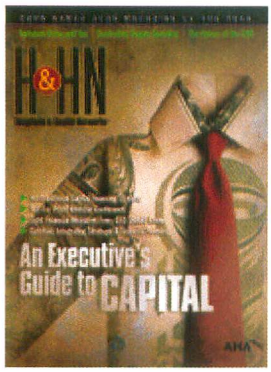
Cover Story

Capital

By Dave Carpenter

Beyond the tried and true in the quest for financing



Not-for-profit health care organizations looking to feed their capital appetites have long preferred fairly straightforward means of obtaining money. Who could blame them for sticking with vanilla over more exotic "flavors" of financing, especially with low interest rates making standard bond issues and bank loans appealing?

Those old standbys remain by far the financing vehicles of choice. But other methods are gaining hold as not-for-profits look elsewhere--usually the corporate world--for successful precedents that can help fund projects without leaving a bad financial aftertaste.

Perhaps the most noteworthy innovation was employed earlier this year by Ascension Health, St. Louis, which used subordinate debt to address a $1.4 billion pension deficit. The nation's largest not-for-profit hospital system issued $612 million in subordinate bonds, with senior debt obligations taking priority.

Making unprecedented use of a technique popular among Fortune 500 corporations, Ascension managed to raise cash to pay down its employee pension funds without either jeopardizing the standing of its existing bond-holders or running afoul of credit rating agencies.

"It may point to the growing sophistication of not-for-profit health systems" to take on different types of debt structures, says John Wells of Fitch Ratings. "It's possible that this could lead to a trend of this type of issue."

Ascension's move drew widespread interest in the not-for-profit sector, even if many others may not have the immediate resources or credit standing to take similar steps.

Randy Fuller, hospital segment manager for GE Healthcare Financial Services, continues to see a lot of "business as usual"--tax-exempt bond issuance and some interest-rate swaps and derivatives to hedge organizations' risk and take advantage of lower interest rates. "I think people are aware there are some unusual financing vehicles out there," he says. "But it continues to be a relatively attractive interest-rate environment, and that's not necessarily driving people to be horribly creative with alternative financing vehicles."

Ascension turned to subordinate debt as a novel way to address its $1.4 billion pension deficit. But it wasn't an obvious step to take. Only one other not-for-profit hospital--Adventist Health System Sunbelt Health Corp. of Florida--had ever done such a deal, and it was small and under the radar of credit rating agencies.

The move came about only after Ascension, a Catholic system, whose hospitals have 17,000 beds in the Great Lakes, Mid-Atlantic, Southern and Western regions, decided not to reduce benefits to its employees or otherwise change its pensions. But executives still wanted to find enough cash to pay down the pension deficit--saving money while also preserving debt capacity.

Ascension had two advantages not shared by all not-for-profits: rock-solid finances, including operating gains for six straight years and nearly $5 billion in unrestricted cash reserves, and a church-plan exemption from federal ERISA regulations, which strictly govern the funding of pension plans.

With assistance from Citigroup and Morgan Stanley, which jointly handled the bond issue, it settled on the senior/subordinate debt structure. The structure made existing bondholders senior; in the unlikely event of a default or bankruptcy, they would always get paid first. The unsecured bonds were issued through the Indiana Health Financing Authority, the Alabama Special Care Facilities Financing Authority and the Michigan State Hospital Finance Authority in February. "Serial mode" or multiannual bonds were used, with terms running from 2007 to 2012 and Ascension using the cash to pre-fund about half of its pension deficit.

Estimated savings for the organization: $387 million over 10 years. "It frees up cash, it lowers our pension expense and it creates a new capital structure for us now that we believe not only gives us flexibility in dealing with the pension issue but also flexibility in the future if we want to deal with any other subordinate debt," says Anthony Speranzo, Ascension's chief financial officer.

Ascension was left with a total of $4.2 billion in debt after the financing. Still, Speranzo saw no major downside to the issue.

"It does leverage the organization a little bit more than it did previously," he says. "But we had a $1.4 billion deficit in our pension--you could argue that that leveraged us."

