Financing the Future II

Report 2: Strategies for Effective Capital Structure Management

In partnership with
GE Commercial Finance Healthcare Financial Services and KaufmanHall
# Table of Contents

## Executive Summary

**Financing the Future II**

**Report 2:**

**Strategies for Effective Capital Structure Management**

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**Executive Summary** ................................................................. ii

**Introduction** ...................................................................... 1

**Capital Structure: A View from 30,000 Feet** .......................... 3

**What Is Capital Structure and Why Is Its Management Important?** 4

- Definitions ........................................................................... 4
- The Benefits of Effective Management ................................. 4
- Eight Strategies for Effective Capital Structure Management .... 5

**Strategy 1. Organize for Effective Capital Structure Management** 5

- Board and Senior Executive Education ................................. 5
- The Team, Expertise, and Consideration of Risk .................... 6

**Strategy 2. Determine the Appropriate Level of Debt Capacity** 7

- Debt Capacity Defined ....................................................... 7
- Approaches to Calculating Debt Capacity .............................. 8

**Strategy 3. Determine the Optimal Mix of Debt-to-Equity Financing and Traditional-to-Nontraditional Financing** 9

- Debt and Equity Financing .................................................. 9
- Nontraditional Debt Offerings ............................................. 9
- Evaluation Criteria ............................................................... 13

**Strategy 4. Select and Achieve the “Right” Relationship Between Fixed-Rate Debt and Variable-Rate Debt** 14

- Debt Basics .......................................................................... 14
- Cost Differential .................................................................. 14
- Moving Toward the Right Mix .............................................. 16

**Strategy 5. Diversify Variable-Rate Debt and Avoid Exposure to Any One Form of Risk** 17

**Strategy 6. Use Swaps and Other Derivatives to Manage Cost of Capital and Capital Structure** 18

- Derivative and Swap Defined ................................................. 18
- Types of Swaps ..................................................................... 18
- Swap and Derivative Management ....................................... 20

**Strategy 7. Pursue a Level Debt Structure with the Longest Possible Final Maturity** 22

- Average Life of Debt and Amortization Schedules ................. 22
- A Closer Look at the Impact .................................................. 22

**Strategy 8. Monitor and Continuously Adjust the Debt Portfolio** 23

**Concluding Comment** ........................................................... 25

**References** ........................................................................... 26
Financing the Future II

Report 2:
Strategies for Effective Capital Structure Management

Executive Summary

The proper and strategic management of capital structure, a critical function of corporate finance, ensures access to the capital needed to fund future growth and enhance financial performance. Capital structure management involves answering the question, What is the appropriate amount, mix, structure, and cost of debt and equity to support the organization’s strategic-financial goals? Capital structure management focuses on creating, shaping, and directing the debt and equity portfolio, as necessary, in response to changing market and financial conditions.

The key benefits of effective capital structure management include increased capital access, added flexibility, and lower overall cost of capital. When organized properly in an organization of any size, a capital structure can be easily adjusted to meet changes in interest rates and the changing shape of interest rate yield curves. Capital structures by themselves can lower the overall cost of capital and can maximize the return of assets versus the cost of liabilities. Clearly, a creatively managed capital structure has become a competitive advantage. Perhaps, most importantly, over a 10- to 20-year planning horizon, the quality of a hospital’s capital structure can cost or save the organization millions of dollars.

Effective capital structure management can be achieved by healthcare organizations through consistent use of the following eight strategies:

- Organize for effective capital structure management
- Determine the appropriate level of debt capacity
- Determine the optimal mix of debt-to-equity financing and traditional-to-nontraditional financing
- Select and achieve the “right” relationship between fixed-rate debt and variable-rate debt
- Diversify variable-rate debt and avoid exposure to any one form of risk
- Use swaps and other derivatives to manage the cost of capital and the capital structure
- Pursue a level debt structure with the longest possible final maturity
- Monitor and continuously adjust the debt portfolio

In an era of slim operating margins, healthcare organizations can ill afford to neglect any aspect of the capital management cycle, in which capital structure assumes a major role. Use of the eight capital structure management strategies described in this report will increasingly reward organizations with the know-how and muscle to achieve a strategic financial competitive advantage.
Introduction

The first Financing the Future series, published from November 2003 through September 2004, began the process of highlighting strategies hospitals and other healthcare providers could use to improve access to capital through successful financial planning and execution. Financing the Future II continues this process. Its cornerstone principle is this: *Adherence to a rigorous corporate finance process is critical to a hospital or health system’s ability to increase access to capital, make wise investments in the organization’s future, and improve financial performance.*

The goal of Financing the Future II is to define, provide examples of, and encourage the implementation of a best practice, corporate finance–based approach to financial management in healthcare organizations. By providing practical, how-to information in the form of concrete strategies, tools, timelines, and other materials, Financing the Future II seeks to help healthcare organizations of all sizes “raise the bar” on financial performance. When completed, Financing the Future II will include six reports for healthcare financial leaders, their staffs, and healthcare executives and board members. Each report will illustrate how actual hospitals and health systems have applied corporate finance principles to achieve successful financial performance and capital access.

Published in May 2005, the first report in Financing the Future II, titled Seven Principles of Best Practice Financial Management, outlined the guiding principles of corporate finance and covered the first three principles in depth. (See sidebar, Seven Principles of Best Practice Financial Management.) This second report in the series focuses on Principle 4: *The “right” capital structure supports strategic-financial goals, while optimizing flexibility and minimizing cost.*

Topics to be covered in future reports include integrated strategic financial planning, along with capital planning and allocation (Report 3); joint ventures with physicians and other partners (Report 4); strategies for
financially struggling hospitals (Report 5); and the outlook for capital access (Report 6). When possible, the lessons learned from practicing CFOs, other financial leaders, and those advising financial leaders, obtained through telephone interviews, will be used to describe best practice processes.

HFMA’s partners for *Financing the Future II* are GE Commercial Finance Healthcare Financial Services and Kaufman, Hall & Associates, Inc. Both companies are deeply committed to ensuring the financial health of hospitals and health systems nationwide through the use of corporate finance principles. GE has been a leader in the application of such principles, which have guided the company for many decades and remain in force today. Throughout its 20-year history, Kaufman Hall has advised healthcare organizations on how to rigorously apply and maintain corporate finance principles to achieve enhanced financial performance. We appreciate the in-depth guidance these partners have provided.

We also wish to express our appreciation specifically to the 18 individuals who contributed information to this report: Martin Arrick, managing director, Standard & Poor’s; Jim Blake, managing director, Citigroup; William O. Cleverley, PhD, president, Cleverley & Associates; Peter L. DeAngelis, Jr., executive vice president and CFO, Catholic Health East; Patrick Dupuis, vice president and CFO, BJC HealthCare; Randy Fuller, hospital segment manager, GE Commercial Finance Healthcare Financial Services; Eric A. Jordahl, senior vice president, Kaufman, Hall & Associates; Kenneth Kaufman, managing partner, Kaufman, Hall & Associates; Gary Krugel, senior vice president and CFO, Swedish Covenant Hospital; Michael W. Louge, senior vice president and CFO, OhioHealth; Andrew J. Majka, partner, Kaufman, Hall & Associates; Jeffrey A. Malehorn, president and CEO, GE Commercial Finance Healthcare Financial Services; Lisa Martin, vice president, Moody’s Investors Service; Frederic Martucci, managing director, Fitch Ratings; Robert H. Rosenfield, partner, McDermott Will & Emery; Anthony Speranzo, senior vice president and CFO, Ascension Health; Therese L. Wareham, partner, Kaufman, Hall & Associates; and Beth I. Wexler, vice president and senior credit officer, Moody’s Investors Service.
Not-for-profit healthcare continues to experience significant change. Beyond such ongoing trends as constrained reimbursement, increasing capital needs, and the widening gap separating “have” from “have not” hospitals, the industry is beginning to cross over from a public model that is driven primarily by mission to a model that balances mission and margin. Central to this transformation is healthcare’s adaptation and use of corporate finance principles that have guided the for-profit world through challenging free-market economic conditions for many, many decades. As mentioned in Report 1, corporate finance in the for-profit world emphasizes maximization of shareholder value; in the not-for-profit world, corporate finance is used to ensure the organization’s continued ability to meet its mission and maintain a level of financial performance needed to fund future initiatives.

The proper and strategic management of capital structure, a critical function of corporate finance, ensures access to the capital needed to fund future growth and enhance financial performance. During at least the past several years, the use of a strategic approach to finance as a whole and to capital structure management in particular by hospitals and health systems of all sizes nationwide has differentiated these organizations from their competitors. Adapting capital structure management approaches and techniques prevalent in the for-profit world, these not-for-profit healthcare organizations are using capital structure for competitive advantage. Other “big-picture” trends related to capital structure include the following:

- Traditional fixed-rate debt has historically dominated debt portfolios of not-for-profit healthcare organizations. However, recent flat returns on equity earnings have made locked-in, fixed-rate debt distinctly less attractive because the cost of borrowing may often now exceed investment returns. “The dramatic yield curve developments following 2001 gave alert organizations an excellent opportunity to lower the cost of capital through the aggressive use of variable-rate debt,” notes Kenneth Kaufman, managing partner of Kaufman, Hall & Associates, Inc.

