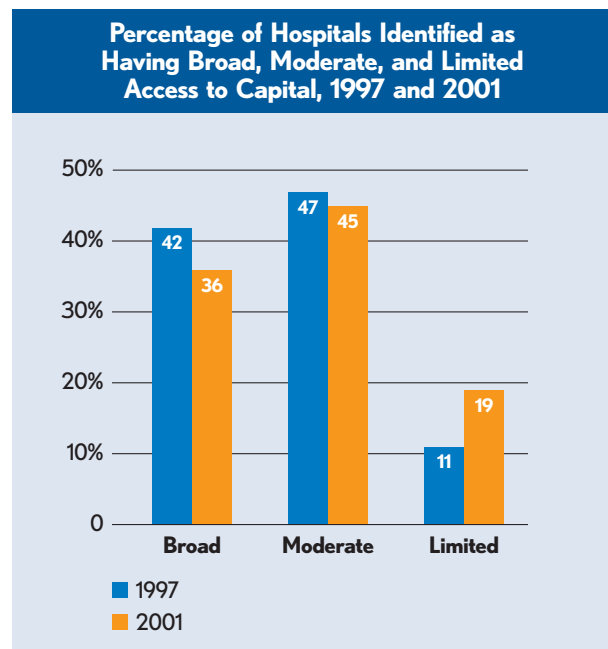
The percentage of hospitals with broad access to capital declined, from 42 percent to 36 percent of the total hospitals reporting. But the percentage of limited-capital-access hospitals rose even more sharply, nearly doubling from 11 percent to 19 percent. (See Exhibit 4.)

Financial results deteriorated for both broad-access and limited-access hospitals. However, financial results of limited-capital-access hospitals deteriorated at a much more rapid pace than those of broad-capital-access hospitals, demonstrating a widening gap between the “haves” and the “have nots.”

Organizational Characteristics Associated with Capital Access

Although no simple profile exists of a hospital with broad or limited capital access, certain organizational characteristics such as bed size, ownership, teaching status, or geography were more likely to be associated with broad or limited capital access. (See Exhibit 5.)

Exhibit 4



Source: Financing the Future, based on Solucient data.

- **Size:** Bed size was only a determinant of hospitals with broad capital access. The broad-access category had more facilities with between 100 and 400 beds and fewer small facilities (under 100 beds). Bed size was not a determinant of limited-access hospitals.
- **Government sponsorship:** Governmental hospitals tended to have a higher proportion of broad-access hospitals and a lower proportion of limited-access hospitals than the general population, which may be linked to tax-revenue access.
- **For-profit/not-for-profit:** For-profit hospitals tended to have a lower proportion of broad-access hospitals and a higher proportion of limited-access hospitals.
- **Teaching programs:** The number of teaching hospitals was disproportionately high on the lists of both broad- and limited-access hospitals, compared to the total population. The level of capital access may relate to the size of the teaching program.
- **Urban/rural:** More limited-access hospitals were urban, while more broad-access hospitals were rural than was expected based on the total population.

The Geography of Capital Access

A key differentiator between broad and limited capital access is geography. This finding likely relates to state-specific issues, such as certificate-of-need laws and Medicaid reimbursement. Some states, such as Maryland, set hospital rates; others, such as New York, bar for-profit owners.

Exhibit 6 shows the top 15 states in each category.

Key findings:

- None of the top 15 states in terms of percentage of broad-access hospitals is in the top 15 for percentage of limited-access hospitals.
- New York ranks first in both proportion and number of hospitals designated as having limited access to capital. Hawaii, the District of Columbia, and Mississippi also ranked high in percentage of hospitals defined as having limited access to capital.
- Delaware, Wisconsin, and Oregon have the highest percentage of broad-capital-access hospitals (California, Ohio, and Texas have the largest number).
- Wisconsin, Minnesota, Indiana, and Louisiana all show both high numbers and high proportions of high-capital-access hospitals.

Exhibit 5

Relationship Between Organizational Characteristics and Capital Access			
2001 Distribution			
	Total	Broad Access	Limited Access
Distribution by bed size			
0-99	56%	50%	55%
100-399	41%	46%	41%
400+	4%	4%	4%
Distribution by ownership			
Governmental	26%	28%	19%
For-profit	15%	5%	22%
Not-for-profit religious	14%	15%	15%
Not-for-profit	46%	52%	45%
Distribution by teaching status			
Non-teaching	75%	72%	72%
Teaching	25%	28%	28%
Geography			
Rural	44%	49%	35%
Urban	56%	51%	65%

Source: *Financing the Future*, based on Solucient data.

Exhibit 6

State-by-State Analysis of Capital Access				
Rank	Percentage of Broad-Access Hospitals	Number of Broad-Access Hospitals	Percentage of Limited-Access Hospitals	Number of Limited-Access Hospitals
1	DE	CA	NY	NY
2	WI	OH	HI	CA
3	OR	TX	DC	TX
4	VT	WI	MS	PA
5	MN	MN	MA	GA
6	OH	IL	AL	IL
7	NH	MI	PA	FL
8	ME	PA	CA	OH
9	CT	IN	GA	MS
10	IN	IA	OH	AL
11	MD	NC	WV	MA
12	MT	KS	RI	MI
13	IA	FL	AZ	TN
14	SC	GA	NJ	KY
15	MI	MO	LA	TN

Source: *Financing the Future*, based on Solucient data.

Exhibit 7 shows the proportion of hospitals within each state defined as having limited capital access, and Exhibit 8 shows the proportion defined as having broad capital access.

Ironically and unfortunately, the states that appear to have a high concentration of limited-capital-access hospitals also depend heavily on health care as an industry, as measured through the Milken Institute's recent Health Pole Index.⁴ Health Pole rankings combine the concentration of health care in a region's economy with its share of national healthcare employ-

ment to depict the importance of the healthcare industry to a specific region in the context of the nation as a whole. The top 10 regions ranked by importance of health care to their economies (against an index of 100.00) are shown in Exhibit 9.

The implications of this comparison are gloomy. Health care plays a vital role in the economies of major cities that are located in states whose hospitals may have limited ability to access capital. Growth of the healthcare industry may be slowed in these regions and significantly affect the local economies.

