hfma roundtable

How Will America Replace Its Rural Hospitals?

About HFMA Roundtables

With this article, HFMA continues a series of "virtual" discussions to offer thought leadership and practical perspectives on healthcare financial issues by leading industry professionals. This HFMA Roundtable is made possible through the support of InnoVative Capital, LLC of Springfield, Pa., and Quorum Health Resources (QHR) of Brentwood, Tenn.

Many of the nation's 2,000-plus rural hospitals are aging. Some may be in immediate need of substantial renovation or replacement. Major construction projects have often been unaffordable for small hospitals. But the financial story for rural hospitals is not all doom and gloom. HFMA's *Financing the Future* series found that more hospitals with broad access to capital were rural than was expected. This indicates an improved capital access environment for rural hospitals and a greater market acceptance of rural hospital credit risk.

Recent regulatory changes have improved the financial viability of rural hospitals and increased their eligibility for capital financing options. Under the federal critical access hospital program, rural hospitals now can receive cost-based government reimbursement for their capital expenditures. This added reimbursement allows more small hospitals to qualify for "AAA"-caliber financing rates secured by mortgage insurance and direct guarantees of the HUD/FHA Section 242 program and U.S. Department of Agriculture community facilities program.

Presented here are the thoughts of four professionals who have experience in the financing of construction projects—a banker and three executives from rural hospitals that are replacing aging facilities or have undertaken other construction projects.

THE PARTICIPANTS IN THIS HFMA ROUNDTABLE ARE:

Alan P. Richman
President and CEO, InnoVative Capital, LLC, a healthcare financial advisory firm and HUD-licensed FHA mortgage lender based in Springfield, Pa. The company specializes in the financing of construction projects for rural, community, and critical access hospitals.

Gary Moore
CEO, Shoshone Medical Center, a 25-bed critical access hospital in Kellogg, Idaho, managed by QHR.

Marilyn A. Hays
CFO, North Valley Hospital, a 25-bed critical access hospital in Whitefish, Mont., managed by QHR.

Larry A. Kidd, FHFMA
CFO and COO, St. Mary's Hospital in Cottonwood, Idaho, an 18-bed critical access hospital, and CFO of Clearwater Valley Hospital, Orofino, Idaho, a 23-bed critical access hospital. Both hospitals are affiliated with Benedictine Health System of Duluth, Minn.

ROUNDTABLE DISCUSSION

► How critical is the need for America's rural hospitals to be replaced?

► **Richman:** Over the past 25 years, operating losses at many small hospitals have left facilities in disrepair and with obsolete medical equipment. These factors contribute to the loss of patients and physicians to tertiary hospitals. Rural hospital closures jeopardize local economies and the health of residents. Yet there is new optimism for the financial viability of small hospitals. The critical access hospital program, growing political support for rural America, and improving hospital profits now make financing a construction project possible for many rural hospitals. Although loans to rural hospitals may still be considered risky, the federal government and, to some degree, the capital markets now recognize the credit strengths of rural hospitals and the urgent need to deliver affordable capital to rebuild these essential hospitals.

► **Moore:** The physical state of our 25-bed hospital, built in 1959, can shed some light on the problem. You cannot get a wheelchair into a patient's bathroom unless it is folded up. The boilers, elevator, plumbing, and electrical infrastructures are antiquated and it is hard to find parts for them. The low ceilings in our facility wouldn't meet current air exchange ratios. All of these problems were only going to get worse with each year. So we decided to replace the whole facility with a new one, which opened in January 2005.

► **Hays:** Many rural facilities are plagued with old and inefficient mechanical systems, code compliance issues, and the presence of asbestos. The layout is geared toward inpatient services at a time when outpatient services are on the rise. It can be difficult to expand these outpatient services if they are located in the core of the facility. All these factors apply to our facility, and made it impractical to remodel due to the high cost. Therefore, we decided to pursue a new replacement facility.

► **Kidd:** We haven't replaced either of our hospitals, but are thinking of doing so eventually. In the next 10 to 15 years, if not now, a lot of rural hospitals are going to need major renovation or replacement. The alternative is to close them, but it's critical that they stay open. People in other areas of the country would be amazed at how far apart hospitals are in Idaho and other western states. To get from one Idaho hospital to the nearest regional medical center is a 142-mile drive over a mountain pass. That's a long drive, even in good weather.

► What process would you undertake to calculate your borrowing capacity and an affordable project size?

► **Richman:** The process differs for each hospital, but North Valley is a good example. An assessment of the financial feasibility of the proposed project was a must. An initial loan was sized from historical results without any demand growth factored in. It was based upon reimbursement changes, interest forecasts, and a rough budget. The hospital's market analysis and forecasts were then evaluated by service line. A final debt-capacity analysis, including sensitivity forecasts, recommended that the hospital convert to CAH status. This became the basis for the maximum project budget and took precedence initially over the architectural and development phase. Although it's natural to want to get started designing the project, North Valley felt it should wait until the budget was set.

