

Focus on
HEALTH CARE FINANCE
White Paper III

Financing Options for
Large Hospitals and
Multi-Hospital Systems

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Note to the Reader

Information in this publication has been obtained from sources believed to be accurate and reliable. However, we do not guarantee the accuracy, adequacy or completeness of any information and are not responsible for any errors or omissions or for the results obtained from the use of such information.

Throughout this paper the use of the words hospital, system and organization will be used interchangeably where appropriate; however, it is important to note that the information is valid for both individual hospitals as well as systems.

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Financing Options for Large Hospitals and Multi-Hospital Systems

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Large hospitals and multi-hospital systems are on the forefront of health care delivery, employing the newest technologies and innovations to provide care not available elsewhere. In addition, their proven ability to integrate multiple hospitals allows a system to continue to drive consolidation to benefit acquirer, target, and community alike. The challenges faced by these facilities are as great as at any time in our nation's history.

Aging baby boomers and increasingly diverse populations create demands for new and different services. Clinical procedures continue to evolve, as do diagnostic techniques and communication technologies, creating potential synergies for collaboration. The amount of capital required to optimally deliver modern healthcare practices, adequately address and manage reimbursement issues, and effectively recruit and retain both specialized and primary care physicians will almost certainly drive continued consolidation of health care delivery entities whose nexus is the multi-hospital system.

Hospitals around the country are in a constant state of renovation in order to remain competitive and provide the best technology and equipment. Bond rating agencies have long recognized that large hospitals and multi-hospital systems are inherently less risky than their smaller, stand-alone counterparts. Raising capital at a reasonable cost is more difficult than ever and a well-run system's capital advantages provide the ability to undertake projects and service line expansions that create high barriers to entry and can positively effect cash flow into the future.

This paper is designed to demystify several long-term financing options for large hospitals and multi-hospital systems and describe the advantages and disadvantages of each. First, as a necessary preamble to the discussion of various financing options, this paper outlines the relationship between a system's strategic plan for future operations and its financial plan. Then, capital funding options are discussed. Each option is a viable financing vehicle in normal market conditions. However during a major economic downturn, such as the one that began in 2008, when the auction rate bond market collapsed, and virtually all bond insurers were downgraded and bank letters of credit became more limited, systems are more challenged to find cost-effective and term-favorable funding solutions. In such risk-averse markets government agency loan programs, like FHA 242 mortgage insurance, may be compelling funding alternatives as other finance options are temporarily sidelined or their effectiveness temporarily diminished. In these times advice and perspective from your trusted advisor is of the greatest value.

In addition, this paper explains how large hospitals and multi-system hospitals are perceived as borrowers. Systems have opportunities to issue debt on their own or with commercial or agency enhancements; each is covered in this paper. Part II outlines specific long-term debt financing options, including traditional and alternative sources of capital. Part III rounds out the financing structure discussion by highlighting the critical role financial risk management plays in a hospital's financial plan. Finally, several appendices provide technical insights.

The funding of a system's growth through the most appropriate financing means helps ensure the proper maintenance of a system's capital structure. A strong capital structure is at the foundation of a system's credit strength, and as such, critical to the ability of a system to optimally fund organizational growth, drive profitability, and deliver enhanced health care services.

PART I

Integrating Strategic Plans and Capital Financing

Accessing capital requires the precise matching of an organization's financial plans with its strategic plans and an informed, unbiased understanding of an organization's ability to borrow. Whether a system chooses to build or acquire a facility, expand or renovate existing facilities, or refinance outstanding indebtedness to improve cash flows, its plans and credit strength will determine its financing options.

Strategic Plans

Systems must evaluate their strategic plans and their funding needs in tandem to accurately determine their best funding options. The first steps toward securing funding of any kind is performing an assessment to determine capital needs and understand credit strengths and weaknesses.

A strategic plan outlines an organization's long-term mission, including any anticipated changes to infrastructure and services in the context of the demands of the markets the organization serves. Strategic plans should be reviewed regularly and updated as needed. Markets change constantly, and long-term strategic and expansion plans should focus on the market's needs and a healthcare provider's unique ability to meet them.

A well crafted financial plan matches a hospital's financial resources to the elements of the strategic plan by quantifying available capital and outlining a capital allocation plan both between facilities and within facilities. The capital allocation plan should be integrated into a strategy to manage assets and liabilities so the organization not only accomplishes its strategic objectives, but improves its capital structure — and hence its credit strength.

The financial plan quantifies capital available from exist-

ing internal and external sources. Internal sources include operations, monetization (sale) of assets, cash and investments; while external capital includes philanthropy, operating and capitalized leases, and long-term debt. This paper focuses on methods to access long-term debt as part of an integrated strategic and capital plan.

When borrowing, systems and their advisers balance long- and short-term goals with creating an optimal capital structure that will maintain or improve the hospital's credit profile. Some borrowers, for example, prefer to make larger equity (cash) contributions to reduce the amount of debt necessary to fund a project. While reducing the amount of borrowed capital may initially seem desirable, such actions often have an offsetting negative impact on liquidity, resulting in a less desirable credit profile. Over-reliance on debt, on the other hand, also can strain an organization's resources. Especially important to a system is deciding which entity will serve as debt obligor. Does a system as a whole guarantee the debt for its components or is it more beneficial for certain facilities or entities to borrow based on their own credit strength? These decisions can effect the organization for decades making it critically important to understand the funding options available and the impact each will have on the organization. The hospital leadership team's ultimate goal is to develop a finance strategy that maximizes the benefits of access to the capital markets and minimizes the cost of such capital.

It is important to recognize that the process of creating an optimal capital structure is fluid and requires thorough analysis. Reliance should be placed on professionals with a comprehensive understanding of the impact of financial decisions on asset management, liabilities and cash flow.

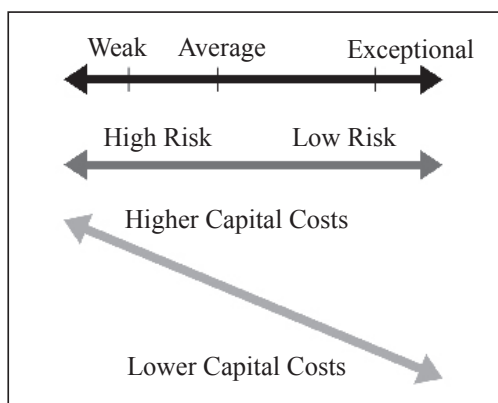
Finally, a key point must be kept in mind when refining a system's capital strategy: Nonprofits are designed to operate for the long-term. They do not have the same goals as

for-profit corporations, which often have exit strategies, and their financial strategies should reflect their mission to serve in perpetuity. Advisers should help systems understand this key difference and take advantage of opportunities to improve overall credit strength and long-term fiscal strategies.