Exhibit 7

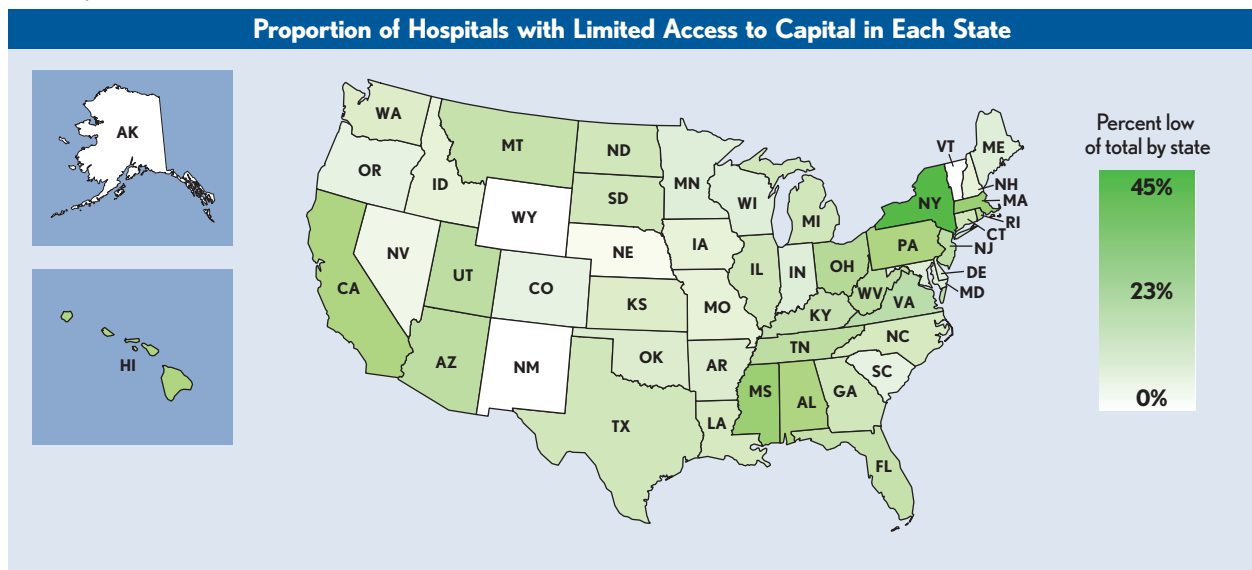
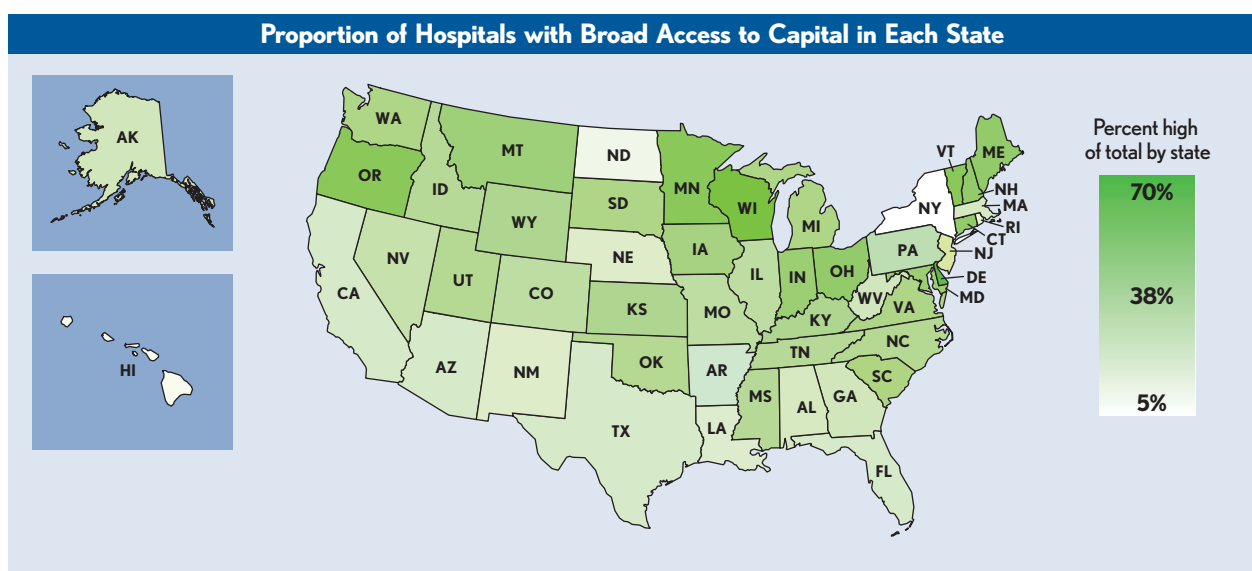


Exhibit 8



Operational Characteristics Associated with Capital Access

Research findings identify a number of operational characteristics that vary significantly between hospitals with broad capital access and limited capital access.

(See Exhibits 10 and 11.) The good news is that management can control many of these. The characteristics are:

- Overall inpatient utilization and trends in utilization
- Mix of acute and non-acute services in the facility
- Payer mix and dependency on governmental payers
- Operating margins
- Efficiency, as measured by average length of stay, full-time equivalent employees (FTEs) per occupied bed, and case-mix-adjusted expense per day

Utilization. Utilization played a key role in determining financial success between 1997 and 2001. On average, broad-capital-access hospitals had a 23 percent higher average daily census (ADC) than limited-capital-access hospitals. ADC in broad-access hospitals declined by only 1 percent in total between 1997 and 2003, while ADC in limited-access hospitals declined by 12 percent. Broad-access hospitals experienced an average increase of 6 percent in total admissions; limited-access hospitals experienced virtually no increase on average. Of course, in some broad-capital-access hospitals, higher ADC may be a factor of the hospital's larger relative size.

Service mix. Higher proportions of acute care appear to be associated with better access to capital. The percentage of acute care days (as opposed to non-acute days including post-acute, rehabilitation, and behavioral health) was 8 percent higher in broad-capital-access hospitals. Furthermore, acute-care days increased (2 percent on average) at broad-access hospitals between 1997 and 2001. On the other hand, the percentage of acute-care days declined by more than 9 percent for limited-capital-access hospitals during the same time period. Medicare case mix was 3 percent higher in broad-capital-access hospitals. And the percentage of ambulatory revenues was 11 percent higher in broad-access hospitals.

Payer mix. Although percentage of Medicare admissions was similar between broad-capital-access hospitals and limited-capital-access hospitals, the Medicaid percentage was lower in the former. Dependence on

Exhibit 9

Analysis of Capital Access and Health Care as an Economic Driver in the Community			
Region	Health Pole Index	% of Limited Access Hospitals	Rank by Highest % Limited Access
1. Boston	100.00	26%	5
2. New York	99.85	43%	1
3. Philadelphia	97.53	23%	7
4. Chicago	92.20	17%	17
5. Los Angeles	55.15	23%	8
6. Washington, D.C.	48.18	27%	3
7. Detroit	44.09	14%	24
8. Long Island, N.Y.	40.66	43%	1
9. Newark, N.J.	39.49	18%	14
10. Minneapolis	36.29	8%	36

Source: *Financing the Future*, based on Solucient data; Milken Institute

Exhibit 10

Median Financial Performance Related to Capital Access Categories		
	Broad Access	Limited Access
2001 operating margin	4.7%	-7.3%
Change in operating margin, 1997-2001	-0.6%	-5.8%
2001 days cash - short-term	33.5	2.7
Change in days cash - short-term, 1997-2001	(1.2)	(4.6)
2001 current ratio	.6	0.9
Number changed from >1 to <1, 1997-2001	-	167
2001 debt service coverage	8.3	(0.1)
2001 debt to capitalization	26%	82%

Source: *Financing the Future*, based on Solucient data

Exhibit 11

Operational Factors Associated with Access to Capital	
Limited-Capital-Access Hospitals	Broad-Capital-Access Hospitals*
High % of Medicaid	High outstanding debt
High asset turnover	Low ALOS
Low occupancy	
High % of nonsalary costs	
High % inpatients	
High ALOS	
Low productivity	

* Only two operational characteristics were identified as associated with broad-capital-access hospitals.

Source: *Financing the Future*, based on Solucient data.

governmental payers (Medicare and Medicaid) was 5 percent lower in broad-capital-access hospitals. The number of Medicare admissions increased by 10 percent in broad-capital-access hospitals between 1997 and 2001, while they decreased by 3 percent in limited-access hospitals during the same time period.

Operating margins. Operating margins declined for both broad-capital-access and limited-capital-access hospitals between 1997 and 2001, but by a much more significant amount for limited-capital-access hospitals. Operating margins for hospitals with limited capital access averaged -1.5 percent in 1997, and dropped even further to average -7.3 percent by 2001. The operating margin for hospitals with broad capital access went from 5.2 percent to 4.7 percent.

Efficiency. Higher efficiency also appears to be associated with broader capital access. Average length of stay (adjusted by Medicare case mix) was lower in broad-capital-access facilities: by 12 percent for Medicare, by 19 percent for Medicaid, and by 15 percent across all payers. The ratio of full-time-equivalent employees (FTEs) per occupied bed (adjusted for outpatient volume) was 9 percent higher in high-access hospitals, but approximately equal when adjusted for Medicare case mix. Case-mix-adjusted expense per day was 9 percent lower in broad-capital-access hospitals.

“Limited Access” Does Not Mean “No Access”

One might assume that the financial criteria used to define a limited-capital-access hospital would, on an individual basis, be a fairly good predictor that a facility would never make it through the bond insurance or rating process. However, research findings suggest these hospitals *do* have access to capital.