- In an attempt both to lower overall cost of capital and to maximize the number of investors, healthcare providers have diversified their product offerings. Fixed-rate debt includes not only “plain vanilla” options, but “long mode” and synthetic fixed options. Variable-rate options include auction rate securities, self-liquidity bonds, daily floaters, weekly floaters, long-mode put bonds, and others. “Sophisticated providers are ‘attacking the market’ with offerings in every single bucket,” comments Martin Arrick, managing director of Standard & Poor’s.

Not-for-profit healthcare organizations have an ever-increasing number of nontraditional financing options from which to choose. Some of these options (for example, real estate investment trusts and participating bonds) have been used extensively for decades in the corporate sector but represent new offerings in not-for-profit healthcare.

- Interest rate swaps and other derivatives are capturing considerable interest and use in the healthcare financing arena. This reflects the fact that hospitals and health systems are seeking financing mechanisms to help manage their balance sheets and/or significantly decrease the organization’s all-in cost of capital without issuing additional debt.

- Some health systems are beginning to think about how their debt is structured. Although not-for-profit healthcare organizations historically have had only one tier or class of debt, multiple tiers of debt are widespread in the corporate world and among public entities, such as toll roads and state and local governments. The “jury is out” on whether senior/subordinated debt structuring is likely to be widespread in the future, but Ascension Health’s February 2005 issuance of subordinated debt captured considerable attention. (See sidebar on page 10, Senior/Subordinated Debt Structuring.)

This report provides a closer look at each of these capital structure trends—the reasons behind them and their impact on the finances of healthcare organizations nationwide. A view from the ground begins with a fundamental understanding of what capital structure is and why capital structure management is important.
What Is Capital Structure and Why Is Its Management Important?

Definitions

Capital structure is the combination of debt and equity that funds an organization’s strategic plan. Capital structure in not-for-profit healthcare organizations, given the nature of tax exemption that precludes their access to the equity capital markets, includes debt and other sources of capital invested in the organizations over time. Capital structure management involves answering the question, What is the appropriate amount, mix, structure, and cost of debt and equity to support the organization’s strategic-financial goals? Capital structure management focuses on creating, shaping, and directing the debt and equity portfolio as necessary in response to changing market and financial conditions. “Active management of the liability side of the balance sheet—the debt portfolio—is as important as management of the investment or asset side of the balance sheet. This is critically important due to the significant benefits that can be achieved,” says Michael W. Louge, senior vice president and CFO of OhioHealth, an eight-hospital system in central Ohio.

The Benefits of Effective Management

The key benefits of effective capital structure management are increased capital access, added flexibility, and lower overall cost of capital. “Organized properly in an organization of any size, a capital structure can be easily adjusted to meet changes in interest rates and the changing shape of interest rate yield curves. Capital structures by themselves can lower the overall cost of capital and can maximize the return of assets versus the cost of liabilities. Clearly, the creatively managed capital structure has become a competitive advantage.

Perhaps most importantly, over a 10- to 20-year planning horizon, the quality of a hospital’s capital structure can cost or save the organization millions of dollars,” notes Kaufman.

“To be an effective steward of the entire balance sheet, both assets and liabilities, a hospital or health system must have a crystal clear view of what it is ‘all about,’ and focus exclusively on its core business(es), spinning off assets, such as real estate and buildings, that are no longer germane to its business and mission. It must understand its position in the marketplace and balance capital spending needs with operational realities and the amount of debt that can be incurred, while preserving a credit rating that will keep the cost of borrowing low,” describes Randy Fuller, hospital segment manager, GE Commercial Finance Healthcare Financial Services.

At any point in time, there is an optimal capital structure. It is one that minimizes the cost of capital at an acceptable level of organizational risk. The management of capital to achieve an optimal structure, whether for a not-for-profit tax-exempt organization or a for-profit publicly traded company, must be approached in a proactive fashion. “Capital structure is not something that you create and then become passive about, or that you forget about and deal with only when issues come up that may be affecting any portion of the debt portfolio,” says Anthony Speranzo, senior vice president and CFO of Ascension Health, the nation’s largest not-for-profit healthcare system, with headquarters in St. Louis.

Effective capital structure management demands that financial leaders pay attention to interest costs on a regular basis, manipulating the capital structure when opportunities emerge to lower overall capital costs.
“The components of a hospital capital structure change regularly. Gone are the days of borrowing money at a fixed interest rate for 30 years and retaining that debt to maturity. Some hospitals have the largest and most complex capital structures in municipal finance, a category that includes public power companies, city and state governments, airports, turnpikes, and others,” says Kaufman.

Effective capital structure management is as critical to continued competitive performance as capital formation itself. “A firm that cannot obtain the amounts of capital specified in its strategic financial plan will not be able to achieve its long-term objectives. Indeed, if the firm finds it difficult to acquire any amount of capital at a reasonable cost, its future survival may be questionable,” comments William O. Cleverley, PhD, CPA, president of Cleverley & Associates, and Andrew E. Cameron, PhD, graduate professor in Health Services Management and Policy of The Ohio State University.

Similarly, a firm that does not actively adjust its debt and equity portfolios to obtain the lowest cost of capital will have trouble maintaining competitive advantage.

Eight Strategies for Effective Capital Structure Management

Effective capital structure management can be achieved by healthcare organizations of any size through consistent use of the following strategies:

1. Organize for effective capital structure management
2. Determine the appropriate level of debt capacity
3. Determine the optimal mix of debt-to-equity financing and traditional-to-nontraditional financing
4. Select and achieve the “right” relationship between fixed-rate debt and variable-rate debt
5. Diversify variable-rate debt and avoid exposure to any one form of risk
6. Use swaps and other derivatives to manage the cost of capital and the capital structure
7. Pursue a level debt structure with the longest possible final maturity
8. Monitor and continuously adjust the debt portfolio

These strategies provide the framework for the rest of this report.

Strategy 1. Organize for Effective Capital Structure Management

Achieving success with any management effort requires laying appropriate groundwork. The essential building blocks for effective capital structure management include obtaining and providing education, establishing the team, and defining the organization’s attitude toward risk.

Board and Senior Executive Education

Education ensures that the board of trustees and senior leaders are on the same page about the benefits and importance of effective capital structure management to the organization’s competitive financial performance. Although all board members and senior leaders may not need to be familiar with capital structure intricacies, such as the many available derivative and swap vehicles, they do need to know enough to ask questions, such as whether a capital structure decision or vehicle might expose the hospital or health system to inappropriately high risk or whether the debt portfolio is being monitored to achieve the lowest possible interest costs.

To fulfill their responsibilities, all board members must receive education about the financial management of the organization. As part of their fiduciary duties and core responsibilities, board members provide financial oversight, which by definition encompasses capital structure management. One specific capital structure-related responsibility identified by The Governance Institute reads: “The board understands its options with respect to acquiring debt and, if applicable, participates in the bond issuance process.”

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[60x712]"The components of a hospital capital structure change regularly. Gone are the days of borrowing money at a fixed interest rate for 30 years and retaining that debt to maturity. Some hospitals have the largest and most complex capital structures in municipal finance, a category that includes public power companies, city and state governments, airports, turnpikes, and others,” says Kaufman.

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Gary Krugel, senior vice president and CFO of Swedish Covenant Hospital, a 314-bed facility in Chicago, comments on his role and the board’s role in the area of capital structure as follows: “I’m not an interest rate prognosticator and will never pretend to be, but twice a year, I share with the board finance committee what the experts are saying about our debt mix. This information helps guide our discussion, and keeps us on top of interest rates and other areas. I’m not in the markets every single day. Although I have a very good understanding of how the markets work and know the basics of financial mechanisms, such as swaps, I need to consult experts who participate in the market each and every day.”

The Team, Expertise, and Consideration of Risk

Healthcare organizations should assign responsibility for capital structure management centrally so that decision making and implementation are coordinated. Both large and small hospitals and health systems generally establish a knowledgeable senior management team that is chaired by the organization’s CFO or vice president of finance. High-quality investment banking, legal, and consulting assistance is usually required as well. At Ascension Health, investment management and debt management are both critical responsibilities of the system’s treasury function. “Treasury management monitors the financial markets as an ongoing and continuous process. Capital structure management occurs within a dynamic risk management framework and methodology,” describes Speranzo.

Healthcare financings have increased significantly in complexity and sophistication during the past 10 years, so whether developed internally or sought beyond the organization, expertise is essential. “The good news is that as capital market sophistication increases, healthcare organizations have additional opportunities to access the capital markets and use the markets constructively to lower overall capital costs. The bad news is that organizations without the required expertise can potentially open themselves to significant harm. Sophisticated transaction risks are common. The question has to be raised: Does the organization understand the risks and how such risks can be mitigated,” comments Kaufman.