**Recognizing Strengths and Weaknesses:
The Credit Profile**

A hospital’s credit strength or financial health is the single most important factor in determining its cost of capital.

Figure 1: Credit Profile and Funding Cost



Organizations with strong financial health have greater ability to repay debt, so tend to be more appealing and less risky to credit enhancement providers or investors who buy bonds. Investors balance their risk with interest rates. Therefore, the stronger the credit profile, the lower the interest rate on the financing, and the less capital costs over time.

Traditionally, investors relied on rating agencies such as Standard & Poor’s, Moody’s, and Fitch Ratings to assign a rating to a debt issue. However, the opinions of rating agencies, while still very useful, no longer carry the significance they once did due to the credibility lost with the swift collapse of issues related to residential mortgage debt that

carried agencies’ highest ratings. The ability of an organization (or its advisor) to directly communicate its credit attributes to potential investors and credit enhancement providers now has an even greater impact on its ability to access capital and the cost of that capital.

Investors and credit enhancement providers review both quantitative and qualitative factors to measure an organization’s credit strength; quantitative factors define a borrower’s ability to repay debt, and they place a borrower within a broad credit range. Qualitative factors determine long-term financial viability and refine the borrower’s position within that credit range.

Financial ratios that demonstrate financial performance are used in quantitative analyses. These ratios can be generally grouped into three categories: capital structure, liquidity, and profitability. Appendix A: Definition of Ratios provides a list of notable ratios with definitions. The following ratios tend to be relied upon most frequently when assessing creditworthiness:

- Debt Service Coverage
- Days Cash on Hand
- Operating Margin
- Debt to Capitalization
- Cash to Debt

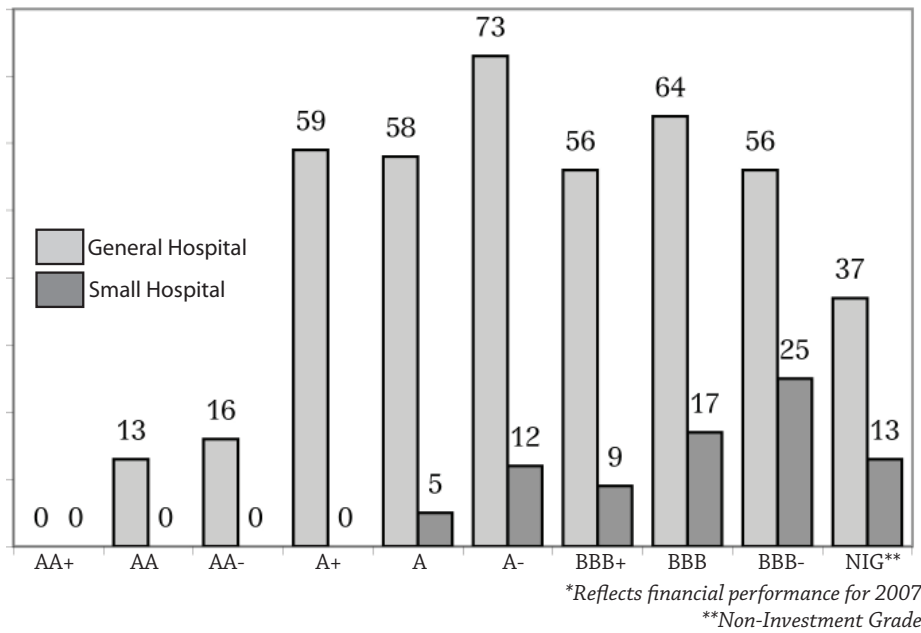
A credit assessment that considers only quantitative financial ratios, however, is inadequate. Credit analysis is both science and art and goes well beyond the system’s financial statements. Qualitative factors such as management, local economic factors, demographic changes, competition, technological capabilities, and medical staff characteristics are important aspects of a system’s credit profile as well. Particular attention will be given to board members’ competence and independence as well as management’s experience and proven skill sets.

Ignoring these qualitative factors can give a hospital and the credit markets an incomplete picture of a hospital's credit profile and its financial options. For example, a hospital with strong financial ratios located in a highly competitive or struggling metropolitan area may find accessing capital more difficult than its financial ratios suggest. Conversely, a well-

Multi-Hospital Systems as Borrowers

The market and geographic diversity of system hospitals, which puts less reliance on fewer physicians, as well as the enhanced technological features multi-hospital systems

Figure 2: S&P Rating Dispersion*: General Hospital vs. Small Hospital



articulated qualitative analysis of a system's market position or area demographics may allow a system to access capital at a lower cost than its quantitative profile might suggest. Appendix B: Factors in Hospital Credit Analysis highlights important considerations in assessing creditworthiness.

After completely understanding its credit profile, a system can work with its financial professional(s) to determine the optimal way to leverage its strengths and/or use strategic enhancements to improve its position on the credit continuum to achieve less expensive capital.

have, provide inherent advantages in the capital markets over stand-alone hospitals. Figure 2 shows that to receive the same credit rating as a multi-hospital system, stand-alone and small hospitals must have substantially stronger financial ratios. Figure 3 uses Standard & Poor's hospital credit ratings to illustrate that the majority of the large hospitals and systems rated by S&P range from "A" to "BBB+" while the relatively few small hospitals rated by S&P fall into the mid- to low "BBB" categories.

The favoritism displayed by rating agencies is not surprising. A system generally operates in at least one

metropolitan area and in many cases, owns several facilities in that area. In addition, it is common for a system to own or affiliate with smaller facilities in its region to serve as feeder facilities to large tertiary care hospitals that form the centerpiece of a system and provide the most specialized, profitable services. A system's size allows it to concentrate highly specialized services (i.e. electro

dent hospitals have a more difficult path to convince a payer that their services are vital to its members if there is another hospital providing similar services nearby. In some markets, a single system is the only provider of tertiary care giving it a clear advantage in negotiations with third party payers who need a contract with the dominant system to insure individuals in the area.