There was little difference between the two categories in the average age of plant—9.8 years for broad-capital-access hospitals and 10.5 years for limited-capital-access hospitals, a difference of only 7 percent. Thus, these two groups of hospitals have replaced their fixed assets at a similar rate.

Long-term debt as a percentage of net fixed assets, however, is 112 percent in limited-capital-access hospitals and 54 percent in broad-access hospitals. This

52 percent disparity may indicate that broad-capital-access hospitals financed significantly less of their capital expenditures than did limited-access hospitals, or that they have paid off their debt more quickly. It also may indicate that limited-access hospitals used their capital for other than hard assets. During the 1990s, many hospitals invested in assets such as physician groups or managed care companies.

Median total long-term debt reported by limited-access hospitals is \$18.6 million, while broad-access hospitals report \$15.0 million, a difference of 20 percent. The average annual debt service for limited-access hospitals exceeds \$1.1 million, while broad-access hospitals report approximately \$0.7 million, a difference of more than 40 percent.

Capital cost per admission, adjusted for outpatient volume, was 9 percent lower in broad-access hospitals. These observations suggest that hospitals we identify as having limited access to capital in fact have a disproportionately high debt burden. While they may be limited in access to capital in the future because of their weak financial condition, they apparently had the wherewithal to issue debt in the past. The data can't pinpoint cause and effect, but findings call into question whether facilities that issued significant amounts of debt under a pass-through capital environment are now paying the price. (*See section, “Effect of Medicare Payment on Capital Investment,” page 19.*)

Limited-access hospitals saw their debt per bed grow 47 percent between 1997 and 2001 compared to 23 percent for high-access hospitals. In addition, their long-term debt to capitalization ratio was extremely high—82 percent—compared with 26 percent for high-access hospitals.

The data also suggest that hospitals we identify as having broad capital access may have had more access to capital (internal or external) in recent years, since the transition from pass-through capital reimbursement. The average annual capital acquisitions for broad-capital-access hospitals between 1997 and 2001 was \$3.5 million per year, which is more than twice the \$1.6 million spent annually by limited-access hospitals. Clearly, limited-capital-access hospitals are accessing capital, although perhaps not from bond issuance. Where there's a will—or perhaps more accurately, a need—to access capital, there appears to be a

way, albeit from a more limited number of sources. Such sources continue to see opportunity among multiple hospital sectors.

Notes Randy Fuller, hospital segment manager for GE Healthcare Financial Solutions, “There’s no doubt that some lenders have come into the financing market or left it, driven by market cycles, economic conditions, or bankruptcy, leaving many providers with extremely

thin liquidity. No matter who continues to provide traditional sources of capital, there are alternative lending sources that can meet a variety of customers’ needs. Customers seeking alternative sources of capital should consider lenders with deep experience in the healthcare sector who can accurately assess the story behind each borrower...and find ways to do transactions that others might not consider.”

4. How Do Hospitals Get Access to Capital?



How do credit rating agencies and capital sources determine the most attractive borrowers seeking capital? Two critical elements help shape a hospital’s access to capital. One is its own financial performance,

both historical and projected, which will determine whether a hospital can take on additional debt capacity. The second is the use of new capital, and what it will mean to the organization. Thus, an effective presentation to credit suppliers includes both hard numbers and a description of hospital management, leadership, market, and strategy.

Capital needs are not determined in isolation, on a per-project basis. Rather, a hospital’s strategic plan is the driving force. A strategic plan should include the hospital’s short- and long-term goals and the steps needed to achieve them, including capital projects. The hospital’s financial plan is one component of operationalizing the strategic plan, and includes actions to ensure necessary operating margin and profit margin, funds allocated to capital projects, and projections regarding the margin and other financial indicators necessary to cover capital costs and debt service.

Who determines how much debt a hospital can carry? With the hospital’s strategic and financial plan as a starting point, management assesses how much capital the hospital needs and what the financial results will look like after the financing and the project are completed. Typically, the board also sets parameters for how much leverage is appropriate to the hospital’s particular situation.

Larry Levine, president and CEO of Blythedale Children’s Hospital, Valhalla, N.Y., is trying to determine whether, for the first time in its 110-year history, the hospital should borrow money. In the past, hospital construction was funded through federal Hill-Burton funds and philanthropy. “The issue,” states Levine, “is the same as with a home mortgage. We know what the bankers say we can borrow. But then we need to think about how much we really want our institution to finance. The final figure could be much lower.”

Depending on the type of financing, the determination of how much capital can realistically be accessed is assessed by a number of parties. For a loan or a capitalized lease, the lender itself typically makes the determination. In the case of bonds or equity offerings, a credit enhancer or a rating agency usually decides. (See sidebar, Planning and Executing a Bond Deal, p. 14.) In states with strong certificate of need programs, regulators assess the viability and public need for a

project to predict financial results. Federal tax law requires that tax-exempt bonds be issued through a municipal financing authority; although the structure of these authorities varies among states, the municipal financing authority may also be involved in the assessment of debt capacity and project viability.

Financial Performance

The old maxim that banks only lend money to people who don't need it has some truth for hospitals. With lenders needing some degree of certainty of repayment over the long term, hospitals must demonstrate financial stability and, often, growth to access capital.

By reviewing the medians issued by the rating agencies—Moody's, Standard & Poor's, and Fitch—hospitals gather clear guidance about what types of financial performance they need to achieve to garner certain ratings. (See Exhibit 12.) Overall, hospitals with higher profit margins, higher days cash on hand, and less leverage tend to get the top ratings, which translate into lower borrowing costs. However, S&P's Liz Sweeney, healthcare director, suggested that ratings are only partially related

to financial results. "Frequently, prospective clients ask us what ratios they need for specific ratings," says Sweeney. "The issue is only partially the numbers, however. What is equally, if not more, important is the story the numbers tell. We try to get a sense of what the organization is all about, how management has dealt with changes in regulations and market conditions, and how the proposed issuance fits their mission and strategy."

But strictly in terms of financial performance, the credit markets assess three categories: profitability, liquidity, and existing capital structure.

Profitability. Credit suppliers typically assess profitability using these indicators:

- Operating margin
- Total margin
- Earnings before interest, depreciation, and amortization (EBIDA) or earnings before interest, taxes, depreciation, and amortization (EBITDA)
- Changes in bad debts and uncollectible accounts
- Changes in payer mix
- Trends in revenue and expense components
- Non-operating revenue to total revenue
- Extraordinary or one-time gains and losses

Exhibit 12

Financial Performance Related to Credit Rating				
2002 Medians	Rating Category			
	AA, Aa	A	Baa, BBB	Below Investment Grade
Operating margin:				
Moody's	2.5%	19%	0.5%	-2.9%
Fitch	2.8%	1.8%	0.7%	-3.0%
S&P	2.3%	1.7%	0.8%	-2.9%
Days cash on hand:				
Moody's	226	160	97	32
Fitch	195	155	112	40
S&P	221	152	108	N/A
Debt service coverage:				
Moody's	6.6	4.1	2.9	1.3
Fitch (EBITDA DSC)	3.5	2.9	2.2	1.3
S&P (max annual)	3.8	3.2	2.7	N/A
Debt to capitalization:				
Moody's	29.9%	38.2%	45.6%	68.9%
Fitch	36.2%	39.3%	48.8%	78.6%
S&P	31.5%	34.8%	41.7%	N/A

Source: Moody's, Fitch, Standard & Poor's

“The concept of margin is foreign,” says Peter K. Markell, vice president, Finance, at Boston-based Partners HealthCare. “People must understand that ‘not-for-profit’ does not mean no margin. Margin equals capital.”