Capital structure decision making should reflect the level of risk the organization wishes to assume. Just as some private investors want to limit their investments to vehicles such as treasury bills, while others gladly purchase individual stocks and futures, organizations have differing levels of comfort with risk. “When it comes to our capital structure and investment strategy, we’re a fairly conservative organization. We pursue fixed debt and passive investments, and although we’re fine tuning our capital structure a bit now, we’ll never be on the front end of aggressive management because that is not our style. We will maintain a fairly conservative capital structure, but we do all the things other organizations do, such as matching our maturities on both assets and liabilities, and applying some variable rates where we are more current and some fixed rates where we have a longer outlook,” says Patrick Dupuis, vice president and CFO of BJC HealthCare in St. Louis.

Each organization must determine its own tolerance for risk. “This process starts with the organization’s evaluation of its strategies, marketplace, and competition. These build into the finance and capital plan, which then rolls into a capital structure, which organizations must assess to understand their level of risk and exposure to such factors as movements in the interest rates. The risk that is right for one organization may not be right for another,” comments Fuller.
Strategy 2: Determine the Appropriate Level of Debt Capacity

Debt Capacity Defined

Debt capacity, the amount of debt an organization is capable of supporting within a particular credit rating profile, establishes the parameters of the debt portion of the capital structure. The figure must expand each year if the organization wants to remain strategically and financially competitive. “The ability to incur additional debt makes hospitals more responsive to their market and more resilient to expected and unexpected changes. Access to new debt capacity is a function of an organization’s creditworthiness, which is based on factual data and expected performance, and the willingness of the capital markets to support an organization’s strategy,” note Therese L. Wareham and Andrew J. Majka, partners of Kaufman Hall.

Debt capacity is a critical issue for organizations. “The amount of debt organizations are willing to incur has to be balanced against their tremendous capital expenditure needs for information technology, new inpatient capacity, outpatient facilities, and a whole host of other spending opportunities. An organization’s overall ability to support or sustain the level of debt is key. Some facilities are looking at splitting their overall debt capacity into two buckets—what they need to spend to support core inpatient businesses versus what they need to spend in other areas. Some hospitals are pursuing joint venture arrangements to obtain capital for outpatient facilities, while preserving debt capacity for inpatient expansion. Different approaches are being used, varying based on an organization’s credit rating, operating performance, and competitive position in the market,” describes Fuller.

The credit rating agencies publish national ratios related to the level of debt capacity organizations generally assume given selected operating and financial characteristics. “Many organizations benchmark themselves against these ratios in order to assess

Exhibit 1

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Key Target</th>
<th>Indicated Capacity (dollars in millions)</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt service coverage</td>
<td></td>
<td>62.3</td>
<td>45%</td>
</tr>
<tr>
<td>Debt to cash flow</td>
<td></td>
<td>60.3</td>
<td>15%</td>
</tr>
<tr>
<td>Cash to debt</td>
<td></td>
<td>38.3</td>
<td>15%</td>
</tr>
<tr>
<td>Debt service to revenue</td>
<td></td>
<td>49.1</td>
<td>15%</td>
</tr>
<tr>
<td>Debt to capitalization</td>
<td></td>
<td>68.0</td>
<td>10%</td>
</tr>
<tr>
<td>Weighted capacity</td>
<td></td>
<td>57.0</td>
<td></td>
</tr>
</tbody>
</table>

MADS is maximum annual debt service.
Note: Certain ratio definitions vary a bit by rating agency.

Source: Kaufman, Hall & Associates, Inc. Used with permission.
their comparative performance with similarly rated organizations. They look at each and every opportunity to improve their ratios, raise their credit rating, and thereby reduce the cost of capital,” says Fuller.

**Approaches to Calculating Debt Capacity**

To determine debt capacity, organizations can use five credit ratio-based approaches:

1. Debt service coverage, which focuses on the relationship between current profitability and maximum annual debt service (MADS)
2. Debt to cash flow, which focuses on the relationship of debt to the sum of total profits plus depreciation and amortization;
3. Cash to debt, which focuses on the relationship between liquidity and debt
4. Debt service to revenue, which focuses on the relationship of MADS to total operating revenue
5. Debt to capitalization, which focuses on the relationship between debt and total capitalization

*Exhibit 1, Approaches to Calculating Debt Capacity,* illustrates how each ratio is calculated. Because the calculations result in different debt capacities, organizations can perform each calculation and, as shown in the exhibit, apply weightings to reflect the perceived importance of each approach. “Generally, the debt service coverage, debt-to-cash flow, and cash-to-debt approaches are weighted higher than the debt-to-capitalization approach. Best practice management of debt capacity is based on maintaining appropriate credit profile targets and balance among these methodologies,” comment Wareham and Majka.

Peter L. DeAngelis, Jr., executive vice president and CFO of Catholic Health East, which recently completed a thorough review of its capital formation and debt structure, notes this: “We completed an analysis of our debt capacity and concluded that it was about $150 million, and that increasing cash flow would be key to adding future debt capacity.” Operating plans must be in place to create the required expanded debt capacity.
O
nce an organization determines its debt capacity, it knows how much it can borrow in the debt markets and how much capital will need to come from other sources, both traditional and nontraditional. Targets for the appropriate debt-to-equity ratio are based on debt capacity, rating agency benchmarks, and tolerance for risk.

Large companies have long tiered their capital structures to reflect their need for capital and to attain the optimal balance between cost of capital and financial risk. “In managing our capital structure, GE makes ample use of the commercial paper and the bond markets, both short- and long-term. Like any other public company, we need to make sure that we are satisfying the regulators and the credit agencies with respect to our overall capital structure, short-term and long-term debt, and the amount of equity and debt we hold. Our capital structure is likely to look different than that of a not-for-profit healthcare organization, due to the key differences in the operations and market risks that are inherent in not-for-profit hospitals,” comments Jeffrey A. Malehorn, president and CEO of GE Commercial Finance Healthcare Financial Services. The sidebar (Senior/Subordinated Debt Structuring) describes debt structuring common in the corporate world, and newly used in the not-for-profit world.

Debt and Equity Financing

Due to the nature of tax exemption, not-for-profit healthcare organizations do not have access to the equity capital markets; their equity capital can come from only four sources: operating cash flow, cash reserves, philanthropic contributions, and sale of assets. Debt financing can be accessed through bond offerings (tax-exempt and taxable), Federal Housing Administration financing, private placements (bonds, notes, loans, or leases), and nontraditional debt instruments. The first report in Financing the Future I, titled How Are Hospitals Financing the Future? Access to Capital in Health Care Today, described each type of arrangement. Additional information about nontraditional offerings follows.

Nontraditional Debt Offerings

Up through the early 1990s, healthcare executives relied almost exclusively on not-for-profit tax-exempt financing. In 2002, 46 percent of hospitals’ external capital came from sources other than tax-exempt bond issues. Financing options that organizations now can choose from include off-balance-sheet (OBS) options, real estate investment trusts (REITs), participating bond transactions (PBTs), receivables financing, and private placements, among other options. “Healthcare providers typically access these options if they want to preserve their debt capacity for traditional vehicles or are limited in their ability to access traditional options,” notes Wareham.

Some leaders may not be aware of the full range of options. “Too often, healthcare financial executives see just fixed-rate or variable-rate bonds as the only options, and don’t consider private placements, leasing, and the whole gamut of financing vehicles available to them,” comments Fuller. He recommends that organizations start with a blank page, establish risk parameters given their position in the marketplace, financial performance, and credit rating, identify available options, and assess each option’s ability to meet capital structure needs given the established parameters. The following nontraditional offerings may be appropriate to healthcare organizations:

**OBS options.** Historically, U.S. healthcare providers have viewed hard assets as something to be owned and, thus, have significant equity tied up in bricks, mortar, and equipment. With increasingly tight capital markets and credit challenges, however, providers may wish to consider OBS financing of real estate or equipment as a
In February 2005, St. Louis-based Ascension Health broke new ground in announcing the issuance of more than $600 million in subordinated bonds. The deal ensured that all then-current bond holders, in effect, became senior creditors. “Traditionally, not-for-profit healthcare organizations have issued one main class or tier of debt, which is not senior or subordinated to anything else, and has one credit rating,” says Jim Blake, managing director of Citigroup, which co-led the Ascension Health offering with Morgan Stanley. “In contrast, many for-profit corporations have debt structures with numerous classes of debt that have different priorities of claim and/or collateral pledges. Generally, these structures include debt classes such as senior secured, senior unsecured, senior subordinated, subordinated and junior subordinated bonds, as well as preferred stock,” explains Lisa Martin, vice president of Moody’s Investors Service, which recently issued a report on this topic. In the event the issuer is unable to make all of its debt service payments, the bondholders of senior debt are paid before the bondholders of subordinated debt. Different debt classes have different credit ratings. Under a simple two-level debt structure, for example, the senior secured debt might be rated Aa3 (AA–), while the junior subordinated debt might be rated A1 (A+). “The extent to which the debt ratings are notched up or down is affected by the size of the issue being rated relative to the hospital’s other obligations,” says Martin.