Figure 3: S&P's Median Ratio Dispersion

	Stand-Alone Hospital Medians ¹ "BBB"	Small Hosp. Medians ² "BBB"
Profitability Ratios		
Operating Margin (%)	2.0	3.1
Excess Margin (%)	4.2	8.2
Liquidity Ratios		
Days Cash on Hand	121.9	174.2
Cushion	8.4	12.3
Cash to Debt (%)	82.0	98.0
Capital Structure Ratios		
Historical DSC (EBITDA)	3.1	3.5
MADS/Revenues	3.4	3.9
Debt to Capitalization	42.7	39.2
Average Age of Plant (years)	9.6	8.7

¹ S&P median numbers taken from "2008 U.S. Not-For-Profit Small Hospital Median Health Care Ratios," which reflect financial performance for 2007.

² S&P Small Hospital median numbers taken from "2008 U.S. Not-For-Profit Stand-Alone Hospital Median Health Care Ratios," which reflect financial performance for 2007.

physiology, advanced radiation therapies) in areas with the highest utility and allows them to avoid duplicating many of the most expensive services at multiple facilities in a market area.

External factors also play a role in the strength of systems. Most metropolitan areas have highly diverse economies and can weather economic cycles with less impact than non-metropolitan or rural areas that are usually more dependent on a few employers to sustain the community. In addition, a system is more likely to carry a significant market share in an area of operation, which provides it power in negotiating reimbursement contracts. Independen-

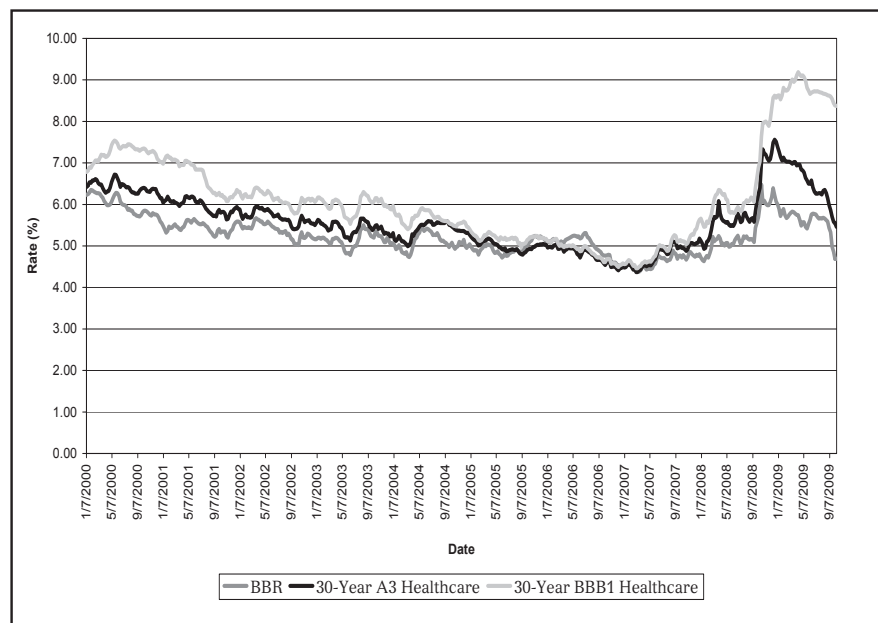
In addition, because they are larger, systems tend to access the capital markets with greater frequency; therefore, as investors become familiar with a system's credit profile and comfortable with its operation, they may be willing to purchase more debt from a system with which they are already familiar.

Systems also have an advantage in deciding who is going to borrow. In cases where a system issues debt based on the system's consolidated credit profile, the debt carries the highest rating that the system is capable of achieving since debt payments are supported by all of the system's components. Alternatively, debt can be assigned to one

or more components of a system. Using specific funding structures (such as FHA Sec. 242 - described below) a system may have the ability to leverage one or more of its components, independent of and non-recourse to, the parent system which may allow the parent system to maintain, or improve, its debt rating and preserve debt capacity for future capital projects.

providers have witnessed historic changes to the financial markets. From the collapse of auction-rate bonds and the collective downgrade of bond insurers, to the restructuring of Wall Street (i.e., Bear Sterns, Lehman Brothers, etc.) and historically high spikes in tax-exempt variable rates, today's capital markets are a far cry from the bullish healthcare finance market of 2005 and 2006. As illustrated

Figure 4: Historical Fixed-Rate Healthcare Yields



Part II Financing Options for Large Nonprofit Hospitals & Multi-Hospital Systems

The Capital Markets for Healthcare Providers

Before outlining traditional and alternative sources of capital for large non-profit hospitals and multi-hospital systems, it is necessary to address the current state of the capital markets for healthcare providers. Since the beginning of 2008 healthcare

in Figure 4, fixed rates for investment grade healthcare providers have skyrocketed in recent months, especially for low investment grade borrowers, as hospital rating downgrades have vastly outpaced upgrades (for the first five months of 2009, S&P has downgraded 23 hospitals and upgraded only 4).

While fixed rates have ballooned, tax-exempt variable rates have remained at historic lows, trading near 30 basis points (0.30%) as of September 2009. However, in order to access variable rates, the majority of healthcare

borrowers require credit enhancement and/or liquidity support via a bank letter of credit. Unfortunately, the banking sector has been pummeled by the country’s soured residential loans, with many of the U.S.’s largest banks receiving substantial funds from the government’s Troubled Asset Relief Program (TARP). As a result, commercial enhancement has become more scarce and more expensive, increasing the net cost of variable rate capital for some hospitals, and prohibiting other hospitals from accessing variable rate debt altogether.

community donations. Grant pools, even at the federal level, are highly competitive, and funding is limited. And while community donations can potentially provide a significant source of capital and demonstrate community support for hospital projects, access to funds is often limited and unpredictable.