► **Moore:** A hospital can spend a lot of money putting together big plans and then not be able to afford them. We had to go through a calculation process to see how much debt service we could cover—a variety of "what if" scenarios, based on market and demographic studies and payer mix. That yielded a total replacement cost that fit our projections of debt service coverage. Then our management company developed a total project budget based on a prototype replacement that it had developed. We massaged the square footage we needed for continuing to do business over the next 20 years, with some projected growth in a few areas.

► **Hays:** Our management company performed a facility replacement market assessment, evaluating demographics, economic climate, competition, medical staff, services, operations, and volume projections. We came up with some preliminary costs for a new facility, and performed financial forecasts to see if the necessary financial ratios for our loan could be met. To improve the financial feasibility, we applied for CAH status. Joining the CAH program increased our Medicare and Medicaid reimbursements, and was key to making this project possible.

► **Kidd:** The first step is to develop a master facility plan, which helps prioritize project needs of the facility. This is typically done internally with the help of outside consultants. Once a project is chosen, then you have to calculate the borrowing capacity and determine funding sources. We rely on our corporate office for support at this juncture. We would work with our board and corporate office to determine the best course of action once all the data are analyzed.

► How would you weigh the options of renovation and replacement?

► **Richman:** I believe the first preference should be a replacement facility. It's often close in cost to the cost of renovation. Also, off-site construction is less disruptive operationally and avoids the chance that structural impediments may be encountered that would make full renovation of an old hospital difficult. Alternative site selection and cost-effective prototype designs are limited to replacement projects. Regardless, cash-constrained hospitals with limited assets may find renovation projects their only affordable option.

► **Moore:** In many cases, including our own, it's more cost-effective to replace than to renovate. There was a lot of emotion in our local community about tearing down the old hospital. People donated money to it. Maybe they helped put in a bathroom, or they sold cakes and cookies for a community fund-raiser. So you need to let the community know that this is a necessary business decision, based on what we can afford.

► **Hays:** Sometimes it makes more sense to spend a few million more and completely replace your facility with a new one that is efficiently laid out, accommodates the kind of patient you see in your community, and provides for growth. Initial estimates put our replacement facility costs at $3 million more than renovation. We chose replacement at a new site, which turned out to be a hot issue in our community due to perceived costs for replacement versus renovation and concerns that the new site would attract commercial development away from other areas. A community-wide committee appointed by the board studied the issue, and decided to support a new facility at a new site with medical-use zoning restrictions.

► **Kidd:** Replacement is usually preferable to renovation. If you do a major renovation, you have to comply with the same building codes as you would if you were doing new construction. That means big expenses, such as removing asbestos and installing sprinklers.

► How do you determine which medical services will be offered in a new or renovated facility?

► **Richman:** Hospitals can rank current and desired future services by importance to the community and profitability. Don't be fooled by the term "nonprofit" hospital. It should not mean "no profit." Due to their limited financial resources, rural hospitals cannot be all things to all people. They may want to build upon a core specialty focus and direct some procedures elsewhere. In the loan underwriting process for Shoshone Medical Center, excluding its essential services, all other inpatient and outpatient services were evaluated for immediate and future profitability. This was done to maximize its potential borrowing amount.

► **Moore:** Shoshone Medical Center eliminated an underused and unprofitable OB unit. Although the new Shoshone Medical Center will not have OB, our architectural plans make room for it in the future. We have also expanded or added other services, keeping in mind that we need to have the specialty physicians to operate them. We're replacing our portable MRI, which now is here one day a week, with a permanent, open MRI. It is expected, according to conservative estimates, to bring a 15 percent increase in MRI use. We are also adding a pulmonary functions room, building on our existing respiratory therapy services.

► **Hays:** Our 56-bed nursing home was losing money and reduced our overall bottom line. As the board knew this would adversely affect our prospects of obtaining HUD 242 financing for either a renovation or replacement project, we decided to close the nursing home. Also, to better understand which new services we should offer, we studied why patients sought care at other facilities to look for opportunities to increase volumes and recruit physicians.

► **Kidd:** Before you add new medical services, you should look at the skill set of your current staff. Will you have to recruit new personnel? I also want to add to Alan's point that the hospital needs to make money on some services. In some cases, savings for the hospital also mean savings for the patient. When we acquired new CT scanners, we were able to reduce charges to the patient by about $250 per scan.

► Which capital sources are especially appropriate for rural hospitals wishing to undertake a major capital project?