In recent years, hospitals have struggled with profitability from operations. In the past year, the aggregate total hospital margin hit 4 percent, its lowest mark since 1993.⁵ Operating margin was 2 percent, down from 4 percent in 1996. One third of all hospitals currently experience negative total margins.⁶ Hospital margins are showing some signs of strengthening due to increased volume and strong managed care rate increases, but these margins are not nearly sufficient to sustain needed levels of operating and capital budget growth.

Profitability has also been dramatically affected by falling interest income. Starting in 1995, hospitals began moving more of their investments from cash and fixed income securities into stocks. Those moves have been devastating for some systems. Traditionally, hospital profit margins have been augmented by investment returns, but in some cases, losses on investments are eating into operational profits. While hospital CFOs have no control over interest rates, their ability to manage risk in their hospital investment portfolios has been an increasing concern by ratings agencies. To manage risk, many CFOs have engaged in interest rate swaps, which are a complicated form of financing used regularly by corporate businesses but not as frequently by hospitals. In future reports, we’ll discuss these financing vehicles and the degree to which they’re used by hospitals.

Liquidity. Credit suppliers typically assess liquidity using these indicators:

- Days cash on hand—all unrestricted sources
- Days cash on hand—short-term
- Current ratio
- Debt service coverage ratio
- Days in accounts receivable
- Days in accounts payable or average payment period

Hospitals can post substantial profits without necessarily sustaining equally impressive cash flow. Conversely, hospitals that have large cash reserves can

weather rough periods of regulatory or market change. They also have funds to invest in strategic change that will allow them to avoid future financial distress.

The credit markets appear to agree. Increasingly, hospitals that have a large amount of cash or investments are viewed as the most desirable borrowers, because their cash serves as collateral for financing. Scott James, senior vice president of Cain Brothers, points out that “rating agencies and bond insurers have really raised the bar on overall days cash on hand—120 days used to be a good indicator of an A rating.” Now, to achieve an A rating, the agencies require between 152 and 160 days cash on hand.

For a large system, 160 days of cash is a sizable sum. Hospital executives privately say such a situation puts them in a quandary. They want to maintain a high credit rating to lower their cost of capital, but often would like to put the cash to work rather than let it just sit on the balance sheet. In future reports, we’ll discuss how hospitals determine how much to spend on capital needs.

Capital structure. Credit suppliers typically assess capital structure using these indicators:

- Long-term debt to capitalization or equity
- Debt to cash flow
- Average age of plant
- Asset turnover ratio

As with other industries, there is no hard and fast rule of thumb for the appropriate amount of leverage a hospital should consider. Michael Hammond, principal of Shattuck Hammond Partners, suggests that “35 percent to 40 percent long-term debt to equity appears to be a normal range for an A-rated hospital or system. Anything less than 30 percent in today’s environment of cheap capital is probably suboptimal.”

However, each organization must do its own internal assessment to determine how much leverage it can handle. Such an assessment typically includes calculating its current and future cost of capital as well as forecasting its profit margin, income from investments, and philanthropy. Organizations also need to determine their own risk profile and whether they’re willing to forgo a higher credit rating to take on more debt.

⁵ “The State of Hospitals’ Financial Health,” Chicago: American Hospital Association, 2002.

⁶ Ibid

Planning and Executing a Bond Deal

The process of issuing bonds is unique to each hospital. Exhibit 13 illustrates the typical process. Following are some important considerations for key phases of the process.

Developing the Project

Initially, hospitals must assess the feasibility of the proposed project and the hospital's debt capacity. People who may be involved are senior members of the management team, department managers, outside consultants, and board members. Often, hospitals establish a steering committee to guide the process.

Another early step is identifying all outside parties that may be involved in the process, including feasibility consultants, legal advisors, architects, investment banker, and bond issuer.

Selecting an investment banker or financial advisor is important and is often done through a request-for-proposal process. The investment banker is responsible for structuring and executing the transaction, including:

- Determining the security for the bonds, which may include the use of credit enhancement
- Obtaining a rating from Moody's, Standard & Poor's, and/or Fitch
- Coordinating the other members of the financing team
- Marketing and selling the bonds to retail and institutional investors

The hospital must identify the issuer of the bonds, typically a state financing authority or municipal issuing authority. The issuing entity usually is responsible for engaging a bond counsel firm, which is responsible for generating the financing documents and rendering an opinion on the tax-exempt status of the bonds.

Involving the right people is key. "In my experience, the smoothest deals for new developments are always with clients that, first, have excellent internal communication between their development and financing team members, and second, are willing to seek the advice of outside financial and legal advisors early in the process," according to Scott James, senior vice president of Cain Bothers. "Pitfalls of planning in a vacuum are plans that are beyond the scope of an organization's debt capacity or projects that for other reasons will not be able to obtain financing."

Developing and Executing the Financing Plan

Hospitals must determine the most cost-efficient and flexible financing plan.

Hospitals with a strong credit profile (BBB+ and above) may have many viable financing options. Hospitals with a weak profile may only have one or two options available. The financing plan may include the use of fixed- or variable-rate debt, structured products such as swaps and collars, and credit enhancement such as municipal bond insurance, bank letters of credit, and FHA mortgage insurance. To the extent a credit enhancement is used, real estate and operating covenants such as debt service coverage, days cash on hand, and additional indebtedness need to be negotiated with the credit enhancement provider.

If there is no credit enhancement, the covenants are driven by the requirements of the institutional bond investors. The hospital will have to consider these covenants carefully, because they may restrict future borrowing and use of the hospital's assets, both real estate and financial.

Executing the plan is the responsibility of the full financing team. In addition to developing financing documents, execution entails various approvals of the bond issuing authority.

Depending on project complexity and geographic location, timeframes for approvals could drastically vary. Also, "closing a new money deal requires more time than a refunding because you're having to explain to rating agencies how the additional debt can be covered, and the construction adds complexity on a number of fronts," says Pierre Bogacz, vice president at Ziegler Capital Markets. "In states with a certificate-of-need law, bed additions can take months or even years to get approved and funded."

Issuing the Bonds

The process culminates with the marketing and sale of the tax-exempt bonds by the investment banker. Typically, this is undertaken through a negotiated underwriting process whereby the investment banker ("underwriter") agrees to buy the whole bond issue from the bond issuing authority at a negotiated price and evidenced by a purchase contract. The underwriter is then at risk and responsible for selling the bonds to the investor community. Delivery of the bonds typically occurs within two weeks of the bond sale.

Timetable of a Bond Deal																			
Month:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Development Phase																			
Internal Feasibility and Debt Capacity Analysis																			
Reimbursement Resolution and Board Approval for Project																			
Local Zoning and Site Control																			
Project Scope Development																			
Design																			
Appraisal																			
Approval Phase																			
Environmental Review and Approvals																			
Certificate of Need Review and Approval (if CON State)																			
Financing Plan Determination																			
Taxable vs. Tax Exempt																			
Equity Contribution																			
Security Structure for Debt-Credit Enhancement																			
Solicitation for Credit Enhancement																			
Bond Issuing Authority Approval Process																			
TEFRA Hearing: A public hearing established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). This hearing is held in the issuer's jurisdiction to allow the public to ask questions about the pending project and financing. The public must be notified 14 days prior to the date of the TEFRA hearing.																			
Inducement resolution: The adoption by the governmental entity that will be issuing a tax-exempt bond of a formal resolution supporting the applicant's request for financing. The resolution is typically adopted at a regularly scheduled meeting of the governmental entity (i.e. city council meeting). Inducements are valid up to a specific date as determined by the governmental entity.																			
Other Local Government Approvals																			
Transaction Preparation																			
Determination of Security Structure																			
Transaction Documentation and Development of Preliminary Official Statement																			
Obtain Rating																			
Issuance																			
Marketing and Pricing of Securities																			
Bid out Investment of Proceeds and Structured Products (if any): This is a process whereby proposals from financial services companies are evaluated to manage the proceeds from the bond issuance until they are needed to be spent in a set of products that are structured or designed to meet the investor's need to maximize return and manage risk.																			
Closing and Delivery of Securities																			

The “Story”

By combining a hospital’s unique circumstances, its financial plan, its capital plan, and its financial profile, a picture emerges that determines capital access.