Long-term debt, usually tax-exempt bonds or taxable notes, is a popular choice for hospitals to access capital. Bonds and notes represent an obligation of the borrower to pay interest to the investor in return for the lending

Figure 5: Bond Ratings

Investment Grade	Moody’s	Standard & Poors/Fitch
Exceptional	Aaa, Aaa1, Aaa2, Aaa3	AAA, AAA-, AA+
Excellent	Aa, Aa1, Aa2, Aa3	AA, AA-, A+
Good	A, A1, A2, A3	A, A-, BBB+
Adequate	Baa, Baa1, Baa2, Baa3	BBB, BBB-, BB+
Speculative Grade		
Questionable	Ba, Ba1, Ba2, Ba3	BB, BB-, B+
Poor	B, B1, B2, B3	B, B-, CCC+
Very Poor	Caa, Caa1, Caa2, Caa3	CCC, CCC-, CC+
Extremely Poor	Ca, Ca1, Ca2, Ca3	CC, CC-, C+
Lowest	C	C

As a hospital evaluates funding alternatives for its capital projects it is critical for the hospital leadership team to recognize that access to capital is ultimately determined by a combination of microeconomic factors (i.e., hospital’s credit profile) and macroeconomic factors (i.e., state of the capital markets), and today’s funding capabilities are markedly different than the not so distant past.

Traditional Sources of Capital

External funding options are composed of gifts, operating and capitalized leases and long-term debt. Gifts include grants and

of capital over a given period of time. The rate of interest is determined by conditions in the capital markets and is influenced significantly by the credit characteristics of the borrower, security provisions provided to bondholders, and the financing structure.

Bonds can be rated or unrated. The ratings, established by rating agencies such as Standard & Poor’s and Moody’s, range from AAA to C, as shown in figure 5, and can change if the borrower’s financial situation changes.

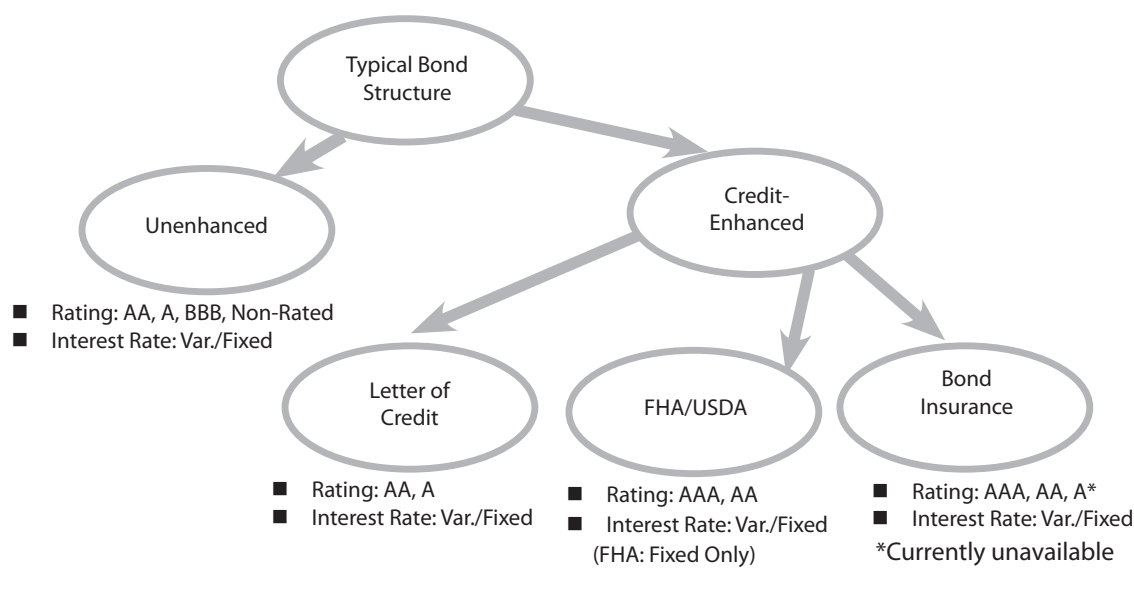
Rating agencies charge a fee to assign ratings to bor-

rowers' bond offerings. Ratings suggest to investors the amount of risk involved in purchasing a particular bond. AAA to BBB bonds are considered "investment-grade." Unrated or low-rated bonds are often referred to as "speculative-grade," "junk bonds" or "high-yield bonds." The higher the bond rating, the stronger the borrower's perceived ability to repay the principal and interest associated with the bond, and the lower the interest rate the

credit rating, but changes the rating on the debt, allowing hospitals to borrow at potentially lower interest rates. Credit enhancement can be provided either by commercial institutions, such as banks and bond insurers, or a public entity such as a federal government agency.

Borrowers with stronger credit profiles generally have more financing options than organizations with weaker

Figure 6: Sources of Capital



borrower must pay to offset investor risk.

Rated and unrated bonds generally can be sold either (1) without any additional enhancement and marketed based on the strength of the borrowing hospital or (2) credit-enhanced using vehicles such as mortgage insurance, letters of credit and bond insurance (Figure 6).

Credit enhancement makes mortgage notes and bonds less risky to the investor and potentially more affordable to the system. Enhancement does not change the system's

financial profiles (Figure 7). Hospitals often will choose to access the capital markets using some form of credit enhancement when they receive interest rate savings greater than the cost of the credit enhancement .

If a hospital decides to issue long-term debt, the first step is to select a financial professional to guide the process. Some borrowers choose to hire both a financial adviser to structure the debt and a separate underwriter(s) to purchase and sell the debt and assist in capital decisions and implementation. Many investment banking firms,