Convincing the investment community of the wisdom of the move was crucial. Jim Blake, managing director of Citigroup, says key investors came on board quickly. "The larger, most sophisticated of the funds were saying, 'What took you guys so long?' " he says. "They liked it a lot."

Winning over the credit rating agencies proved tougher. Ascension, which did not want to go ahead with anything that might jeopardize its high credit rating, needed six months of discussions to convince them that the rare use of subordinate debt by a not-for-profit was appropriate.

Both the high additional debt total and the uniqueness of the deal warranted the extra scrutiny, say analysts at the three major rating agencies. "You can't get a complete pass just because you make the additional debt subdebt," says Martin Arrick, managing director at Standard & Poor's. "There is a magnitude question, first and foremost.... In the case of Ascension, we were able to be very comfortable with what they're doing. No. 1, they're doing very well. No. 2, they were exchanging one liability [pension debt] for another one."

For the most part, only the strong and financially savvy need apply when it comes to subordinate debt, which Wells says likely would be "reserved for the AA, stronger type credits." Ascension had the subordinate debt issue rated at a favorable AA-, one notch down from its primary debt rating, which remained the same despite the added debt load.

However, subordinate debt issues could be appropriate when seeking capital to apply to pensions, acquisitions and other uses, according to Blake--not just as creative financing for the well-heeled. It's even common with weak credits in the corporate world.

Speranzo realizes most not-for-profits can't match his organization's financial resources, but he advocates similar transactions for those that can manage them.

"Is it right for everybody? Probably not," he says. But "the CFOs and senior management at organizations such as ours need to always be looking at their capital structure and how they can use it to their advantage. It's incumbent on organizations to be active in terms of their capital structure."

Synthetic Refundings 'Hot'

One new financing trend--the growing popularity of synthetic refundings--is a response to the rising interest rate environment. It became hot in February and evolved rapidly after that, says Kenneth

Kaufman, founder and managing partner of KaufmanHall, financial consultants, Northfield, Ill.

Entailing the use of derivatives, a synthetic refunding consists of issuing variable-rate debt and then swapping it to fixed rate. Its attractiveness lies in the recent flattening of the long-term yield curve; while short-term interest rates have been steadily pushed higher by the Federal Reserve, long-term rates have not followed. The savings come in by taking advantage of the difference between the yield curves.

"It's a pretty technical transaction with a lot of tax and derivative issues to it ... and requires a lot of education to make sure the benefits outweigh the risks," Kaufman says. "However, the savings have been very profound for a number of organizations."

More straightforward interest-rate swaps--fixed-rate to variable and vice versa--also have become increasingly common with big organizations. Derivatives, too, are now tapped more often as a tool than in the past. But analysts say the use of variable-rate debt remains somewhat underutilized among not-for-profit health systems and is likely to spread as rates rise and organizations become more sophisticated in their asset-liability management.

Overcoming the Small and Rural Bias

Often passed over or distrusted by investment banks, smaller and rural hospitals tend to be the victims of size bias, justifiable or not. The FHA-242 hospital mortgage guarantee program, rarely used until recently, gives them their own special funding opportunity.

Kevin Ponton, president of the SprainBrook Group, a health care consulting firm in Hawthorne, N.Y., says the program, administered jointly by the U.S. Departments of Housing and Urban Development and Health and Human Services, highlights a new era of capital finance for rural hospitals that he equates with the Hill-Burton construction program in terms of historical significance.

"There are a lot of small hospitals that just don't get on the radar for access to capital markets purely because they have too few beds and all the risks that are associated with that," he says. "This opens up access to financing for hospitals that are tiny."

The FHA-242 program has taken hold nationwide only relatively recently--expanded after federal officials took steps to ensure more financial assistance for candidates from outside New York state and New England. Rural hospitals seeking financing under the program must have a state certificate of need, or an alternative study of market need and financial feasibility. While critical access hospitals have been among the prime recent beneficiaries of the program's geographical expansion, a CAH designation is not required.