“Debt capacity is not as formulaic as people would like it to be; it needs to be driven by strategy,” says Jim Costello, senior vice president of Lehman Brothers.

The credit markets view financial indicators as a first step in assessing debt capacity and creditworthiness. The second step considers a number of qualitative factors, especially the relationship between the use of the proposed capital, the hospital’s circumstances, and the hospital’s strategic and business plan. The capital markets want to know whether the capital project will generate profits through enhanced revenue, enhanced efficiencies, or improved competitive position.

Some of the major qualitative considerations are:

- Ownership, affiliation, and tax status
- Governance, management, employees, and medical staff
- Regulatory and economic environment
- Competitive conditions and trends

Ownership, affiliation, and tax status. In general, hospitals that are part of systems tend to have better access to capital. Rating agencies may allow systems to achieve higher credit ratings with some lower thresholds—such as days cash on hand—because they generally see less risk in a system than a stand-alone hospital. In addition, stand-alone hospitals that are purchased by for-profit systems nearly always cite access to capital as one of the advantages to joining the system. Because for-profit hospitals have access to the equity markets, which are closed to not-for-profits, they are perceived to have an easier journey on the road to capital access.

However, exceptions exist to both of these maxims. For example, hospitals that are part of systems—regardless of whether they’re for-profit or not-for-profit—often go through a rigorous process to gain capital within the system itself. A stand-alone hospital in a shrinking market that couldn’t borrow money by itself may not be able to make a case for capital from a system either. In addition, a system may require an equal or greater degree of financial discipline to access its capital.

Hospitals that are part of academic medical centers or universities face special issues. “Internal competition for capital is often fierce,” says Jim Costello of Lehman Brothers. “The mission of an academic medical center clearly places research at the center, though the patient care dimension of an academic medical center or university requires significant capital investments that are an important element of the overall research and academic mission. The challenge, of course, is to balance the competing capital needs between the research and patient care activities of the institution.”

In addition, access to capital for investor-owned systems ebbs and flows with the stock market. While 2001 was a strong year for equity offerings, interest waned in 2002 and 2003. In recent years, equity offerings represented a low percentage of capital for hospitals, usually less than 5 percent.

Governance, management, employees, and medical staff. Rating agencies and bond insurers place great importance on governance, management, and staff stability. The issues that were most frequently cited by the capital markets as critical to the financing decision were:

- *Governance:* Is the board involved in a meaningful way in strategic decision-making for the hospital? Does the board have the necessary skills to make informed decisions? Do skills of board members complement those of the management team?
- *Management:* Has management proven its ability to weather regulatory change and market threats? Do senior managers inform and educate their board? Do they have demonstrated relevant experience? Do they use effective methods to monitor and improve performance? Do they use systematic strategic and financial planning? Do they assess and serve community needs?
- *Employees:* How have labor conditions in the market-place affected quality and cost? How stable is the employee base?
- *Medical staff:* How loyal is the medical staff, and are physicians typically “splitters” with other institutions? Can the medical staff sustain long-term growth in volumes? Does the medical staff contain the right mix of specialties?

- *Overall integrity:* Does the organization have proper controls in place that ensure integrity with ethical, regulatory, and legal standards? Is the management team trustworthy?

Regulatory and economic environment. Changes in Medicare, Medicaid, and regulations all affect how a hospital generates, saves, and spends cash, which in turn affects need for and access to capital. For example, hospitals will need to spend a significant amount of funds on disaster readiness. The credit markets also view creditworthiness in terms of the underlying economy surrounding the hospital. Economically challenged areas tend to see increasing numbers of uninsured or underinsured patients, as well as population declines.

However, challenging external forces are not by themselves a red light for capital access. As Ray Sweeney, executive vice president of the Hospital Association of New York State, says, “Lenders don’t avoid lending to hospitals based on changes in regulations that affect all institutions. The real key is management’s proven track record in responding to regulatory changes, relative to competitors.”

Market conditions and trends. No hospital is an island, and its role in the industry as well as its market is an important consideration for capital access. Notes Craig Kornett, senior director of Fitch Ratings, “We like to see organizations investing their bond proceeds in projects that build on strengths they already have, programs that fit with their current missions and strategies and that strengthen their core businesses. Major market share shifts for new services and programs have traditionally been more difficult for hospitals to achieve, and therefore the returns on investment of bond proceeds have been smaller.”

Market assessment includes regulatory environment. For example, according to Pierre Bogacz, vice president at Ziegler, “Lack of competition is a big factor. Investors like facilities in states that have certificates of need.”

And competition extends to the credit market itself. A key factor in a credit enhancer’s decision may include other deals that it insures in the same marketplace. A credit enhancer is less likely to insure a hospital that competes directly with one already in its portfolio.

Preparing to Access Capital

The amount of capital needed is just one of many considerations hospitals make while preparing to access capital. Hospitals must consider the cost of capital, the need to enhance credit, and the means to enhance debt capacity, such as monetizing assets.

Cost of capital. One of the reasons the hospital bond market has been so robust lately is that interest rates are at historic lows. “There’s a sale on money,” says Shattuck Hammond’s Michael Hammond. “You should be able to exceed a 5 percent return on investable assets.”

Projects that have an expected return that is greater than the organization’s weighted average cost of capital (WACC) will generate additional free cash flow and will create a positive net present value. Capital expenditures that earn less than an organization’s WACC will result in a decrease in value.

Credit enhancement. When hospitals want to access capital, the first determination is whether the hospital can obtain an investment grade rating and whether the rating requires credit enhancement. In general, the ability to obtain credit enhancement has proven more difficult in recent years. Moody’s, S&P, and Fitch all extend ratings based on their own criteria. If the deal includes credit enhancement, the rating may be little more than a formality; the check of creditworthiness will be made during the application process for credit enhancement.

Financial guarantors are an integral part of the healthcare financing market, bridging the gap for many organizations by insuring healthcare credits. In 1998, 60 percent of municipal bond issuances were commercially insured, but that percentage had dropped to 27 percent by 2000 (the most recent data available).⁷ The last few years have seen an increase of commercially insured bond deals, but nothing matching the peak in 1998. Some guarantors have changed their criteria for underwriting bond insurance, essentially defensive maneuvers that respond to greater default risks of some healthcare organizations. Not only have underwriting guidelines tightened, but bond insurance prices have increased as well, with premiums estimated to have doubled since 1998.⁸

⁷ Ziegler Capital Markets Group, “Capital Access Issues: Recent and Current Environment,” South Carolina HFMA Annual Institute, June 4, 2003.

⁸ Cain Brothers, “Is the Sky Falling? Capital Leaves Healthcare,” *Strategies in Capital Finance*, Spring 2000, Volume 29.

Federal and state credit enhancement programs exist, including the Federal Housing Administration (FHA) 242 mortgage insurance program, which recently began extending its reach beyond the Northeast. (See sidebar, *FHA's Expanding Role*.)

However, some hospitals' financial results and underlying creditworthiness make them unacceptable risks for either commercial or FHA insurance. Some states have specific programs to provide credit enhancement for uninsurable hospitals that are deemed "safety net" facilities.

Monetizing assets. Monetizing assets—such as medical office buildings and ambulatory care facilities—is not just a means to generate cash, but also to enhance debt capacity, both of which can help hospitals fund "core"

acute care projects. Moving medical office buildings and ambulatory care facilities off the balance sheet means less leverage for the hospital, which can improve its rating. Often, lenders discount the earnings from non-core assets because they lie outside the hospital's core operations. Hospitals often find they will increase their borrowing power by converting the asset to cash.