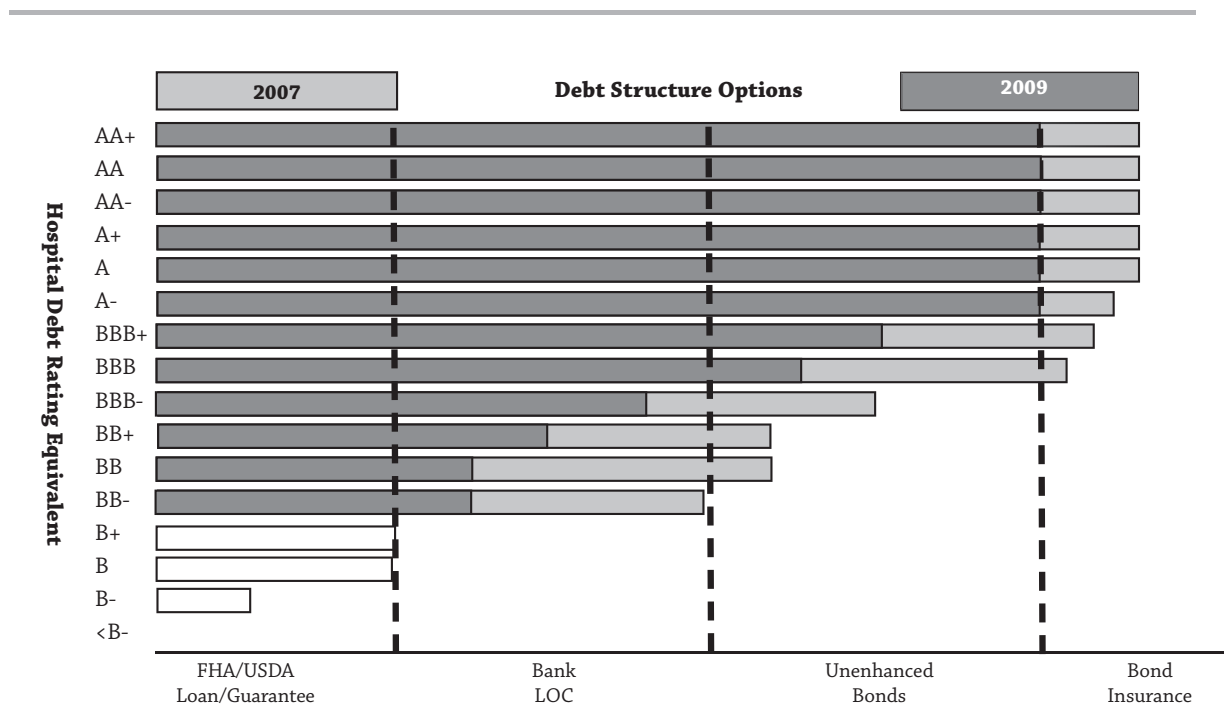
however, can effectively provide both services, creating a seamless and singular process that often saves the organization time and money. The investment banker/adviser a hospital selects should have health care and capital market experience as well as expertise in the full range of financial options available to hospital systems. Boutique firms that specialize in health care may be as, or more, capable than large Wall Street, or “bulge bracket”, firms at obtaining the lowest cost of capital because they can be knowledgeable in a wide variety of structures to fund a specific industry rather than a few structures to fund many industries. Depending on the situation, it may be desirable to employ more than one underwriter, called a syndicate, to complete a debt sale to take advantage of the individual strengths of each firm to minimize capital costs and maximize distribution to investors. Other parties central to the transaction can be found in Appendix D: “Key Participants in Hospital Financings.”

Each hospital must evaluate its situation to find the optimal funding option, as no two situations are alike. Only after a thorough financial analysis and a clear understanding of the current credit profile should the hospital leadership team move to evaluate the hospital’s capacity to take on new debt, refinance existing debt or implement other long-term strategies to bridge the gap between the strategic plan and internal resources. Due consideration should be given to all available financial options, as the effectiveness and benefits change with interest rates, fees and other market factors. The option which initially seems the most cost-effective may actually be more expensive in the long term.

A) The Rating Process

A hospital with investment grade financial ratios may desire to secure a public credit rating. A credit rating quantifies the hospital’s financial strength in the form of a type of

Figure 7: The Credit Continuum



letter grade. Hospital ratings are provided by three primary rating agencies: Fitch, Moody's and Standard & Poor's. The process for securing a credit rating takes approximately 30 to 45 days, and typically begins about 60 to 90 days prior to the bond issue closing. To begin the process, the hospital's financial advisor or investment banker will forward the selected rating agency(ies) credit information regarding the hospital. This information will include the hospital's historical financial data, financial projections (if any), project plans, demographic information, management and board biographies, payer and physician mix and other data detailing the hospital's credit profile. The information will also likely include draft bond documents.

The rating agency will complete a preliminary review of the information and then hold an in-person meeting where hospital management, with the aid of its financial advisor or investment banker, will present the organization's credit profile. This is either held on site at the hospital or at the rating agency offices. The presentation provides an opportunity for the rating agency analysts to ask questions regarding the hospital's financial performance, proposed projects and other credit characteristics of the hospital. If the hospital has any potentially negative credit characteristics, it is important to demonstrate how management has, or is, correcting them as it provides an opportunity to display management talent. In addition, all positive credit characteristics need to be highlighted for the rating analysts. Following the rating presentation and any subsequent conference calls, the rating agency's credit committee will make a rating determination.

The rating determination will be detailed in a rating report and included in the hospital's bond offering documents which are available to investors and/or credit enhancement organizations. The rating agency will revisit the rating report on at least an annual basis upon receipt of the borrower's audited financials for the life of the bonds and upgrade, downgrade, or affirm the credit rating after its

periodic review. Additionally, it will assign a positive, negative or stable rating outlook. It is important to proactively manage this process in order to maintain, or possibly seek an upgrade, in the rating. If the organization hopes to finance future projects in the public debt markets, maintaining an investment grade rating is imperative. See Appendix C: Rated Bonds for more information on ratings.

B) Unenhanced Bonds

Systems with excellent credit strength may choose to issue bonds without additional credit enhancement.

Figure 8: Unenhanced Bonds

Unenhanced Bond Characteristics	
Tax-Exempt	Yes
Fixed-Rate Option	Yes
Variable-Rate Option	No
Est. Max Term	30 Years
Est. Max Amortization	30 Years
First Mortgage Required	Typically
Non-Recourse	No
Debt Service Reserve Fund	Yes
Prepayment Penalties	Yes
Underlying Rating	Optional
Enhancement Renewal Risk	No
Ongoing Financial Covenants	Yes
Structuring & Closing Timeline	150 Days

Investor acceptance of unenhanced, rated or unrated, bonds sold on the credit profile of the borrowing entity fluctuates based on credit market conditions. Unenhanced debt offerings are supported solely by the borrower's credit characteristics. Bondholders are typically provided collateral in the form of either a first mortgage and lien on property assets, a pledge of the organization's revenues and a lien on trustee-held reserves, including a debt service reserve fund. Appendix E: Security and Covenants provides additional information on security provisions.

Unenhanced bonds are typically structured as fixed-rate with various intermediate maturities and a final amortization of 25 to 30 years from the date of issuance. The financing normally includes pre-payment penalties in the first ten years, commonly called the call feature or lock-out period. These penalties can be structured in a number of ways from “hard-locks,” meaning a period in which no pre-payment can occur, to scaled penalties (i.e. 5% in year 5, 4% in year 6, etc.) where pre-payment can occur, but an incentive exists to allow the bonds to remain outstanding. Most tax-exempt hospital bonds include a feature called a sinking fund that leads to principal being redeemed each year, similar to a traditional home mortgage, to avoid a large balloon payment or the need to refinance at maturity, a common feature in the taxable corporate bond market. Sinking funds are paid to a Trustee who assigns bonds to be redeemed with those funds. Since sinking funds are planned in the Bond Documents there is no pre-payment penalty associated with sinking fund payments even if the payment occurs during a pre-payment hard-lock or penalty period.