In a sale-leaseback transaction, the third-party investor purchases the hospital’s project (or property) and then leases it back to the hospital or a related organization. The sale gives the hospital a cash infusion, which is then available to its general needs and can generate additional investment income. Because OBS financing is not shown as a liability on the hospital’s balance sheet, it can be a way to finance capital needs. OBS financing structures, such as operating leases, sale/leasebacks, synthetic leases, and joint ventures or master leases, effectively let a hospital “own” and use an asset that is technically owned by a third-party investor. As such, neither the asset nor the liability is recorded on the hospital’s or lessee’s balance sheet.

**Senior/Subordinated Debt Structuring**

In February 2005, St. Louis-based Ascension Health broke new ground in announcing the issuance of more than $600 million in subordinated bonds. The deal ensured that all then-current bond holders, in effect, became senior creditors. “Traditionally, not-for-profit healthcare organizations have issued one main class or tier of debt, which is not senior or subordinated to anything else, and has one credit rating,” says Jim Blake, managing director of Citigroup, which co-led the Ascension Health offering with Morgan Stanley. “In contrast, many for-profit corporations have debt structures with numerous classes of debt that have different priorities of claim and/or collateral pledges. Generally, these structures include debt classes such as senior secured, senior unsecured, senior subordinated, subordinated and junior subordinated bonds, as well as preferred stock,” explains Lisa Martin, vice president of Moody’s Investors Service, which recently issued a report on this topic. In the event the issuer is unable to make all of its debt service payments, the bondholders of senior debt are paid before the bondholders of subordinated debt. Different debt classes have different credit ratings. Under a simple two-level debt structure, for example, the senior secured debt might be rated Aa3 (AA–), while the junior subordinated debt might be rated A1 (A+). “The extent to which the debt ratings are notched up or down is affected by the size of the issue being rated relative to the hospital’s other obligations,” says Martin.

Blake describes the following benefits of a senior/subordinated debt structure:

1. **Ability to access liabilities at different price points, depending on credit spreads.** When credit spreads are very tight, i.e., when the difference between debt rated AA and debt rated BBB+ is 15 or 20 basis points, for example, an organization may want to access its subordinated debt, because it is less costly to do so and senior debt capacity can be retained. When credit spreads are very wide, such as 200 to 300 basis points, the organization may want to access its senior debt.

2. **The potential for additional debt capacity.** Organizations may be able to add additional capacity in aggregate by having more subordinated debt relative to their senior debt, and still maintain a higher senior rating. For example, an organization with aggregate debt rated A+ might wish to structure its debt with senior and subordinated tiers. This would allow the organization to have some debt rated a higher AA–, but still keep the greater capacity currently enjoyed at the A+ level.

There are costs associated with changing an existing debt structure and restructuring takes time. “Senior/subordinated debt restructuring is something healthcare organizations will want to do only if they are doing a major financing. Tiering of debt in health care is likely to be led by the strong credits over the next few years. However, further out, the weaker credits will follow given the even more significant financial benefits they can achieve due to wider notching of deeply subordinated, non-investment-grade bonds,” offers Blake.
sheet, debt ratios, such as debt-service coverage and debt-to-capitalization, are improved, which is critical to credit status. (It should be noted that a sale-leaseback could also be an on-balance-sheet transaction, depending on when the asset is “sold.”)

Highly dependent on the credit of the lessee, synthetic lease structures are typically structured with relatively short initial terms and lower lease payments. This structure reflects “interest only” economics on the underlying debt, unlike other lease types that include amortization of principal. Synthetic leases contain purchase options concurrent with the renewal dates. The purchase price equals the fair market value of the leased asset, which can never be less than the amount of outstanding underlying debt. This requirement often causes termination payment to become a contingent liability on the lessee’s balance sheet.

Master leases can be used for real estate or ongoing equipment programs, and can also be on or off balance sheet. Typically involving joint ventures with a developer, master leases for real estate have been used most frequently with long-term-care and retirement facilities. The joint venture relationship spreads the financial risk and ensures the involvement of someone who understands the real estate business. Typically, the developer puts up the capital, supervises the construction of the project, and operates it once it is complete. The provider obtains the certificate of need, if required, offers services, and develops referral networks to ensure a steady business flow. The less capital a provider contributes to the joint venture, the less profit it stands to make, but the objective often is vertical or horizontal integration without significant financial risk.

Not every venture lends itself to OBS financing, nor does every healthcare entity have access to all these types of financing. Moreover, the extent to which the capital markets view OBS financing as debt depends on whether the assets financed are strategic or ancillary to the core business and the overall magnitude of OBS exposure. Healthcare financial leaders should carefully weigh both whether a project lends itself to OBS financing and the trade-offs among the balance sheet benefits, income statement effects, and any potential loss of control over the asset.

---

**Exhibit 2**

<table>
<thead>
<tr>
<th>Types of Assets</th>
<th>True Operating Lease</th>
<th>Synthetic Lease</th>
<th>Sale-Leaseback</th>
<th>Joint Venture (master lease)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment and real estate; new or existing</td>
<td>Equipment and real estate; only for new assets</td>
<td>Typically real estate</td>
<td>Typically real estate</td>
<td></td>
</tr>
<tr>
<td>Approach</td>
<td>Acts like traditional debt, but OBS</td>
<td>Lessee takes depreciation as owner; effectively a medium-term revolver applied to longer term assets</td>
<td>If previously owned property must be a true operating lease; if previously capitalized lease, ineligible for sale-leaseback treatment</td>
<td>Developer provides equity and financing based on host’s minimum occupancy agreement and ground lease</td>
</tr>
<tr>
<td>Taxable versus Tax-Exempt</td>
<td>Either</td>
<td>Either</td>
<td>Either; existing property may not be eligible for tax exemption</td>
<td>Typically taxable</td>
</tr>
<tr>
<td>Lease Payments</td>
<td>Includes amortization of underlying principal so payments usually larger than synthetic lease; can have escalators and annual fees; subject to Financial Accounting Standards Board</td>
<td>Probably lowest if structured as interest only in lease payments; can have escalators and annual fees; subject to FASB</td>
<td>Includes amortization of underlying principal so payments are usually larger than under a synthetic lease; can have escalators and annual fees; subject to FASB</td>
<td>Structured to meet developer minimum return; excess shared with host</td>
</tr>
</tbody>
</table>

*Source: Kaufman, Hall & Associates, Inc. Used with permission.*
Although in essence all of the four basic methods of OBS financing described earlier involve an operating lease, each has subtle distinctions and separate accounting treatments, and each offers different trade-offs, such as higher control with less walk-away ability versus less control with easier walk-away ability. (See exhibit 2, Off-Balance-Sheet Vehicles.) “The rating agencies are scrutinizing operating leases much more carefully and have signaled that they are viewing operating leases as on-balance-sheet obligations and capitalizing the lease payments,” says Majka. Martin of Moody’s Investors Service comments: “The key question with an OBS transaction is, Does the transaction create a debt-like obligation and is the hospital likely to make payments on that obligation? If the answer is yes, off-balance sheet does not mean off credit. Accounting and legal treatment has no bearing on credit implications. If it looks and smells like debt, it’s usually debt from a credit rating perspective.”

**REITs.** A REIT is an entity whose primary activity is to purchase a portfolio of real estate assets, such as hospitals, nursing homes, or medical office buildings, and lease the property to one or more operators. REIT investors earn their return through lease payments and the eventual sale of trust properties. They typically are interested in high performing properties that do not need to be directly owned by a healthcare entity. REITs permit healthcare organizations to obtain cash for real property, reduce overall cost of development transactions, achieve OBS financing, and under certain circumstances, maintain control of facilities and property.

**PBTs.** Used to finance projects in other industries for more than 20 years, participating bonds have recently been introduced in healthcare finance as an alternative to equity joint ventures for not-for-profit and public hospitals. PBTs are now being used to structure hospital/physician transactions involving new debt for facilities or refinancing of existing hospital debt. “PBTs enable the sponsoring hospital to preserve a higher percentage of operating income, retain ownership of all assets and operations, preserve the low cost operating environment of a tax-exempt charity, and greatly reduce the regulatory risks associated with hospital/physician transactions,” notes Robert H. Rosenfield, partner of McDermott Will & Emery. “They align incentives for physician and hospital financial performance. Bond performance can also be linked to non-financial indicators, such as improvement in quality of patient care and patient satisfaction. PBTs can be used to create investment opportunities in any facility that could be structured as a joint venture, such as ambulatory surgery centers and imaging centers, and can also be used with existing facilities. They do not involve an advance refunding,” adds Rosenfield. (See sidebar, How Participating Bond Transactions Work.)

**Receivables financing.** With reduced payment to providers, liquidity has become an issue requiring securitized funding mechanisms. Receivables financing is one such mechanism that can be considered by hospitals experiencing tight liquidity situations. It involves the sale or pledging of an organization’s accounts receivables and the securing of financing against such receivables.
In a sale, commercial paper is typically issued and the administrative requirements are extensive. The seller (the hospital in this case) has limited recourse, must meet the requirements of financial accounting standards, and must qualify for OBS treatment of the receivables financing. This type of financing can also be structured as a revolving line of credit secured by the accounts receivable. The borrower is usually required to submit detailed information on the outstanding accounts receivable in order to draw funds against the line of credit.