To monetize assets, hospitals increasingly turn to third-party ownership alternatives, such as real estate investment trusts (REITs). Seven publicly traded REITs specialize in health care, as do a handful of private firms. "Except in strategic situations, many medical office buildings no longer need to be owned by the hospitals, so we're seeing more third-party models," says Pierre Bogacz, vice president at Ziegler. "There

FHA's Expanding Role

The FHA 242 program, which typically is used by hospitals that do not meet commercial credit enhancement criteria, is expanding its reach. Until recently, almost all of the 242 program's portfolio rested in New York and New Jersey because of the struggling financial condition of hospitals in those states. Now, "the goal of the FHA mortgage insurance program at this point is to diversify its portfolio of insured facilities and thereby build protection for the program. We want to maintain public accessibility for the long term," says Chris Boesen, director of the Office of Insured Facilities in the U.S. Department of Housing and Urban Development.

The 242 program may be used for new buildings and renovations and all costs normally associated with a capital improvement project. There is no limit on the amount of debt that can be insured; the mortgage can cover up to 90 percent of the replacement value of the assets pledged as security for the debt.

In the past, hospitals often avoided the FHA 242 program because its fees were higher, the application process took longer, and the liens and covenants were more restrictive. With the increase in commer-

cial insurance premiums, tightening commercial insurance criteria, and an overhaul of the FHA application process to shorten the financing timeline, more rural and urban hospitals throughout the country are applying for the program. Applicants now include critical access hospitals, major teaching programs, capital requests for assets other than bricks and mortar or acute care beds, and significant proportions of refinancing.

HUD officials say the number of hospitals on its watch list has not increased despite national deteriorations in healthcare credit and well-publicized defaults of commercially insured facilities. Boesen points out that the application process, which hospitals viewed as cumbersome in the past, is actually "an added protection for the board and management. We have eliminated a lot of the 'process' in the application and retained the 'substance.' Our extensive upfront application review, the covenants and reserves we build into the deal, and our active monitoring process provide additional assurance to the board and bondholders that the hospital will be able to service its debt."

are a lot of untapped opportunities out there if the CFO is willing to go through the balance sheet item by item and review all assets and liabilities based on the institution's strategic plan."

That sentiment is echoed by Todd Lillibridge, president and CEO of Lillibridge Healthcare Real Estate Trust, a Chicago-based real estate investment trust: "Five years ago, approximately 70 percent of the market was not thinking about using their capital more effectively through monetization. Today, roughly 60 percent of the market is in a two- to three-year analysis process, and approximately 20 percent-plus of the market is currently leveraging their capital more effectively."

Effect of Medicare Payment on Capital Investment

Under the current system, regardless of whether a hospital spends capital, it receives the Medicare capital cost component for inpatient discharges. Incremental capital payment is not tied to actual capital expenditures, unless the capital project results in additional Medicare volume. Hospitals that invested in the plant during the days of "pass-through" are now caught in a downward spiral. (See sidebar, North General Hospital's Predicament.)

Because the 1990s were times of underinvestment in hospital infrastructure, executives often used the "add-on" to pay for operational costs. In effect, that meant they were using funds for tomorrow's development on today's operations.

An example of the impact of payment methodology on capital spending is already being observed in one segment of the industry. Nearly one-third of rural hospitals have converted to critical access hospitals, which means they have reverted to cost-based reimbursement. Already, those hospitals have increased their level of capital investment. Capital expenditures increased 37 percent at critical access hospitals, compared with 31 percent for other similar rural hospitals that did not convert to critical access, according to a recent University of Minnesota study.⁹ The study said these percentages may not be statistically significant because of the "lumpy" nature of capital expenditures. However, critical access status did affect these hospitals'

North General Hospital's Predicament

In the 1980s, North General Hospital (NGH), a 200-bed hospital in Harlem in New York, began plans to build a replacement facility for its rapidly aging physical plant. Through a combination of political capital and state subsidization, NGH built a \$150-million facility that opened in 1992.

At the opening, NGH had a capital cost per discharge of \$1,750. The planning work that supported this project anticipated a continuation of pass-through capital from government payers, which made up 90 percent of NGH's business.

But in 1992, Medicare began transitioning to its federal rate for capital. Because NGH was new and its debt burden was high, its transition was downward. And its current fully federal capital rate is \$450. In total, this transition has meant more than \$11 million to NGH since 1992 and more than \$2 million on an annual basis in lower Medicare capital reimbursement.

"Hospitals that issued debt in the late 1980s and have large capital cost structures face a constant struggle to make enough of a return on operations to cover capital cost," says Domenic Segalla, the hospital's CFO.

capital structure. The hospitals became more profitable, prompting them to depend less on local donations and government support, the study reported.

An Ongoing Challenge

No matter how large, how well-known, or how well operated, all hospitals today expend an enormous amount of energy maintaining the best possible financial profile, in large part to ensure access to funds needed to maintain competitive position and to meet increasing demand. "In the end," says Partners' Peter Markell, "it's all about cash. If you can make money, there will be plenty of capital." The problem is, making money is not so easy to do in health care today.

⁹ The Financial Effects of Critical Access Hospital Conversion, Jeffrey Stensland, Ph.D., Project Hope, Gestur Davidson, Ph.D, Ira Moscovice, Ph.D., Rural Health Research Center, Division of Health Services Research and Policy, School of Public Health, University of Minnesota, January 2003.

5. Steps Toward the Future



Capital is available to hospitals, and many, if not all, hospitals seem to access capital on a regular basis. Although the gap between the “haves” and the “have nots” has been widening in terms of financial results, hospitals at all levels of

financial performance and creditworthiness appear to have had access to capital over recent years.

Nonetheless, access to capital remains highly rooted in the three measures of financial stability: profitability, liquidity, and capital structure. However, suppliers of capital are not only interested in “the numbers.”

Management can make its case for capital access more compelling by focusing on the “story” behind the numbers. This “story” should be grounded in a solid strategic plan. Hospitals seeking to make their case to capital suppliers would be well-advised to consider the following practical suggestions:

- *Know thyself.* Watch the trends in your own numbers and benchmark yourself against reasonable competitors.
- *Know the gap.* Set a series of organizational goals in terms of overall leverage and profitability; set a goal for return on investment (ROI) of future expenditures. Run financial scenarios that show you achieving those goals over a period of time, and figure out how big the difference is between who you are and what you want to be.

- *Know what you want.* Understand the financial implications of the strategies you want to achieve and the services you want to provide. See what services make and lose money now; are there any that are not core to your mission that you can divest? Understand the ROI of any expenditure you plan to make in the future.
- *Know what you can afford.* Constantly challenge and question expenditures. Make sure that the expenditure meets your target ROI or that there is some other significant reason to spend.

The senior financial executive has the unique and vital role of assessing each decision in financial terms. It’s up to you to make sure that others in the organization (your board and other senior management team members) understand the implications of your hospital’s spending actions. The age-old question of mission or margin has re-emerged. If you can’t make a positive margin, it’s clear that the capital markets are going to be less willing to lend to you. And then you can’t meet your mission goals. Expenditures become much less critical to a hospital’s mission when they are shown to hurt the financial position or to prevent the achievement of other goals.

The next *Financing the Future* report will be released in January 2004. It will look closely at the *need* for capital. The report will explain and quantify the catalysts of capital spending, and will discuss how capital spending is changing. Forthcoming reports will forecast the demand and supply of capital into the future, offering tools to help hospitals improve their financial performance and practical strategies for capital planning and access—all of which will help the healthcare field *Finance the Future*.

Appendix: Sources of Capital

Healthcare organizations must find capital to survive. Some organizations are reducing capital needs by delaying building and expansion plans, while other organizations are charting a new course by accessing new or little-used sources of capital. One thing is certain: organizations that wish to thrive must be able to respond to changing conditions quickly. The information that follows is a “nuts and bolts” view of many of the capital sources available to healthcare organizations. Some of these capital sources are traditional, such as bonds, bank loans, and philanthropy. Some of them are less well-known, such as sale of assets, leases, REITS, and partnerships, but may grow to be a regular and primary source of healthcare capital in the future.