Since bond investors rely on the credit strength of the borrowing entity to assess repayment ability, considerable due diligence must be conducted by finance team members and extensive disclosure provided to investors in the official statement. This may include a market and financial feasibility study conducted by a recognized accounting firm experienced in assessing similar projects, examination by a rating agency, as well as full disclosure of the hospital’s operations and historical financial results. There is also a requirement for ongoing disclosures of information to rating agencies and/or investors through a Nationally Recognized Municipal Securities Information Repository (NRMSIR), such as Bloomberg LP.

Factors to Consider

Borrowers who issue bonds and notes on their own merit

do not have to pay fees to use credit enhancement provided by a bank, bond insurer or government agency; but they may find capital more expensive over time and be subject to higher or longer prepayment penalties, potentially more restrictive covenants and other investor requirements. This option may be more or less appealing to borrowers depending on the bond offering’s size, its prospective rating and market interest rate levels. Unenhanced bonds have been a viable source of funding for hospital systems for decades and for many years were the only long-term bond option available. Its suitability depends on credit spreads, yield curves, and investor appetites. Your finance professional should be able to articulate the circumstances to consider this option.

Two of the most important considerations when determining whether to use unenhanced bonds at any point in time are the yield curve and credit spreads.

The Yield Curve

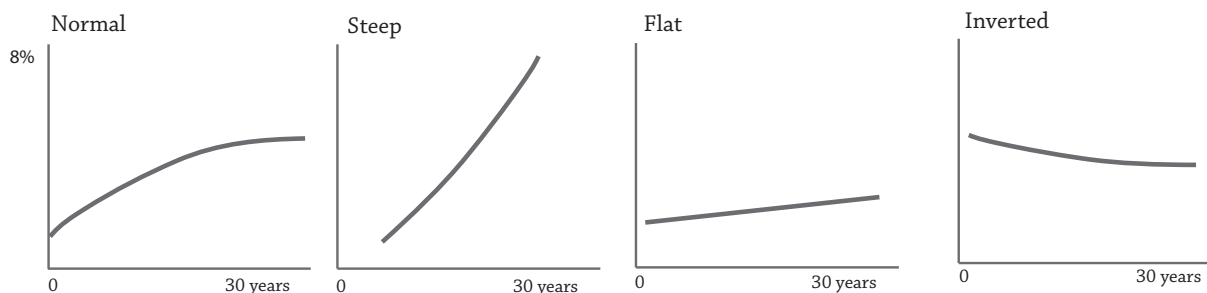
The yield curve indicates the time risk an investor assumes when purchasing a debt obligation. Figure 9 demonstrates several examples of yield curves. A “normal” yield curve depicts an environment in which the cost to borrow funds for a shorter period (e.g., 5 years) is less than the cost to borrow funds for a longer period (e.g., 30 years) reflecting the lower risk of principal payment default associated with a shorter time horizon. Normal curves also vary in steepness, or the slope of a curve. A steep slope reflects a large difference between perceived short and long-term risks, and therefore, interest rates, while a flat curve indicates that the cost to borrow funds in the short term is the same as the cost of long term funds. Yield curves can actually become inverted where the cost to borrow short-term funds is higher than the cost of long-term funds. Both flat and inverted curves frequently occur during periods where central banks are employing “tightening” policies, wherein a central bank, such as the US Federal Reserve Bank, uses

tools at its disposal to make funds for lending less available in an effort to slow economic growth. In flat and inverted curve environments, long-term borrowing becomes more attractive to borrowers relative to shorter term alternatives.

Hospitals that issue a relatively large amount of debt can take advantage of a yield curve in any environment through the judicious use of serial and term bonds. Term bonds are traditional tax-exempt bonds where a stated maturity occurs at some date in the future and sinking fund payments redeem some value of the total maturity each year and serial bonds are issued in a series with a full maturity occurring in every year of the serial bond series in lieu of a sinking fund.

or highly rated bonds in a similar category (i.e., AA+ rated hospital bonds). When credit spreads are wide (i.e., the borrowing cost of a lower-rated borrower is notably higher than the cost of capital for a higher-rated borrower) some of the enhancement techniques described below become particularly attractive because the cost of the enhancement is less than the cost savings associated with obtaining a higher rating. Conversely, when credit spreads are narrow (i.e., the borrowing cost of a lower-rated borrower is near the cost for a higher-rated borrower) the benefit of enhancement may be low and unenhanced bonds become a relatively more attractive option for all borrowers. Credit spreads are usually particularly pronounced for longer-term issues and

Figure 9: Yield Curve Examples



In a normal yield curve environment an organization may save a significant amount in interest expense by issuing more than one series of bonds as opposed to a single term bond with sinking fund redemptions, see figure 10.

The Credit Spread

Credit spreads reflect the additional borrowing cost associated with borrowers with different ratings. Credit spreads are usually described as a margin to an index (i.e., Treasuries, Bond Buyer Revenue [BBR], SIFMA, LIBOR swaps, etc.)

fluctuate over time.

Bank Loans, Private Placements and Bank-Qualified Bonds

Another source of unenhanced capital comes from traditional commercial bank loans in the form of real estate or equipment term loans. These products are readily available from local and national banks. Interest rates associated with these loans can be fixed or variable. Long amortizations, similar to traditional bonds, can be obtained, but a lender is

usually only willing to commit to provide the funding for a limited period (5-10 years) creating the need to refinance or pay down outstanding principal at maturity. Furthermore, most lenders are unwilling to commit to fixing the rate of the loan for its entire period.

Commercial banks can provide a hospital with a short-term loan to begin work on a project in anticipation of a longer-term tax-exempt bond financing. This type of financing can be thought of as a bond anticipation loan where a commercial bank is committing to a short-term (< 1 year) loan to be paid off with the proceeds of a bond issuance. These loans carry some risk to a hospital; for instance, if a loan

anticipation loan is its ability to provide capital that allows project work to begin without the multi-month delay usually associated with issuing tax-exempt bonds.

Tax-exempt bonds also can be privately placed with financial institutions such as local banks. This structure may allow the system to reduce issuance costs, but it is usually not viable for larger issues where better execution is obtained using other options.

