FROM FINANCIAL CRISIS *to new facility:*

a small hospital revitalized

On the brink of failure just four years ago, West Shoshone Medical Center in Kellogg, Idaho prepares to make history as the first district owned critical access hospital to build a new state-of-the-art, replacement hospital with innovative FHA 242 financing from HUD.

Six small towns strung along interstate 90 in northern Idaho have relied on West Shoshone Medical Center for healthcare since 1958. The top-notch facility was built to serve the booming silver mining region; its hard times began when the region's hard times began, with the closing of the mines.

In the next decades, like most rural hospitals, Shoshone faced trouble, after challenge, after disappointment. Laden with debt and borrowing to make payroll, it managed to stay open, but upgrades, expansions, new equipment, added services…were out of reach.

Fast-forward to 2003. The area's 14,000 residents are invited to a groundbreaking for a brand new hospital…designed to serve today's needs and styled to blend into the quaint Alpine Village style of Kellogg's new tourist economy.

CEO Gary Moore was unwilling to accept defeat. "We had to make some tough choices," he explains, "like converting to critical access status, curtailing unprofitable services…getting back to basics." The critical access hospital (CAH) program was intended for rural facilities like Shoshone, struggling with low Medicare operating and capital funds, shrinking volumes and an aging facility. Shoshone, a QHR (Quorum Health Resources) managed hospital, and the board worked through the entire CAH conversion decision process and then utilized its reimbursement experts to help ensure reimbursement levels would be adequate to sustain the hospital for the foreseeable future.

The hospital's bottom line responded, even as the community began to rebound. With a federal Superfund cleanup restoring the region's pristine environment,

Kellogg was developing a new identity as a ski resort. "We started to get our financial house in order, paying down debt and even investing in new radiology equipment," Moore reports. "We wanted to be ready to grow with the community."

Moore knew that the right next step for Shoshone was a new facility. But how could this hospital — recently turned around and still hampered by a lack of reserves — qualify to borrow millions? Again, refusing to take no for an answer, he explored the possibilities: "We found that a small rural hospital is considered about as risky as a dot-com when it comes to accessing capital. But, our consultants helped us find a tremendous opportunity."

The tremendous opportunity was the HUD-FHA 242 mortgage insurance program. Established in 1968 under the National Housing Act, this program has historically been concentrated on providing loan guarantees for northern urban hospitals, and not broadly marketed to smaller facilities nationwide. Recently adapted for CAH hospitals with new amended underwriting and loan processing criteria, the HUD program was now actively soliciting eligible small rural hospitals eager for federal assistance in securing low cost capital for construction. While HUD itself does not make hospital loans, it insures the mortgages, and in doing so, it helps organizations like Shoshone find affordable long-term financing.

Working on behalf of small hospitals like Shoshone, Alan Richman, CEO of InnoVative Capital, sees the value of the 242 program. "This is big news, says Richman, "so many of our nation's small rural hospitals are in need of replacement. And most have difficulty accessing capital because the loans are too small for the big investment banking firms, too large for small banks, and too risky for either. This program changes all that. It's good for everyone: the local bank makes manageable working capital loans without construction risk; the hospital builds the facility it needs; the community keeps healthcare local, and the federal government helps perpetuate the delivery of affordable quality healthcare nationwide."

A small rural hospital is considered as risky as a dot-com, when it comes to accessing capital.

When preliminary analysis identified sufficient community support for a new hospital, Moore formed his team. "The key was in the lock, ready to be turned," CFO Richard Mikkelson remembers, "We found that critical access hospital cost-based reimbursement allowed us not only to survive as a profitable ongoing concern, but also to afford a new facility." Shoshone worked to develop a strategic plan, market analysis and pro forma's, and worked with consultants to design a facility that met the needs of the community and afforded the hospital the forecasted cash flow necessary to support the construction of a replacement facility. A twenty-five bed hospital totaling 48,000 square feet was designed; it has now been approved as a model for rural replacement facilities.

Tough choices needed to be approved by the hospital board, in its quest to structure a hospital that could generate enough revenue to interest any investor or lender, including HUD. First, it was determined that Shoshone's small size, limited balance sheet, and the risks inherent in a small hospital with a restricted physician base, would deter investors from purchasing bonds backed solely by the hospital — without credit enhancement. For the same reasons, private credit enhancement was not an option.

continued on next page

These barriers, coupled with HUD's posture as a forward thinking lender that puts a significant underwriting emphasis on financial and operational projections, suggested that HUD was the best option for Shoshone.

Prior to meeting with HUD and eventually submitting an application for mortgage insurance, Shoshone would need to address not only the challenges systemic in rural hospitals nationwide, but also a number of issues unique to Shoshone as it relates to specifics of the HUD 242 Program. To start, (1) the hospital's negative cash position required lines of credit from local banks to provide cash to fund the design, development and financing costs; (2) appraisals were needed for its clinics to access whether the value of Shoshone's pledged property was sufficient to meet HUD's ten percent equity requirement (since a cash contribution by Shoshone was out of the question); (3) a detailed EPA-approved construction manual was produced that set forth the manner in which a hospital project could be constructed on this SuperFund site; and (4) a long-term lease structure was developed in cooperation with the Idaho Health Facilities, since Shoshone could not meet HUD's mandated mortgage pledge as a district-owned hospital. After these steps were successfully implemented, the HUD process began with the submission of the group's preliminary findings to HUD for its pre-assessment.

The next step was a pre-application meeting, held with representatives of HUD and Health and Human Services on-site at the hospital. This meeting was attended by board members, the working group and civic leaders. The findings of the hospital's market analysis and feasibility study made it clear to all working group members that the project was financially viable. "Critical access hospital cost-based reimbursement made this project viable for Shoshone; without it, a loan would have been impossible to obtain," reiterated one of the Shoshone consultants.

While the loan submission process was an arduous chore, the loan application was submitted to HUD and approved in May 2003. Instead of funding the loan with the proceeds of the sale of tax-exempt bonds, the hospital quickly locked into a low cost, privately-placed Ginnie Mae collateralized direct loan. This funding method was chosen to eliminate the negative arbitrage that was exhibited in a bond financing, reduce the closing costs, shrink the hospital's loan amount by approximately $750,000, and also reduce its loan closing cash costs by $100,000. To borrow almost $18,000,000 in this GNMA structure, Shoshone's loan closing costs were less than $100,000 (coupled with its pledged security package). Further, this structure allowed the hospital to "lock in" an interest rate 30-45 days earlier than a bond financing. Due to this timing, Shoshone locked into a sub six percent rate — a rate more common for hospitals ten times its size — without any onerous covenants.

Christopher D. Boesen, Director, HUD Office of Insured Health Care Facilities, commented on the process: "There are tremendous opportunities in rural health care, especially for critical access hospitals, and HUD looks forward to working with many more hospitals like Shoshone. They should be applauded for their hard work and dedication to providing quality health care in rural America."

"HUD changed the future of healthcare for the valley," comments CEO Gary Moore. "It took a team of experts to make it happen, but the program gave the valley new hope." HUD's announcement of the Shoshone loan guarantee was made on May 15, 2003; closing on the mortgage is scheduled for September 15. Construction will begin in September 2003, with the hospital's opening slated for early 2005. For more information, contact Gary Moore, Shoshone CEO, at 208-786-0681.