**Private placements.** Hospitals may also want to consider a private placement arrangement for their debt for smaller capital needs or in between major bond issues. This type of financing involves a lender who will both underwrite and hold a bond issue. Although the coupon rate paid on this type of financing is usually higher than that paid in the bond market, the transaction costs are typically much lower, resulting in “all-in” rates that can be comparable to those found in the bond market for some borrowers.

**Evaluation Criteria**

When considering which traditional and nontraditional financing vehicles are appropriate for an organization’s circumstances and credit position, healthcare leaders should consider 12 factors:

- **All-in borrowing rate.** This is the total cost of capital, including interest and ongoing fees involved with maintaining the financing.

- **Costs of issuance.** Tax-exempt bonds typically have higher costs of issuance than do taxable bonds, but in either case, organizations should carefully evaluate these costs.

- **When the money is needed.** The timing of when the hospital needs to spend the money may affect its choice of vehicle. Direct lending from banks and private placements usually can be secured the most quickly.

- **Use of proceeds.** The tax status of the financing option depends on the tax status of the entity for which the financing is being sought.

- **Credit position.** The credit available to an organization largely determines which vehicles it can access.

- **Document structure and underlying security requirements.** The weaker the credit, the more security is required. The underlying security required by some financing vehicles can limit an organization’s ability to issue debt in the future.

- **Covenants.** There are two basic categories of covenants—maintenance and incurrence. *Maintenance covenants* are routine requirements that the borrower must meet on an annual and sometimes quarterly basis; for example, the liquidity covenant of days cash on hand. *Incurrence covenants* are special requirements that must be met in order to undertake a particular action; for example, sale or disposition of property. Organizations should always seek the least restrictive covenants possible.

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

- **Interest-rate risk.** The best course is to achieve a mix of fixed- and variable-rate debt that minimizes interest-rate risk.

- **Average useful life versus average maturity.** Tax-exempt financing rules require that projects eligible for tax exemption be specifically delineated in the documents that support the borrowing.

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

- **Prepayment penalties and unwind provisions.** Different financing vehicles have differing premiums or prepayment penalties associated with an early redemption date.

“All capital decisions should support an organization’s strategic plan, provide as much flexibility as possible given existing and pending laws or restrictions, involve the lowest overall cost for the risk of the asset and liability portfolios, and allow for future financing needs,” notes Wareham.
Strategy 4: Select and Achieve the “Right” Relationship Between Fixed-Rate Debt and Variable-Rate Debt

Every organization has a different “right mix” of fixed-rate to variable-rate debt. The mix is dependent on the organization’s bond ratings, availability of bond insurance, the amount of free cash, the investment policy and the board’s attitude toward risk, and changing interest rates.

Debt Basics

Fixed-rate debt, a security whose interest rate does not change during its lifetime, is a form of committed funding. Committed funding generally is not subject to renewal risks and is considered a permanent component of the organization’s capital structure to maturity, providing the organization maintains its bond covenants. “When incurring fixed-rate debt, the organization is insulated from most major risks, including fluctuating interest rates, credit quality deterioration, healthcare industry perception, changes in tax law impacting the attractiveness of tax-exempt debt, and international events impacting marketability of bonds,” comment Wareham and Majka.

In contrast, interest rates for variable-rate debt, a security whose rate changes are based on market conditions, fluctuate periodically (for example, daily, weekly, or monthly). Variable-rate debt can take both committed and uncommitted forms. Uncommitted debt is debt adversely affected by actual or perceived erosion of a healthcare organization’s credit quality or of the healthcare industry. An irrevocable bond insurance policy covering the debt to maturity ensures committed funding. For example, insured auction rate securities and insured variable-rate demand notes are considered committed debt, but the organization is not insulated from risk related to interest rates, remarketing, changes in tax law, industry perception, and insurer downgrades.

“Organizations with a relatively weak credit rating should not have a lot of uncommitted debt, because it adds a newer and different level of risk,” says Kaufman. “Given these exposures, variable-rate debt adds an element of risk to a healthcare organization’s overall capital structure, but historically, variable-rate debt has provided borrowers on average with lower all-in costs of capital than fixed-rate debt,” note Wareham and Majka.

Cost Differential

A 15-year look at fixed-rate and variable-rate interest cost yields shows that, with the exception of one moment during the entire period, variable-rate interest costs have been lower, and at many points significantly lower, than fixed-rate costs. (See exhibit 3, The Case for Variable-Rate Debt.) “It’s important to focus on the absolute difference in interest rates between the Revenue Bond Index (RBI), which tracks fixed-rate costs, and the Bond Managers Association index (BMA), which tracks variable-rate costs. In some instances during the past four years, the difference has been as large as 3.5 percent to 4.5 percent. This means that during the past 15 years, organizations that had a strong enough balance sheet to use variable-rate debt, but opted for fixed-rate debt instead, thinking that it was going to be a safer and more appropriate way to go, actually wound up paying significantly more in debt service payments,” says Kaufman.

Swedish Covenant Hospital historically pursued a 70 percent fixed-rate to 30 percent variable-rate debt mix. “However, by this mix, we would have missed out on a huge opportunity over the past few years with the low variable rates currently being experienced. Part of the finance committee’s charge to me is to watch the
rates, and when the rates look like they’re getting ready to move or we hit a target, we should be ready to act quickly. I monitor our plan and rates every week with assistance from our investment banker. Our actual mix of debt moved to 56 percent fixed-rate and 44 percent variable-rate during one period in time, but given the low fixed rates now available, our target has moved back to a 70 percent fixed-rate to 30 percent variable-rate mix,” describes Krugel.

How do the agencies that rate healthcare debt evaluate an organization’s mix? Beth Wexler, vice president and senior credit officer of Moody’s Investors Service, comments as follows: “No one shoe fits every issuer, so Moody’s has no specific quantitative benchmark or rule of thumb on determining the proper mix between fixed-rate and variable-rate debt. Some organizations can have as much as 50 percent or more of their debt in variable-rate mode. We view the practical limits of the amount of variable-rate debt as driven by two factors—interest rate risk and liquidity risk. The appropriate mix for the organization depends upon the issuer’s ability to handle potential large swings in interest rates on the variable-rate exposure. In evaluating the mix, we examine the organization’s financial cushion, asset liquidity and investment management, cash flow tolerance for rising interest rates, and budgeting practices.”

Exhibit 3

The Case for Variable-Rate Debt

Historical BMA and RBI

Past three months

<table>
<thead>
<tr>
<th>Yield (%)</th>
<th>BMA</th>
<th>RBI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.50</td>
<td>5.50</td>
<td>5.50</td>
</tr>
<tr>
<td>2.00</td>
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<tr>
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<td>4.00</td>
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<tr>
<td>0.50</td>
<td>3.50</td>
<td>3.50</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Yield (%)</th>
<th>BMA</th>
<th>RBI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>3.00</td>
<td>2.00</td>
</tr>
<tr>
<td>0.50</td>
<td>2.00</td>
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</tr>
<tr>
<td>0.00</td>
<td>1.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current</th>
<th>RBI</th>
<th>BMA</th>
<th>Spread</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.96%</td>
<td>1.74%</td>
<td>3.22%</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>5.95</td>
<td>3.07</td>
<td>2.88</td>
</tr>
<tr>
<td>Maximum</td>
<td>7.83</td>
<td>7.89</td>
<td>N/A</td>
</tr>
<tr>
<td>Minimum</td>
<td>4.73</td>
<td>0.70</td>
<td>N/A</td>
</tr>
</tbody>
</table>

1 Reflects market conditions as of March 2, 2005
2 The Revenue Bond Index (RBI) is based on 30-year bonds issued by 25 different revenue bond issuers for a variety of purposes including housing, transportation, hospitals and pollution control. The RBI is widely used as a benchmark for long-term revenue bonds
3 The Bond Market Association (BMA) Index is calculated by taking the weighted-average of the clearing rates for 250 of high-grade tax-exempt short-term issues with weekly resets. The BMA Index is a widely used proxy for high-grade weekly bonds

Source: Kaufman, Hall & Associates, Inc. Used with permission.
A recent report from Fitch Ratings indicates that variable-rate debt issuance composed a record-setting 63.4 percent of total healthcare debt rated by that agency in 2004. According to the report, Fitch believes an appropriate amount of variable-rate debt will differ for each hospital and health system; Fitch notes the use of more than 50 percent variable-rate debt is acceptable in situations where a hospital or health system has very strong liquidity levels and cash flow, or has an asset management policy that effectively hedges fluctuations in interest rates. Fitch believes it is imperative that hospitals appropriately match their interest rate exposure on both the asset and liability sides of the balance sheet. A comprehensive asset/liability management strategy can be extremely effective in managing the effects of changing interest rates and adding more predictability for purposes of planning.