When tax-exempt bonds are “bank-qualified,” banks can deduct 80% of their purchase and carrying costs, and can pass along the savings to borrowers by way of a reduced in-

Figure 10: Bank Loans

Bank Loan Characteristics	
Tax-Exempt	No
Fixed-Rate Option	Yes
Variable-Rate Option	Yes
Est. Max Term	10 Years
Est. Max Amortization	25 Years
First Mortgage Required	Yes
Non-Recourse	No
Debt Service Reserve Fund	No
Prepayment Penalties	No
Underlying Rating	No
Enhancement Renewal Risk	No
Ongoing Financial Covenants	Yes
Structuring & Closing Timeline	60 Days

Figure 11: Bank-Qualified Private Placements

Bank-Qualified Private Placement Characteristics	
Tax-Exempt	Yes
Fixed-Rate Option	Yes
Variable-Rate Option	No
Est. Max Term	25 Years
Est. Max Amortization	25 Years
First Mortgage Required	Yes
Non-Recourse	No
Debt Service Reserve Fund	No
Prepayment Penalties	Yes
Underlying Rating	No
Enhancement Renewal Risk	No
Ongoing Financial Covenants	Yes
Structuring & Closing Timeline	90 Days

is obtained and markets or operations change significantly from the assumptions made at the time of the loan it may become costly to issue longer-term bonds. A system may prefer to wait for a more opportune time to issue bonds, but the maturity of the loan could force a system to borrow in longer-term markets or face significant penalties from the lending institution in the form of higher rates on a short-term loan, prohibitive financial covenants, and other operational restrictions. The primary benefit of a bond

interest rate. Until recently, only \$10 million in bonds could be designated bank-qualified by any single bond issuer (often the local municipality) in one year, and the bonds had to be issued for qualified tax-exempt obligations. However, the American Recovery and Reinvestment Act, which became law in February 2009, increased the amount of bank-qualified bonds that can be issued in 2009 and 2010 to \$30 million and applied this new limit to the borrower, not the bond issuer. The Act also created a temporary rule

that allows banks to deduct 80% of the cost of buying and carrying any tax-exempt bond, bank-qualified or not, to the extent that their tax-exempt holdings do not exceed 2% of their assets. The increased limit should expand the number of issues that are eligible for bank-qualified designation, making this option more attractive to systems than historically has been the case.

C) Commercial Enhancement

Hospitals also have the option to obtain commercial enhancements in order to secure lower interest rates on their bonds. These include letters of credit and bond insurance.

Letters of Credit

A letter of credit issued by a commercial bank is an irrevocable obligation to make principal and interest payments in the event the borrower is unable to make payments. With that credit support, a hospital can issue bonds backed by the bank’s credit strength at correspondingly lower interest rates. Borrowers pay letter of credit banks a fee to utilize this option. The cost of a letter of credit is largely driven by the perceived credit risk of the organization and typically includes a one-time upfront fee along with an annual charge. Letters of credit are usually issued for three- to five-year terms and can be renewed or substituted, while the bonds they enhance have variable interest rates and generally amortize over 20 to 30 years. Letter of credit structures provide more flexibility than many other options, but banks may be hesitant to extend credit. The project and the obligor’s credit profile must fit into the conservative underwriting requirements of a commercial bank.

There are two types of letters of credit, stand-by and direct-pay. A stand-by letter of credit is used when a hospital utilizes its own high investment grade rating to back the

bonds (unenanced), has sufficient liquid assets to cover the principal amount of the bonds, and is comfortable providing a self-guarantee for payment of the bonds if necessary.

The stand-by letter of credit provides liquidity support to the bond issue, a requirement of buyers of variable-rate bonds. Liquidity support refers to the mechanism available to quickly pay off principal and interest in the event of a failed remarketing (sale of variable rate bonds). Alternatively, a direct-pay letter of credit provides credit enhancement and liquidity support. Investors receive

Figure 12: Letters of Credit

Letter of Credit Characteristics	
Tax-Exempt	Yes
Fixed-Rate Option	Yes
Variable-Rate Option	Yes
Est. Max Term	30 Years
Est. Max Amortization	30 Years
First Mortgage Required	Typically
Non-Recourse	No
Debt Service Reserve Fund	No
Prepayment Penalties	No
Underlying Rating	No
Enhancement Renewal Risk	Yes
Ongoing Financial Covenants	Yes
Structuring & Closing Timeline	120 Days

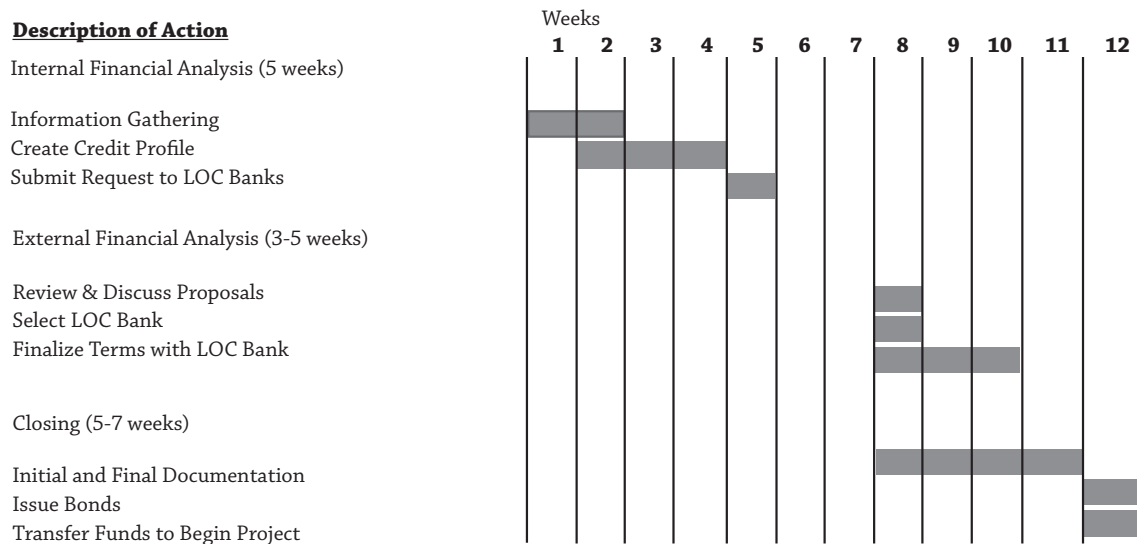
normal principal and interest payments from the commercial bank providing the letter of credit and the commercial bank is immediately reimbursed for debt service payments by the hospital. Direct pay letters of credit are commonly used for low investment grade or non-investment grade systems where the investor demands assurance that payment will not in any way rely on the credit strength of the underlying system if the system does not have sufficient liquidity to cover the entire principal amount of the bonds.

