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Capital Improvement Financing Options: A Market Update

Over the past two years, many community hospitals have been preparing to access funds in the capital market for replacement or significant renovation.

Many investment bankers were saying that the period represented a great time to borrow, because the "yield curve" was flat and "credit spreads" were compressed. The flat yield curve meant that the interest rate for short-term borrowing (e.g., 5 years) was not much different than the long-term rates for 30 years. The spread compression meant that interest rates for hospitals with mediocre credit didn't differ very much from those for hospitals with excellent credit.

A Return to Normalcy

The past six months have brought changes in interest rates and available capital, which reflect a more "normal" borrowing environment. Specifically, long-term tax-exempt interest rates for hospitals have increased. The lower Fed Funds rate has had an indirect effect on short-term (less than 5 years) rates but not on long-term rates. Rather, the yield curve has begun to assume its natural shape, and long-term interest rates—which carry more risk because there is more time during which the lender must rely on the borrower to pay them back—are higher than short-term interest rates again. That's normal.

Also, the market has begun to appropriately price risk. Credit spreads have widened, meaning that although the interest rate a hospital with excellent credit pays is not as good as it was a year ago, it is now significantly better than that of a hospital which would not be able to receive an investment grade credit, given their financial situation or small revenue base (i.e., critical access hospital). A hospital with a credit rating of "A" from Standard & Poors may be paying 0.5% more than it did last year. A nonrated hospital may be paying an additional 2% or more in annual interest.

Variable Rate Debt

To lower their cost of capital, hospitals can issue variable-rate debt, which 95% of the time has a lower interest rate than fixed-rate debt.

The lower rate does not come without its associated risks. First, it is less predictable. The interest rate resets at a specified period of time, most typically weekly, but can be constructed to reset monthly, semiannually, annually, or after a specified number of years.

Secondly, variable-rate debt requires "credit enhancement," or borrowing the credit strength of a bond insurer or a bank that has a better credit rating than the hospital. Today, the bond insurance market is all but nonexistent, with only a few insurers surviving the storm of the subprime lending crisis with their good credit intact.

The other option is a letter of credit (LOC), which is a "short-term" credit enhancement for five years or less, can be obtained from banks.

Banks have increased their LOC rates and some have decided not to issue LOCs to new customers or are requiring that certain accounts be held by them (e.g., investments, operating accounts). That said, variable-rate debt is still an attractive alter-

Examples

September 2006: An Illinois critical access hospital completed a nonrated, fixed-rate tax-exempt bond financing for a 25-bed replacement hospital. The interest rate on the 25-year bonds was 5.1%.

April 2008: A Colorado critical access hospital completed a nonrated, fixed-rate tax-exempt bond financing for a 15-bed replacement hospital and the improvement of a skilled nursing facility and two assisted-living facilities. The interest rate on the 35-year bonds was 8.0%.

June 2008: A Michigan critical access hospital completed a nonrated, fixed-rate tax-exempt financing for a significant renovation, including 25 single-occupancy inpatient rooms. The interest rate on the 30-year bonds was 6.73%.

native to fixed-rate debt if managed correctly and used as part of an overall debt portfolio.

High-Risk Hospital Bonds

The most significant change will be for those hospitals that are sorely in need of replacement/renovation but are what investors term “high risk.” These hospitals had been able to access capital through a private placement or a limited public offering.

Rather than offering bonds to a large number of capital providers and allowing them to compete for bonds, thus getting the lowest rate for the hospital, hospital bonds in this category were purchased by a select group of direct lenders or sub-groups of institutional investors specializing in high-yield investments. As a part of the fallout from the subprime crisis, these capital sources have either put new lending initiatives on hold indefinitely or are restricted in their ability to purchase high-risk bonds.

Translation: High-Risk Hospital

Sample Characteristics:

- Days Cash on Hand (<30 Days)
- Debt-Service Coverage Ratio (<1.10)
- Debt to Capitalization (>70%)
- Negative Historical Operating Margins (several years running)
- Small Physician Base (<5 active staff)
- Frequent Management Turnover

Government Loan Programs

Government loan programs have begun to see renewed attention because of attractive rates and attempts to improve the application/approval process. HUD 242 now has a “fast track,” which gives approval for the loan in three months for certain borrowers. This is good in concept, but it remains largely untested.

The USDA, which offers both a direct-lending and a guaranteed-loan program, has kicked off a major initiative for financing CAHs, which included a training session on lending to CAHs for their field representatives this past fall. By utilizing the direct USDA loan, which has limited availability, and the USDA loan guarantee together, the blended rate of the overall debt may be better than the hospital can obtain in the capital markets.