Moving Toward the Right Mix

Achieving the right mix of variable-rate to fixed-rate debt requires planning, timing, and proper execution. In June 2003, Ascension had only 30 percent of its debt in variable-rate vehicles. Using independent asset/liability management studies performed by investment bankers, Ascension’s leaders chose a variable-rate debt target of 60 percent. “The studies looked at the difference between the returns of the organization’s investment portfolio and the interest cost of our debt portfolio. Hundreds and hundreds of simulations were run in order to try to match these up,” notes Speranzo. Achieving the targeted right mix involved conversion of a significant amount of fixed-rate debt to variable-rate debt, so leaders developed a detailed plan to convert the debt over an expected five-year period.

OhioHealth also conducts asset liability modeling with Monte Carlo simulations to determine the prudent ranges of variable-rate debt, given the organization’s liquidity position and investment policies. “We carefully consider how to achieve the lowest cost of capital given organizational tolerance for risk. Our goal with the modeling is to determine the percentage of variable-rate debt we could take on to lower our cost of capital, and how to minimize the P&L impact of rate fluctuations. Right now our policy is 50 percent/50 percent, but we just did a new study that shows that, given our strengthening balance sheet, we could actually have more variable-rate debt,” describes Louge.

Catholic Health East, whose mix was 85 percent fixed to 15 percent variable in 2002, studied the variable-rate exposure assumed by other large healthcare organizations. “We noted that many large systems had much more variable-rate exposure than we did, thereby lowering their overall debt service and favorably impacting relevant credit ratios. Importantly, we also noted that rating agencies have not penalized large, diverse systems for increasing their variable-rate exposure. We found that CHE could increase its variable-rate debt to approximately 35 percent of its total debt within our acceptable risk-tolerance limit. CHE has principally used interest rate swaps to increase variable-rate exposure, producing an average of approximately $3.5 million of incremental annual debt service savings,” describes Peter L. DeAngelis, Jr., executive vice president and CFO.
Strategy 5: Diversify Variable-Rate Debt and Avoid Exposure to Any One Form of Risk

Variable-rate debt comes with certain risks, including basis risk, put risk, bank risk, credit risk, and failed auction risk. A diversified variable-rate debt portfolio can mitigate these risks and lower the organization’s overall cost of capital. Variable-rate vehicles include variable-rate demand bonds backed by a bank letter of credit, insured auction rate securities, uninsured auction rate securities, investment banker proprietary products such as “direct lending” or “direct funding,” and in the cases of the strongest credits, unenhanced variable-rate demand bonds.

Basis risk, risk resulting from interest rate variance, is unavoidable, but can be mitigated by certain types of derivative products. Put risk—the risk that bonds can be “put” back to the hospital by the lender—can increase as capital structures are built over time. Identifying time periods of highest risk and actively seeking to smooth that risk are important issues for financial leaders. A hospital with all of its variable-rate debt in a vehicle with a put option carries considerable capital structure risk. Use of auction rate programs can reduce put risk. Use of auction rate programs also can eliminate bank risk, the risk that renewal of a bank letter or proof of credit will come at an inopportune time. Credit risk, the risk that an organization’s credit rating changes while it is using certain programs that are dependent upon the organization being at a certain credit level, is mitigated through the use of insured variable-rate demand bonds or insured auction rate programs. Risk of a failed auction, which occurs when there are more sellers of an issuer’s paper on an auction date than there are buyers, and the whole offering is not resold, can be reduced through use of variable-rate demand bonds and other vehicles.

Exhibit 4

<table>
<thead>
<tr>
<th>Transition of Variable Rate Product Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/30/00</td>
</tr>
<tr>
<td>100%</td>
</tr>
<tr>
<td>51%</td>
</tr>
<tr>
<td>9%</td>
</tr>
<tr>
<td>43%</td>
</tr>
<tr>
<td>14%</td>
</tr>
<tr>
<td>Total VR exposure: $777m</td>
</tr>
</tbody>
</table>

Source: Ascension Health. Used with permission.
In 2000, Ascension Health had all of its variable-rate exposure in weekly, variable-rate demand obligations “floaters” that were 100 percent supported by self liquidity. Adopting a mantra of “diversify, diversify, diversify,” Ascension Health’s leaders selected a wide range of variable-rate financing vehicles, including taxable commercial paper, weekly VRDOs (self liquidity), annual VRDOs, auction rate securities, synthetic variable rate, and other structured variable-rate debt products. (See exhibit 4, Diversification of Variable-Rate Debt.) Ascension Health’s leaders recognize the need to minimize exposure to put risk and credit risk.

Because Ascension Health had all of its variable-rate debt in a vehicle with a put option structure (weekly floaters), it carried considerable capital structure risk in 2000. “An unforeseen industry-related event or an economically or internationally related event that results in the exercising of that put option could seriously compromise the organization’s cash and credit position. Product diversification, which increased use of debt with no put risk (i.e., auction rate securities), and a staggered put bond strategy reduced our overall put exposure,” notes Speranzo.

Strategy 6: Use Swaps and Other Derivatives to Manage Cost of Capital and Capital Structure

As an organization’s capital structure increases in complexity, the importance of the use of derivative strategies also increases. Derivatives provide a mechanism to maintain a flexible capital structure and to make real-time adjustments to the capital structure as demanded by both the interest rate and competitive environments. Derivatives also permit appropriate matching of assets to liabilities as interest rate and stock market conditions change. “Derivatives offer the biggest and best thing to come along in hospital finance in the last five years. Derivatives offer a host of advantages, but like any good thing, derivatives come with significant risks as well,” says Kaufman.

**Derivative and Swap Defined**

A derivative is any sort of contract that manages or adjusts the character of underlying securities, whether debt or equity. Functions of derivatives include capital structure management—adjusting the relationship of fixed-rate to variable-rate debt—and interest rate management—repositioning the organization on the yield curve as interest rates change. The sidebar briefly describes relevant types of derivatives. (See sidebar, Types of Derivatives.)

An *interest rate swap*, a type of derivative, is a contract between two parties to exchange interest rate modes on a specific amount and type of debt. In the healthcare world, the hospital borrower is one counterparty, and a commercial or investment bank the other counterparty. “Swaps are not new. They are common tools of treasury management in the private sector and are becoming increasingly common in the public/not-for-profit sector,” comment Wareham and Majka.

Swaps offer a means of synthetically changing the fundamental interest rate characteristics of debt, but importantly, swaps and derivatives are financial products, not debt. Like other contracts, they can be reversed at any time, but like bonds, the value of the contracted trade changes as interest rates go up and down.

**Types of Swaps**

There are three basic types of interest rate swaps: fixed payer swaps, fixed receiver swaps, and basis swaps. (See exhibit 5, Three Types of Swaps.) A description of each follows.

**Fixed payer swaps** convert variable-rate debt to fixed-rate debt. A hospital with variable-rate debt contracts with a swap counterparty to provide fixed payments over the life of the swap in exchange for receiving variable payments based on a defined index.

The economics depend on the term of the swap. This is determined by the fixed payer rate and by the
difference between the variable payment from the counterparty and the actual variable cost of funds paid by the hospital to the bondholders (basis risk).

The variable rate paid by the counterparty to the hospital can be an index (BMA or LIBOR) or the hospital’s actual cost of funds. Set weekly by the Bond Market Association, the BMA index is a proxy for high-grade tax-exempt weekly adjustable bonds. The London Interbank Offered Rate, or LIBOR, is the rate of interest paid on U.S. dollar deposits at major London banks. It reflects short-term taxable interest rates and is the most widely used index in the swap market.

**Fixed receiver swaps** convert a hospital borrower’s fixed-rate debt into variable-rate debt. A hospital with fixed-rate debt contracts with a swap counterparty to provide variable-rate payments over the life of the swap in exchange for receiving fixed-rate payments.

The economics depend on the term of the swap. This is determined by the fixed receiver rate and the selected variable index. The closer the maturity dates of the swaps and the bonds, the less the net cost of the variable rate to the borrower. The variable rate paid by the borrower to the counterparty is typically a market index rate, such as BMA or LIBOR.

---

**Types of Derivatives**

- **Interest rate swap**
  - Contract to exchange interest rate payments

- **Plain-vanilla cap**
  - Protection from increases in floating rates above strike price

- **Chooser cap**
  - Protection from interest rate spikes on a retroactive basis

- **Collar**
  - Protection from increases above a cap but reduction in benefits if rates decline below a floor

- **Corridor**
  - Protection from increases within a range of interest rates between two strike prices

- **Knockout cap**
  - Protection from increasing interest rates up to a threshold where the cap “knocks out”

---

**Exhibit 5**

**Three Types of Swaps**

- **Fixed Payer Swap**
  - Bondholders ➔ Hospital ➔ Fixed Payment ➔ Variable Cost of Funds ➔ Counterparty

- **Fixed Receiver Swap**
  - Bondholders ➔ Hospital ➔ Variable Payment ➔ Fixed Cost of Funds ➔ Counterparty

- **Basis Swap**
  - Counterparty ➔ Hospital ➔ % of 3-Month LIBOR ➔ BMA ➔ Counterparty

- **Counterparty ➔ Hospital ➔ Fixed Receiver Rate ➔ % of 3-Month LIBOR ➔ BMA ➔ Hospital**

*Source: Kaufman, Hall & Associates, Inc. Used with permission.*
Basis swaps result from combining a tax–exempt fixed-to-floating swap with a LIBOR floating-to-fixed swap. The percentage of LIBOR received is the BMA fixed receiver swap rate divided by the LIBOR fixed payer swap rate. The net result is a benefit because the hospital receives a percentage of three-month LIBOR and pays BMA.