► **Richman:** Nothing affects the feasibility of a hospital project more than interest rates. Obtaining low-cost funding should be the objective. One method is to engage a HUD-licensed lender to obtain FHA 242 mortgage insurance and underwrite a direct loan, or enhance a municipal bond issue. Although they may be time-consuming, FHA- or USDA-guaranteed loans reduce interest rates and provide huge annual savings. When a hospital has modest borrowing needs, time

sensitivity, or local tax support, it should also consider unrated debt, general obligation bonds, and bank loans.

► **Moore:** While our local bank provided an interim loan, permanent financing for our $18.5 million project was out of the question. We selected the HUD 242 program for that purpose. Because a HUD-guaranteed loan would have an interest rate on a par with AA or AAA bonds, our forecasts now seemed promising. During the process, HUD officials visited a few times and reviewed our financials each month, but our board maintained control. What's great was our loan did not require municipal bonds or tax guarantees, and doesn't limit our community's ability to pledge taxes for future infrastructure improvements such as sewers and parks.

► **Hays:** Our $29 million project loan will be guaranteed with FHA mortgage insurance and funded by either a Ginnie Mae-backed direct loan or municipal bonds. The HUD program targets rural facilities in the CAH program and has more manageable eligibility requirements and covenants than other options we explored. Due to the complexity of the HUD application process, we benefited by having consultants with HUD experience.

► **Kidd:** We might decide to use the HUD 242 if we replace a facility at some point in the future. For our smaller projects, we came up with some creative solutions. For example, we financed a new ER at Clearwater Valley Hospital mainly with a $500,000 appropriation from Congress. That amount is the limit for one congressional appropriation, and we have had a total of three, including a USDA grant. They are not easy to get, but we had a wonderful grant writer, and our congressman believed in our plan. The second appropriation funded the purchase of a CT scanner at Clearwater Valley. St. Mary's scanner was purchased with two private bequests. We used tax-exempt bond financing from the Idaho Health Facilities Authority to build a clinic near St. Mary's.

► What advice would you offer financial executives at rural hospitals contemplating major capital construction projects?

► **Richman:** Hire experienced professionals. For any local or national firm, credentials, accomplishments, and references must be verified and show relevance to your specific situation. First-timers should be avoided, as on-the-job training of consultants is unwise. Hospital management needs a thorough understanding of the financing and development process, to best align the expectations of its board, doctors, and local community with reality. Also, hold off making major announcements to the community until the outcome is certain. This preserves credibility and goodwill and makes for a robust celebration at loan closing.

► **Moore:** You will have a lot of money at your disposal, amounts that you have probably never seen before. Do not waste it. Before you hire an architect, you need to know how much you can borrow. I would highly recommend considering the HUD 242 loan. That was our savior. Critical access status brought us back up to our needs financially. Even if you're new to cost-based reimbursement, as we were, HUD allows you to restate your financials back three years to meet eligibility requirements for a positive operating margin. While the HUD application process is not difficult, it can be frustrating. But if there are no major problems, it should take only eight or nine months for approval.

► **Hays:** It's a long process, so be patient. Develop a strategic plan upfront, perform due diligence, and educate your board. You should be able to continually incorporate plan changes and updated financial information to make sure the project is still feasible. Also, our banker holds regular conference calls with all members of the project team. That keeps everyone updated on changing project costs and financial limitations. Another piece of advice: Involve your community, staff, and physicians in the decision-making process. Seek their input and support. Community members can help you identify potential donors for a capital campaign.

► **Kidd:** My advice is to leave no stone unturned. That's how we came up with the congressional appropriation. One other thing: public hospitals that rely on tax levies are going to have to take a real hard look at

selling off their facilities to private health systems. The public is not enthusiastic about funding projects with tax dollars. Clearwater Valley Hospital, which our system operates, is still county-owned, but the county is considering selling it to us.

► Before you received your loan, how did you balance your liquidity position with project-related capital outlays, and did it require the deferral of plant maintenance?

► **Richman:** As the hospital's financial adviser or banker, we begin by requesting financial statements and two-year forecasts. A good adviser will run sensitivity tests of profitability and cash reserves incorporating the project. Overlaying the timing of planned project development outlays with forecasted financials generates a cash flow budget. A liquidity-challenged hospital may seek the support of an interim credit facility, as well as a financial partner, or defer nonessential capital expenditures. Community fund-raising early in the planning stages can help. But capital budgeting is dynamic and has to be constantly updated by the hospital and its project team.

► **Moore:** Before the new facility could open, we desperately needed some portable radiology equipment and monitors, which we will later move to the new facility. We acquired this equipment after the loan closing. Our local banker helped with credit lines and the timing was good, with some cost-report receivables coming back to the hospital.

► **Hays:** We obtained a line of credit to assist with our upfront project planning, design, and financing costs in order to maintain our cash levels for operations. After the building project is completed, debt leverage for future purchases may be severely limited. If you know that you will need to replace your CT scanner within a year or two of completing construction, you should build that cost into the current project. ●