Small hospitals are a big group; half of all U.S. hospitals have fewer than 50 beds and 70 percent have no more than 80. But the strength in numbers doesn't translate to credit access for individual organizations. North Valley Hospital in Whitefish, Mont., is located in a growing area, but the federally insured program proved to be the only means for the 25-bed critical access hospital to borrow $30 million for building a replacement facility.

"I don't see a lot of lenders willing to take a risk on a small, rural hospital," says Craig Aasved, North Valley's CEO. "For us, the 242 program was the only option. It is clearly a program for a rural hospital to make a project a reality."

The CEO added a cautionary note: Though worthwhile, the program is very complicated and time-consuming and requires consulting assistance to navigate. "I don't think hospitals, especially small hospitals, are prepared to go down the path of 'Do they qualify?' and 'How do they qualify?'--they need the outside expertise of somebody else."

The 242 loans are available for construction, financing, refinancing, remodeling or expansion. Fixed-rate interest is applied, although variable-rate swap structures may be considered.

Attractive Terms

Shoshone Medical Center in Kellogg, Idaho, tapped FHA-242 to build just the second critical access hospital financed with a loan insured by the program. Its 25-bed, 42,000-square-foot replacement facility opened in January.

Shoshone's chief executive, Gary Moore, says obtaining the government-backed loan was such a cumbersome process that he can understand why some CEOs are fearful of getting involved. But ignoring the program would be a mistake, based on the positive experience for Shoshone, which used the strong credit rating it received from the program to borrow $18.5 million at highly favorable fixed rates over 27 years.

"We've got a AAA rating that even larger hospitals couldn't get, and an under 6 percent loan," he says. "We have a federally insured loan, and that's a huge piece of insurance if Congress decides to take away cost-based reimbursement. It's just a really secure feeling to have a package like this."

Two local banks offered to give Shoshone $1 million credit lines, Moore says, but "there wasn't anybody else in this world that would have financed $18 million."

Another idea for small municipal hospitals trying to increase their debt capacity is to persuade their communities to designate a sales tax to supplement hospital revenues, says consultant Alan Richman, president and founder of InnoVative Capital, a licensed FHA mortgage lender and hospital consulting firm in Springfield, Pa. The combination of community and hospital support, along with the interest savings of FHA-242 mortgage insurance, may be the optimal route for many, he says.

Regardless of the financing, rural hospitals should seek outside help, says Richman, whose firm worked with both North Valley and Shoshone. "Most small hospitals have little experience accessing the capital markets," he says. "Imagine--you could be born, get married and die between the times that some of these hospitals have borrowed money."

Consolidating for Capital?

Capital-hungry hospitals may be headed for another wave of consolidation, based on historical trends and what's been happening in the health insurance industry, where mergers have gotten bigger and bigger. In 2004, coming off the lowest annual total of mergers and acquisitions since 1988, the number of transactions jumped from 37 to 58 and the volume of those deals--involving both profits and not-for-profits--quadrupled to $9.5 billion.

Smaller rural hospitals are likely to be heavily involved in any consolidation trend, says consultant Kip Perlstein. They'll be doing it to try to boost their market share and their access to technology.

"The cost of technology plus the cost of compliance plus the cost of going to electronic records--it's just hard to be a smaller hospital trying to afford all that," says Perlstein, managing director of Navigant Consulting in Richmond, Va.

A consolidation craze hasn't yet taken hold, however, and there's no guarantee that any given merger will dramatically improve a hospital's credit rating or access to capital.

Fitch's Wells, for one, is skeptical. Consolidation, he says, "should mean better access to capital, if you assume that the stronger are going to be acquiring the weaker. But access to capital in general for health care systems is not great. There has been a hesitancy in the past on the part of investors and many who provide capital."

Whatever the means, doing everything possible to shore up credit and become attractive to the credit market should be the priority for not-for-profit health care organizations, Kaufman says.

"Instead of worrying about traditional and nontraditional financing mechanisms, what CEOs and boards should be worried about is their credit," he says. "They should be trying to make it as good as possible because there are some real opportunities out there for structural savings to occur in the capital market if your credit is good enough to qualify."

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