Swap and Derivative Management

The usefulness of swaps and other derivatives to tax-exempt healthcare organizations depends almost entirely on the relationship of taxable to tax-exempt interest rates. This relationship changes all the time, so the right derivative one day may not be right the next. Following 9/11, fixed receiver swaps, which swap fixed-rate debt for variable-rate debt, were common as organizations took advantage of lower variable rates. “Due to the way the yield curve has changed, right now we’re mostly seeing fixed payer swaps, which swap variable-rate debt for fixed-rate debt,” comments Kaufman. Swap values change as market conditions change. As interest rates increase, for example, the value of a fixed receiver swap decreases; as rates decrease, the value of the swap increases.

Fitch Ratings recently reported that the use of interest rate swaps by healthcare providers with debt rated by that agency increased significantly to 33 percent of total debt issuance in 2003 from 14 percent in 2001. “Most of the swaps were floating-to-fixed rate swaps, as hospitals sought to lock in low interest rates while limiting overall risk in a rising interest rate environment,” notes the agency’s report.1

Swedish Covenant Hospital has been “doing” interest rate swaps since 1996. “Right now, we’re converting some debt from variable rate to fixed rate. But that doesn’t mean we’ll continue doing this, because, we use interest rate swaps to hit our fixed-rate or variable-rate debt targets as they change over time. This has been very successful for us, and we’re very knowledgeable of how such swaps work and the risks involved. For example, because long-term interest rates have been declining, we decided to take some of the risk off the table and fix more of our debt. We executed one fixed-payer swap, which took us to our targeted mix, and we’re looking at doing another swap this week that will take us above the targeted fixed-rate percentage. Opportunities created by fluctuating interest rates arise quickly. In order to use interest rate swaps to manage our debt risk and mix, we’ve put in place a structure (called the ‘bond approval group’) that enables us to act quickly to change our debt mix and lower overall capital costs,” notes Krugel.

Ascension Health also uses fixed payer and fixed receiver swaps as one mechanism to adjust the relationship between fixed-rate and variable-rate debt. This repositions the organization’s debt on the yield curve as interest rates fall and rise and as the shape of the yield curve changes and offers an effective technique for managing the cost and risk associated with the organization’s debt portfolio.

Education about swaps and derivatives and proactive management are critical. “An active derivative program requires active management and a high level of independent expertise. Derivative traders are the new ‘rocket scientists’ on Wall Street. Insufficiently educated healthcare executives are not in a position to properly represent their organizations in the pricing process. Large dollars are at stake,” cautions Kaufman. Because derivatives come in a multitude of forms, it has become more difficult for healthcare financial leaders and board members to determine which trades are appropriate for the organization and which are either speculative or subject the organization to excessive risk. “Because of fiduciary responsibility to the communities they serve, healthcare organizations should never be doing a speculative trade,” comments Kaufman. Speculative trades occur when a trade is not hedging any existing debt on the balance sheet.

A high-quality swap program starts with the solid education of the board and senior leaders about swap benefits and risks, and ensures clear objectives, a rationale, an implementation plan, and post-implementation monitoring and management. A comprehensive swap policy should then formalize all of these items. The rating agencies are beginning to request such policies of organizations that hold derivatives. “If your organization has credit strength, you should be taking advantage of creative financing techniques such as swaps. The stronger the credit, the greater the use of new financing techniques. However, when used without a coherent strategy or by borrowers with finances that are already vulnerable, such financial products can result in adverse credit consequences,” notes Frederic Martucci, managing director of Fitch Ratings.2
Swaps and derivatives are difficult to understand and at times, intimidating. Nevertheless, for large and small healthcare organizations, swaps are a potentially valuable financing strategy. “The single best approach is for organizations to be proactive in understanding swaps, in framing how and where they might be used, and in developing swap and other derivative-related policies and procedures. Getting to this point takes time and focus, but the return on invested effort often can be high,” advises Eric Jordahl, senior vice president of Kaufman Hall.

The sidebar outlines the benefits and risks of each type of swap. (See sidebar, Benefits and Risks of Swaps.)

<table>
<thead>
<tr>
<th>Swap Type</th>
<th>Benefits</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Payer</td>
<td>• Locks in fixed rates quickly and for little cost; if rates go up, the swap has positive value to the hospital</td>
<td></td>
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<tr>
<td></td>
<td>• Enables hospital to add fixed-rate debt without actually issuing true fixed-rate debt</td>
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<tr>
<td></td>
<td>• Provides greater budget predictability</td>
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<td></td>
<td>• May provide a closer match between assets and liabilities</td>
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<tr>
<td></td>
<td>• Could allow for investment of bond proceeds at the higher fixed rate</td>
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</tr>
<tr>
<td>Fixed Receiver</td>
<td>• Under current market conditions, can provide interest cost savings</td>
<td></td>
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<tr>
<td></td>
<td>• Can better match interest income with interest expense (assets to liabilities)</td>
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<tr>
<td></td>
<td>• Since there is no exposure to bank credit facilities, eliminates renewal or price inflation risk and the need to negotiate covenants with a bank</td>
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<tr>
<td></td>
<td>• Eliminates the hospital’s exposure to event risk</td>
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<tr>
<td></td>
<td>• Depending on timing, this type of swap can allow for the investment of bond proceeds at the higher fixed rate</td>
<td></td>
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<tr>
<td></td>
<td>• Can be managed, which enables the hospital to benefit from market changes</td>
<td></td>
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<tr>
<td>Basis</td>
<td>• Can provide an immediate annual cash flow benefit, based on the relative value of the floating rate indexes</td>
<td></td>
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<tr>
<td></td>
<td>• Can act as a hedge against higher tax-exempt variable rates by using a taxable index; as interest rates increase, so does the positive benefit</td>
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<tr>
<td></td>
<td>• As marginal tax rates increase, cash flow benefits can improve</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Under current market conditions, would provide interest cost savings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• May require additional covenants or potential posting of collateral; healthcare organizations should keep in mind with all types of swaps that commercial banks as counterparties do not typically require collateral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Required mark-to-market accounting treatment may not be favorable</td>
<td></td>
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<tr>
<td></td>
<td>• Basis risk could be sizable unless there is an exact swap of a hospital’s cost of funds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potential cost (or benefit) from early termination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Counterparty’s credit risk may be problematic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• All-in variable payments may exceed the underlying fixed rate due to variable-rate risk and tax risk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Because BMA is reset on a weekly basis, the variable-rate portion of the swap may move in a direction unfavorable to the hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The credit risk of the counterparty may be problematic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Additional covenants or potential posting of collateral may be required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potential cost (or benefit) from early termination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mark-to-market accounting may not be favorable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potential cost (or benefit) from early termination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Accounting treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potential covenants and collateral posting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Credit risk of the counterparty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cash flow benefit of basis swaps can decrease or become negative if marginal tax rates decrease and/or the supply of tax-exempt floaters increases</td>
<td></td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, Inc. Used with permission.
Strategy 7: Pursue a Level Debt Structure with the Longest Possible Final Maturity

Average Life of Debt and Amortization Schedules

The average life of an organization’s overall debt and its amortization and maturity structure have a significant impact on current and predicted cash flow and debt capacity. The lowest net present value of any payment structure is generally the longest amortization obtainable in the capital markets and permitted by tax law.1

However, as capital structures are built through the issuance of additional debt, amortization schedules tend to “shorten up”—that is, the average life of the debt in number of years to maturity decreases—and annual payments become uneven. With each new series of bonds, it is important to pay special attention to the total average life of the debt and the actual payment schedule. “Paying close attention to this issue can have a powerful cash flow impact on an organization from year to year. One might assume that multiple organizations each with $100 million in debt are paying roughly the same average debt service each year. Nothing could be further from the truth; the variability is enormous,” notes Kaufman.

Organizations that are shortening up their debt and paying that debt over 15 and 20 years are actually paying a higher cost for the debt than those organizations paying over a 30-year period. Similar to how a home mortgage works, stretching out the amortization period for the longest possible period of time produces the lowest net present value of payments. Debt restructuring can ensure level debt payments with longer average life.

Hospitals typically use a 30-year amortization period, but some are stretching this out even further. Because of the way individual series are issued, the average life of a 30-year bond issue is generally between 20 and 22 years, so organizations need to be examining the average life of their total debt and making sure it’s not shortening up. “We’ve seen hospitals get in serious trouble when debt service payments increase dramatically at a point in time when the organizations can least afford such increased payments,” comments Kaufman.