Furthermore, the USDA has made strides in allowing for co-lenders. For example, hospitals that have a loan from the local bank at a good rate would not necessarily have to refinance

that debt with USDA. This option is not a characteristic of a HUD 242 loan.

Implications to Management and Boards of Today’s Financing Environment

In the grand scheme of historical interest rates and capital accessibility, it is still a very good time to borrow. Hospitals have been caught up in recent market shifts, despite being a relatively safe investment; most aren’t going anywhere. However, expectations of financing rates and options for capital providers continually evolve, and the risks, costs, and limitations of the various financing options should be carefully considered within the context of your hospital’s specific situation throughout the planning process.

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Wipfli was invited to attend the annual meeting of the Committee on Healthcare Finance in Washington, D.C., to hear about new FHA initiatives on financing. The message from FHA was that they listened to the complaints of many of borrowers and brokers about the HUD program and are rolling out the first of a series of significant improvements to the processing of loan applications. First and foremost, the review and servicing of HUD 232 and HUD 242 loans will be done by the same department. This step is intended to have loan applications serviced by staff with health care expertise, which now includes former hospital CFOs, CPAs, lawyers, a nurse, and a former state finance authority executive. Additionally, HUD has undergone a “lean office” initiative with the goal of reducing unnecessary complexity and duplication of effort. Lean office is the application of the Toyota Production System principals to white-collar office work processes.

For HUD 232 residential care (e.g., nursing homes, assisted-living centers) loans, the lean office process has reduced the number of steps required to process a loan from 57 to 16. Furthermore, the new online application process and standardization of forms reduced the number of times the same information (e.g., health care organization’s name and address) is entered from 26 to 1. For the HUD 232 loan, this improved process is expected to result in significantly shorter processing times from application to firm commitment (48 to 11 days) and from firm commitment to closing (98 to 29 days). That’s a difference of 2.5 months. Plans for applying the lean office process to HUD 242 are in the works. If the FHA can deliver on its promises, then perhaps a HUD loan will become a palatable, and even perhaps an attractive, option for high-yield credits.

The bigger challenge of today for many small or independent community hospitals is that management and boards have minimal or no experience in planning for and securing financing for a replacement hospital facility. In fact, a replacement facility could very well be the largest project a community will see in a generation, which only adds to the pressure of decision making. Furthermore, management teams in the small hospital space are “lean” and are stretched to the limit just running the day-to-day operations of the hospital, let alone sorting through the range of financing options presented by a wide range of capital providers. Some financiers offer a particular financial product (i.e., HUD 242), and others offering a full array of financing products (e.g., fixed-rate bonds, bank-qualified bonds, derivatives, etc.). Fully understanding and comparing the options requires, at a minimum, the following:

- An understanding of the terms used by investment bankers
- Familiarity with changing indexes (i.e., MMD) and credit spreads
- Comprehension of swaps, pricing, and the associated risks
- Knowledge of market rates for financing costs
- Options for structuring the financing
- Expectations of reasonable debt covenants

The demands of the existing environment have led to an increasing number of hospitals utilizing the services of financial advisors (FAs). FAs assist hospitals in making decisions on the

type of financing structure, the impact of such financing on the hospital's existing financial position/future borrowing needs, and which financiers should be considered for accessing capital. Additionally, FAs must act in the best interest of the hospital and should have no financial interest in the type of financing. Involving FAs early in the planning process will ensure that the key questions are addressed:

- Is the project financially feasible, and does it incorporate new interest rate assumptions into planning?
- What financing options, other than the capital markets, should be considered?
- What are the risks associated with each of the financing options?
- How will a particular financing option affect the hospital's ability to borrow in the future?
- How much are the financing costs associated with a particular financing option, and are those costs reasonable?

Regardless of whether or not your hospital hires an FA, updated expectations of financing rates and options for capital providers should be incorporated into project planning, and flexibility to change the plan for finance and financing source should be maintained until the design is complete. The risks, costs, and limitations of the various financing options should be carefully considered within the context of your hospital's specific situation, and the long-term implications should be considered.

Kelly is director of financial advisory services and a former health care investment banker. She advises health care organizations on preparing for financing related to replacement/renovation. Using her “insider” expertise, she helps organizations evaluate all financing options and educates management and board members on the risks and associated costs of each. The benefit to your organization is ensuring that capital is obtained at a fair market rate and is the lowest cost option, given the particular circumstances of your organization.



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