The paragraphs below describe each source of capital or credit enhancement. The matrixes that follow provide an at-a-glance view of the uses, access methods, and risks of each.

Capital Sources

Tax-exempt bonds. Revenue bonds are limited liability obligations. The security for revenue bond issues is provided by a pledge of a specific revenue stream—usually derived from the project being funded or the enterprise. There may also be a mortgage on the property financed. Revenue bonds may be supported by a third-party credit enhancement (i.e., bank letter of credit, bond insurance, FHA mortgage insurance).

General acute care hospitals issued 2 percent more bonds in 2002 than in 2001¹, showing an overall tightening of the tax-exempt bond market as investors become more selective and credit enhancement costs continue to increase. Additionally, investors are requiring more financial disclosure and transparency in the reporting process.

As an alternative to the traditional bond market, some healthcare organizations are pursuing creative financing methods that include synthetic floating rate

debt and off-balance sheet monetization. Synthetic floating bonds are the result of a conversion from fixed rate liabilities to floating rate liabilities through an interest rate swap.² In off-balance sheet monetization transactions, hospitals typically sell non-core assets such as medical office buildings, but still retain control of tenants and some fees.

Taxable bonds. Taxable bonds are used by for-profit healthcare companies that do not have access to the tax-exempt or municipal bond markets. They are also used by not-for-profit organizations for hospital-related uses not qualifying for tax-exempt financing, such as medical office buildings.

Currently, historically low taxable interest rates and compressed spreads between taxable and tax-exempt interest rates have increased the attractiveness of the corporate and taxable municipal bond market, resulting in significant taxable bond issuances in recent years.³

Venture capital and public equity offerings. Venture capital funds (VCs) provide early-stage money and operating assistance for companies as they navigate from a business concept to a public company. As a company becomes more mature, it may “go public” through an initial public offering (IPO). To raise additional capital, the company may sell stock through secondary offerings.

Sixteen healthcare companies went public in 2002, and to date, one has gone public in 2003. The majority of healthcare IPOs have been successful, and the companies are trading above their initial offering price. Most of the recent IPOs are small medical device manufacturers.⁴

Sale of assets. One method that some hospitals have used to raise capital is to sell the hospital to another hospital or a healthcare system. Sometimes, this results in a change in tax status for the acquired hospital. This method is typically used by hospitals that perceive a

¹ Center for Medicare and Medicaid Services, “Healthcare Industry Market Update - Acute Care Hospitals,” April 29, 2002.

² Healthcare Finance Forum, “The Future of Not-for-Profit Healthcare Capital Financing,” June 14, 2002.

³ Center for Medicare and Medicaid Services, “Healthcare Industry Market Update-Acute Care hospitals,” April 29, 2002.

⁴ Jenks Healthcare Business Report, “Health Care IPO Door Opens, But Just a Crack,” July 2003.

lack of access to capital in the markets and may result in conversion of a not-for-profit hospital to a for-profit hospital.

Between 1970 and 1995, 7 percent of non-profit hospitals converted from non-profit to for-profit status.⁵ As institutions continue to look at this option, there is a growing regulatory movement to prohibit the transfer of community assets outside of states, hindering these conversions to large for-profit corporations.

In addition, many hospital systems are selling certain real estate assets, such as medical office buildings and outpatient buildings. Such sales help hospitals deleverage their balance sheets and can help minimize possible regulatory and legal risks that arise when hospitals lease to physicians.

Banks and other financial services companies. Banks and other financial services companies offer a variety of financing options including mortgage loans, credit and/or liquidity enhancement facilities, working capital loans, term loans, revenue and/or tax anticipation notes, equipment loans and leases, and financial derivatives. Banks also may provide letters of credit that enhance a hospital's ability to access capital. Banks typically work with organizations that have healthy balance sheets and strong debt service capabilities, while commercial finance companies will do deals that span a broad spectrum of provider types and financial profiles.

The availability of capital from commercial banks was greatly reduced in the late 1990s, but has shown some growth very recently, even as the consolidation of the banking industry has reduced the number of lenders.

Capital leases. Banks, financial services companies, and equipment manufacturers provide capital lease options that allow healthcare companies to obtain equipment while avoiding the full cost of purchasing.

Currently, an estimated 30 to 50 percent of imaging diagnostic systems are leased.⁶ The estimated size of the healthcare equipment leasing market in 2002 was \$5.8 billion in new volume and is projected to reach \$7.4 billion in volume by 2005.⁷

Joint ventures (JVs) or partnerships. JVs are partnerships formed to share risk and expertise and as a method for one organization to access capital through another organization. Generally, JVs involve physicians who want some management and financial control in a venture, such as an ambulatory surgery center.

The boom in specialty hospitals and ambulatory surgery centers has been financed in large part by physician private company partnerships, although some have been done with physician/hospital partnerships.

Real estate investment trusts (REITS). REITS provide capital through the purchase of healthcare properties and realize their investment return through the subsequent property lease.

The sale of hospital assets to REITS, especially medical office buildings (MOBs), is becoming more advantageous to healthcare organizations. Analysts believe that several trends will increase this market, including rising real estate values, new buyers entering the market, MOB purchasers being more comfortable with healthcare organizations retaining some operational control of the sold properties, and the increased risk of hospitals remaining in a landlord position.⁸

Private philanthropy. Charitable trusts and foundations and individual donors can be a source of capital for hospitals. Recently, healthcare philanthropy has declined. Total cash donations fell from \$4.89 billion in 2001 to \$3.64 billion in 2002,⁹ although the proportion of philanthropy as a source of capital increased between 1997 and 2001.

Public grants. Government grants are often available to health systems that serve a special purpose such as rural or critical access hospitals. Many states are currently using tobacco settlement monies for healthcare grant programs.

With many state legislatures looking to bridge large budget gaps, various cost savings and revenue enhancement methods are being discussed. Tobacco settlement revenue has provided a steady source of healthcare grant money during the last few years and is slated to continue for the next decade under many state settlement terms. One potential risk is that states may attempt to securitize these "annuities" to address budget deficits resulting from the economic downturn.

⁵ Cain Brothers, "What Does the Research Say About Hospital Tax Status Conversions?" *Strategies in Capital Finance*, July 2002, Volume 38.

⁶ R.S. Carmichael & Co. Inc., "Healthcare Equipment Leasing, 2003: U.S. Market Dynamics and Outlook," *Equipment Leasing Association*, January 8, 2003.

⁷ *Ibid*

⁸ Cain Brothers, "From Strategic Assets to Tactical Investments," *Strategies in Capital Finance*, Summer 2003, Volume 41.

⁹ Association for Healthcare Philanthropy, "Report on Giving FY 2002," (draft document).

Credit Enhancement Sources

Letter of credit. Letters of credit are an unconditional and irrevocable guarantee from a bank in the form of a sight draft. Typically, a letter of credit is drawn on to make debt service payments on bonds, and then the bank is reimbursed by the borrower. The letter of credit enables the bonds to obtain the short-term and long-term ratings of the bank providing the letter of credit.

Letter of credit availability decreased significantly in the 1990s due to bank consolidation and perceived decline of the credit quality of the healthcare sector. Recently, availability has increased and pricing has stabilized.

Bond insurance. Bond insurance is an unconditional and irrevocable commitment from a municipal bond insurance company to make scheduled bond debt service payments in the event of non-payment by the underlying borrower. The bonds secured by the municipal bond insurance policy carry the rating of the municipal bond insurer.

The bond insurers AMBAC, FGIC, and MBIA are effectively out of the healthcare market except for very high-quality providers. The bond insurers ACA, Radian Asset Assurance, and FSA are still in market for BBB and better credits.