A Closer Look at the Impact

Exhibit 6. Average Life of Total Debt and Its Impact on Cash Flow and Debt Capacity, illustrates the significant impact of average life of total debt on cash flow and debt capacity. In Scenario One, the organization incurs $600 million of new debt in a traditional series fashion, essentially “filling in the back end” of the amortization schedule. In Scenario Two, the organization adds new debt and restructures the old debt extending 30 years into the future to achieve level debt service payments over a longer average life. In Scenario Three, the organization adds new debt and restructures existing debt extending 40 years into the future to achieve level debt service payments over the longest average life. Using this strategy, the organization effectively adds $720 million of debt to its existing structure, but only increases MADS by $3.6 million—significantly less than the $32.2 million increase occurring using the traditional approach represented by Scenario One.
Strategy 8: Monitor and Continuously Adjust the Debt Portfolio

To maintain maximum flexibility, lowest possible interest costs, and acceptable levels of risk, organizations must proactively and regularly adjust their portfolios as changes occur in the market and in the portfolios themselves.

Using what they call a “bucket chart,” Ascension Health’s leaders continuously monitor diversification of the system’s debt portfolio. The chart lists all debt instruments—both fixed-rate and variable-rate products—their current status, scheduled financings, and other potential changes that may occur in the portfolio. (See exhibit 7. Monitoring the Mix of Debt Instruments: The “Bucket Chart” Tool.) The “holes” in the bucket—the $0 sums for selected instrument buckets—occur for very specific reasons, perhaps tied to diversification goals, capital costs, risk minimization, or other factors. The “principal paydown” column in the “scheduled” portion identifies the dollars that will shift as principal is paid off. The “put bond” column enables leaders to identify the quantity of put bonds that will come due to start considering whether to roll these over, and if so, for what lengths of time (30 days, 60 days, a year, two years, and so forth). For example, the chart indicates that $290 million of synthetic put bonds will come due in 2009 and that these will be rolled from synthetic to uninsured auction rate securities.

Exhibit 7

<table>
<thead>
<tr>
<th>Debt Instrument</th>
<th>June 2004</th>
<th>Scheduled</th>
<th>Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Rate Bonds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Fixed</td>
<td>$568</td>
<td>($223)</td>
<td></td>
</tr>
<tr>
<td>Synthetic Fixed Rate</td>
<td>$1,053</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Synthetic Put Bonds</td>
<td>$290</td>
<td></td>
<td>($290)</td>
</tr>
<tr>
<td>Multi-Annual Put Bonds</td>
<td>$340</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative Total Fixed</td>
<td>$2,252</td>
<td>($223)</td>
<td>($290)</td>
</tr>
<tr>
<td>Variable Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxable CP (with Bank Line)</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly VRDOs (self liquidity)</td>
<td>$352</td>
<td>($7)</td>
<td></td>
</tr>
<tr>
<td>Annual VRDOs (self liquidity)</td>
<td>$582</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly VRDOs (with Bank Line)</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auction Rate Securities (uninsured)</td>
<td>$98</td>
<td>($13)</td>
<td>$290</td>
</tr>
<tr>
<td>Auction Rate Securities (insured)</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Synthetic Variable Rate</td>
<td>$100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Structured Variable</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative Total Variable</td>
<td>$1,132</td>
<td>($20)</td>
<td>$290</td>
</tr>
<tr>
<td>Cumulative Total</td>
<td>$3,385</td>
<td>$3,142</td>
<td>$3,141</td>
</tr>
<tr>
<td>% Variable Rate</td>
<td>33.5%</td>
<td>35.4%</td>
<td>44.7%</td>
</tr>
</tbody>
</table>

Source: Ascension Health. Used with permission.
The “potential” financing columns identify what Ascension Health might be doing in the financial markets in future years. Pension prefunding is one of its current activities as reflected in the first column. The “new money” column includes capital needed to satisfy the system’s integrated strategic financial plan (ISFP). The final column tracks progress toward achieving the desired debt mix. Through the use of this tool, leaders can examine the effect on risk exposure and the cost of capital when changes are made to either existing capital structure or planned capital financings.

Ascension Health also uses a “rollover calendar” to monitor ongoing put risk given timing of bond rollovers. (See exhibit 8, Variable Mode Bond Rollover Calendar.)

“Organizations cannot just accrue debt and forget about it. They need to continuously monitor how their capital structure is performing in supporting strategic financial goals. The rigorous use of calendar management (described fully as Principle 2 in the first report) ensures that an organization revisits its strategic-financial assumptions on an annual basis and assesses its current financial performance. Organizations must then monitor the market regularly for interest rate changes, and identify and evaluate new opportunities to enhance capital structure. Revisiting and continuously readjusting the debt portfolio ensures lowest possible cost of capital and maximum flexibility,” notes Fuller.

Exhibit 8

Variable Mode Bond Rollover Calendar

As of August 31, 2004

**Tennessee**
1/4/2005
HEFB 2001 B-2 ($100.0 million)
(current rate is 1.20%)

**Tennessee**
8/3/2005
HEFB 2001 B-1 ($81.5 million)
(current rate is 1.85%)

**Michigan**
11/15/2005
MSHFA 1999 B-2 ($85.0 million)
(5.20% since 11/1/99)

**Michigan**
1/15/2008
MSHFA 1999 B-3 ($85.0 million)
(5.375% since 11/1/99)

**Michigan**
11/15/2007
MSHFA 1999 B-4 ($85.0 million)
(5.375% since 11/1/99)

**Tennessee**
1/4/2005
HEFB 2001 B-2 ($100.0 million)
(current rate is 1.20%)

**Indiana**
3/1/2005
IHFFA 2001 A-3 ($100.0 million)
IHFFA 2001 A-4 ($100.8 million)
(current rate is 1.05%)

**Indiana**
7/5/2005
IHFFA 2001 A-1 ($100.0 million)
IHFFA 2001 A-2 ($100.0 million)
(current rate is 1.73%)

**Indiana**
3/1/2005
IHFFA 2001 A-3 ($100.0 million)
IHFFA 2001 A-4 ($100.8 million)
(current rate is 1.05%)

**Indiana**
7/5/2005
IHFFA 2001 A-1 ($100.0 million)
IHFFA 2001 A-2 ($100.0 million)
(current rate is 1.73%)

**Michigan**
11/15/2004
MSHFA 1999 B-1 ($85.0 million)
(5.05% since 11/1/99)

**Michigan**
7/15/2007
MSHFA 1999 B-4 ($85.0 million)
(5.375% since 11/1/99)

**Michigan**
11/15/2007
MSHFA 1999 B-4 ($85.0 million)
(5.375% since 11/1/99)

**Michigan**
11/15/2008
MSHFA 1999 B-3 ($85.0 million)
(5.30% since 11/1/99)

Source: Ascension Health. Used with permission.
Concluding Comment

The importance of effective and efficient capital structure management to an organization’s long-term competitive strategic-financial performance cannot be overemphasized. To obtain the significant financial and competitive advantage achievable through effective capital structure management, hospitals and health systems must consistently use the eight strategies outlined in this report.

Healthcare leaders first must ensure that their boards of trustees and senior executive teams are fully educated as to the value of effective capital structure management and that an appropriate finance team is in place to deliver the needed expertise. Second, to maintain the highest possible credit rating, leaders must determine how much debt the organization is able to incur and not exceed the targeted amount. Third, determining the optimal mix of debt-to-equity financing and traditional-to-nontraditional financing, fully identifying and investigating available options, and securing those most appropriate given credit and risk parameters are critical and ongoing management functions. Fourth, leaders must select and achieve the right relationship between fixed-rate and variable-rate debt and tweak the mix as needed given the changing interest rate environment and organizational realities. Fifth, exposure to any one form of risk must be minimized by diversifying the use of variable-rate debt vehicles. Sixth, leaders should consider use of swaps and other derivatives to manage the cost of capital and capital structure and to make adjustments as demanded by the interest rate and competitive environments. Seventh, debt amortization schedules must be carefully constructed to ensure the lowest cost of capital and lowest present value of debt service payments. Eighth and finally, healthcare leaders must proactively and continuously monitor and adjust both debt and investment portfolios as changes occur in the capital markets and in the portfolios themselves.

In an era of slim operating margins, healthcare organizations can ill afford to neglect any aspect of the capital management cycle, in which capital structure assumes a major role (See exhibit 1 in Report 1). Use of the eight capital structure management strategies described here will increasingly reward organizations with the know-how and muscle to achieve a strategic financial competitive advantage.
References


e. These strategies and their discussion in the narrative of each section were derived from Kaufman, K., “Understanding Capital Markets,” presented at 2005 Congress on Healthcare Management, Chicago, Mar. 15, 2005.


i. Available at www.financingthefuture.org.


Financing the Future II

HFMA’s Financing the Future series began the process of highlighting strategies hospitals and other healthcare providers could use to improve access to capital through successful financial planning and execution. Financing the Future II continues this process. By providing practical how-to information in the form of concrete strategies, tools, timelines, and other materials, the second Financing the Future series seeks to help healthcare organizations of all sizes “raise the bar” on financial performance. Financing the Future II is being developed in partnership with GE Commercial Finance Healthcare Financial Services and Kaufman, Hall and Associates, Inc., and will include six reports for healthcare financial leaders, their staffs, and healthcare executives and board members. For more information about Financing the Future II, visit www.financingthefuture.org.

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Kaufman Hall

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