FHA section 242 mortgage insurance. FHA 242 mortgage insurance provides a credit enhancement to tax exempt or taxable debt. The 242 program does not limit the amount of insurance, but there is a maximum 25-year mortgage term. An FHA-insured mortgage can cover up to 90 percent of the replacement value of the assets pledged as security for the debt.

Until very recently, the 242 program was used primarily in New York and New Jersey. However, because of the program's success, it is now expanding to additional states.¹⁰ More recently, the 242 program is being used for Medicare-designated critical access hospitals—hospitals that receive cost-based rather than formula-based reimbursement from Medicare.

Local taxes. Public tax-supported healthcare organizations often have the ability to increase revenues through local taxing authorities.

As federal and state governments push current budget shortfalls down to local units of government, tax burdens are continuing to increase. Saddled with a soft local economy in many areas, public hospitals may find it harder to make a successful case for further tax increases.

¹⁰ Health Care Finance On-Line, "The Revolution of HUD 242," April 2002.

Capital Sources at a Glance

Capital Source	Best Use	Access Method	Risks
Tax-exempt Bonds	Large infrastructure projects, new buildings, extensive renovations.	Bonds are issued by a government authority on behalf of an institution that is a government-supported or non-profit 501(c)3 health system.	Access is limited by an organization's credit profile and debt capacity. Revenue bond monies are backed by revenue from operations and require the organization to maintain the revenue stream.
Taxable Bonds	Large infrastructure projects, new buildings and extensive renovations, medical office buildings, and any other for-profit activity.	Taxable bonds may be privately placed or underwritten in the corporate or taxable municipal bond market.	Bond debt can lead to increased leverage and credit risk, especially if hospitals do not increase overall cash flow generation.
Venture Capital and Public Equity Offerings	Venture capital funds look for high returns. Healthcare service companies typically are a small percentage of the overall VC market. In general, equity offerings have financed expansions by for-profit hospital chains.	Individual terms are negotiated directly with underwriters and VCs, and many will assist the business through the IPO process.	With venture capital funding and preparation for public offering comes a reduction in management control. The current IPO market is very competitive, as the general downturn in the market has decreased the number of healthcare IPOs substantially. Publicly traded companies also may be subject to takeover, although this has been a rare occurrence in health care.
Sale of Assets	In most cases, capital raised through a conversion of a not-for-profit to a for-profit as a result of a sale is funneled into a foundation that funds local health initiatives. Hospitals may increase their overall access to capital by becoming part of a system that is profitable and therefore has access to capital regardless of any changes in tax status.	The majority of conversions are direct sales to a for-profit corporation. Federal and state laws require that the proceeds from the sale continue to be used for charitable purposes.	Tax status conversion does not ensure future success. Even with greater access to capital, serious operating and debt issues may still remain. It is not uncommon for these converted entities to convert back to a non-profit at a later date. In addition, community leaders may feel a loss of control in the future direction of the local hospital.
Banks and Other Financial Services Companies	Banks and other financial services companies may provide smaller or short-term capital needs (less than \$10 million) or when other capital options are not available. However, commercial finance companies often offer a variety of solutions for transactions of more than \$10 million.	Banks and financial services companies' loan terms are negotiated on a deal-by-deal basis and are influenced by the type of obligation, strength of the borrower, and term of the loan.	Collateral requirements are negotiable but always required. Hospitals may be required to secure loans with gross receipts pledges and mortgages. Covenant violations may result in loss of control of the hospital.

Capital Source	Best Use	Access Method	Risks
Capital Leases	Capital leases are traditionally used for large equipment acquisitions, such as imaging and laboratory diagnostic equipment, and often are accompanied by service contracts. A capital lease may be advantageous to organizations that use equipment with frequently changing technology.	Individual capital lease terms are directly negotiated and typically require a 36- to 84-month lease term.	Non-payment of the capital lease may result in the loss of a major capital asset needed for the core business.
Joint Ventures (JVs)/Partnerships	JVs are best for healthcare organizations that have an innovative solution or product but very little access to capital, and in situations where healthcare providers and physicians want to align incentives.	JV terms are individually negotiated between the two organizations.	Smaller organizations in the JV may lose substantial management power. Owners often do not plan for future management, for example, how to pass on ownership when current physician partners retire.
Real Estate Investment Trusts (REITS)	REITS are best suited for healthcare organizations with large amounts of property and facilities and organizations with underutilized facilities. Hospitals are most likely to sell medical office buildings or outpatient centers to REITs. The sale of property to a REIT typically results in a large cash infusion to the healthcare organization.	REIT terms are individually negotiated between the parties. Some property sales are structured to leave some control with the healthcare organization through retention of the “ground” rights.	REIT investments are highly dependent on real estate market rates. Selling property to a REIT results in a healthcare organization giving up control over a primary asset and foregoing any benefits from the future appreciation of the sold asset. Unless contractually structured, hospitals may lose the ability to determine appropriate tenants for the buildings.
Private Philanthropy	Philanthropy is best used for specific expansion/renovations that are compatible with a naming rights campaign. High-profile services and facilities tend to be most popular, such as cancer centers, pediatric and birthing centers, and research facilities.	Two primary methods of accessing philanthropic funds – a grant process from charitable trusts and foundations and donor solicitation. Large donations are often pursued through a naming recognition campaign for capital projects.	Accessing philanthropy is a highly competitive process, with numerous institutions chasing after the same dollars. Philanthropic funding is heavily dependent on hospital marketing/PR efforts and/or charismatic management/board. Lackluster returns on Wall Street mean that donors have less money to donate. In addition, some regions are more generous givers than others. Salt Lake City is among the most generous, while Hartford, Conn., is among the least. ¹¹
Public Grants	Grant funding is most often used for specific expansions and renovations relating to the institution’s specialized purpose or a service that serves an important public need, such as emergency departments and burn units.	The healthcare grant application process is typically administered through state health departments and local governments.	Grants are won in a competitive process, with many institutions competing for a limited number of funds. Grants should not be relied on for recurring capital improvements and expansion/renovations.

¹¹ Chronicle of Philanthropy

Credit Enhancement Sources at a Glance

Vehicle	Best Use	Access Method	Risks
Letter of Credit	Letters of credit are used to secure a fixed rate or variable rate bond issue (taxable or tax-exempt).	Initially, a credit package is assembled describing the credit picture of the hospital. For higher credit quality health-care providers, letters of credit are typically solicited from a handful of regional banks and a few national banks. For lower credit quality healthcare providers, letters of credit may only be available from the relationship bank or other smaller local banks, if at all.	Letters of credit are typically obtained for a three- to five-year period. As such, the borrower is subject to renewal risk. Often a bank will renew the letter of credit, but if the credit of the borrower has deteriorated, the renewal may have more stringent financial covenants and a higher cost.
Bond Insurance	Bond insurance is used to secure a fixed-rate or variable-rate bond issue (taxable or tax-exempt)	Initially, a credit package is assembled describing the credit picture of the hospital. After the credit package is developed, a request for proposal would be solicited from the bond insurer. However, there are very few bond insurers still active in the healthcare market.	None. The bond insurance policy is in place for the life of the bonds.
FHA Section 242 Mortgage Insurance	The 242 program must be used for new buildings or substantial rehabilitation. A minimum of 15% of the proceeds must be used for new projects and all costs normally associated with a capital improvement project. The balance of the proceeds may be used for refinancing.	The 242 program requires completion of a rigorous HUD application process, including the completion of a feasibility study. In response to recent hospital complaints regarding the complexity of the application process and the lack of state-sponsored feasibility studies in non-CON states, HUD has streamlined the 242 process and expanded its marketing of the program.	No significant risks identified.
Local Taxes	Tax revenue can be used to improve credit profiles or to increase debt capacity for a bond issuance.	Healthcare organization must get local government and/or voter approval for tax increases. This approval process often requires decision-maker/voter education campaigns.	A healthcare organization attempting to raise/implement taxes may not receive decision-maker /voter approval.

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