Bonds issued with a letter of credit are called variable rate demand bonds (VRDB), and as the name implies, the rate on the bonds is variable and in most cases resets at a regular frequency, typically every day or week. In periods of low short-term interest rates it is not uncommon for these bonds to bear a coupon of under 1%. The downside to these potentially low interest rates is that investors need to be assured that they can liquidate their positions on short notice. Remarketing agents are responsible for coordinating the sale (remarketing) of VRDBs to investors.

In periods of great turmoil, as experienced after the col-

and terms of reimbursing the letter of credit provider. The bonds are not canceled in this scenario, and a remarketing agent can usually place the bonds with third party investors once the market returns to a state of normalcy (assuming the letter of credit bank is still highly rated). At that time, the letter of credit provider is reimbursed the par value of the bonds that are sold back to investors. Of note, most investors monitor and evaluate the credit strength of commercial bank letter of credit providers due to the large volume of bank letter of credit backed issues they hold. In uncertain market conditions, many inves-

Figure 13: The Process for Issuing Tax-Exempt Debt Using Letter of Credit (LOC) Enhancement



lapse of Lehman Brothers in September 2008, or when a bank is downgraded, the liquidity feature of the letter of credit can be called upon to pay off investors in the event there are no buyers for the bonds, termed a failed remarketing. In this infrequent, but real scenario, a system, if providing a self-guarantee, would need to potentially liquidate a portion of its own investment portfolio to pay investors or reimburse the letter of credit provider if using a stand-by letter of credit. If the system is using a direct-pay letter of credit, there is more flexibility in the timing

tors will demand a premium rate to accept bonds backed by hospital liquidity and a stand-by letter of credit since an investor needs to dedicate resources to evaluating and monitoring a system's operations.

Once a system obtains an acceptable letter of credit, it can issue tax-exempt bonds that carry the same rating as the letter of credit provider. The primary benefits of this approach are lower costs of issuance and lower annual debt service when compared to some other structures, especially

in low short-term rate environments. The process for obtaining a letter of credit is generally shorter than that of other enhancement options, and up-front closing costs are relatively low. Unlike some alternatives, there is a yearly fee determined by the risk associated with the hospital to maintain the letter of credit (~1-2% for direct-pay letters of credit).

Recent expansion of the Federal Home Loan Banks' (FHLB) authority to provide letters of credit for tax-exempt transactions affords systems the ability to work with unrated or low-rated community banks and gain access to the usually high investment grade ratings of an FHLB. An FHLB letter of credit provides up to a 10-year term and its annual fees (in addition to the annual fee paid to the participant member bank(s)) are relatively low, currently ranging from 20 to 45 basis points depending on the FHLB and letter of credit structure. However, FHLB member banks are required to post collateral with the FHLB equal to the amount of the letter of credit, making this option overly restrictive for some member banks. Additionally, community banks often have low lending limits prohibiting them from providing all of the required letter of credit capacity.

Bond Insurance

Bond insurance, like a letter of credit, is a form of credit enhancement that guarantees investors will be paid even if the hospital cannot make its scheduled payments. This generally allows the system to access capital at much lower interest rates than it could have without enhancement and was a very popular option for many years.

Several companies have historically offered this option, including AMBAC, MBIA and FSA. Each bond insurer has its own credit rating based on its own unique credit profile, and their individual appetites for certain credit risks have varied significantly, as will the market's acceptance of bonds enhanced by their insurance. These factors must be

taken into consideration when evaluating bond insurance credit enhancement options, especially during times when most of the insurers lose their high credit ratings.

Prior to the collapse of the auction rate bond market in 2008, bond insurance was generally available to systems that could independently achieve an investment-grade rating of BBB or better. It could be used for both fixed-rate and variable-rate structures, and was generally less expensive on an annual basis than the letter of credit option. However,

Figure 14: Bond Insurance

Bond Insurance Characteristics	
Tax-Exempt	Yes
Fixed-Rate Option	Yes
Variable-Rate Option	Yes
Est. Max Term	30 Years
Est. Max Amortization	30 Years
First Mortgage Required	Yes
Non-Recourse	No
Debt Service Reserve Fund	Yes
Prepayment Penalties	Depends
Underlying Rating	Yes
Enhancement Renewal Risk	No
Ongoing Financial Covenants	Yes
Structuring & Closing Timeline	120 Days

the cost is paid up front; therefore, bond insurance may not be the most cost-effective option for hospitals that expect to pre-pay their bonds or restructure the debt before the final scheduled maturity. Unlike letters of credit, there is no annual fee to maintain bond insurance.

Bond insurers tend to be more receptive to slightly longer amortizations (25 to 30 years) than banks providing letters of credit. Insurers are generally indifferent to a project's geographic location, and tend to focus on larger projects when compared to letter of credit banks. Unfortunately, most bond insurers were downgraded in 2008 because they provided insurance to pools of residential mortgage loans.

For the foreseeable future, bond insurance is not expected to provide the benefit it once did. As of mid-2009 most insurers are considered insolvent, and at the time of this writing the only remaining AAA-rated bond insurer that has an interest in insuring health care debt is the merged insurer Financial Security Assurance/Assured Guaranty.

D) Agency Enhancement

In recognition of hospitals’ essential roles in society, the federal government created several funding and credit enhancement programs to assure that hospitals can access capital in order to continue their missions, evolve with changing technology, and remain competitive and viable. Government agency enhancements put the full credit support of highly rated federal agencies behind hospital loans and bonds, making them more attractive (less risky) to potential investors.

FHA Sec. 242 Mortgage Insurance

The Federal Housing Administration introduced its 242 hospital mortgage insurance program in 1968. Since then more than 300 loans have been insured for more than \$10 billion in 40 states and Puerto Rico. Project sizes have ranged from a few million dollars to nearly a billion dollars and participants range from small, stand-alone Critical Access Hospitals, to some of the country’s largest systems. Borrowers taking advantage of this type of credit enhancement must work with FHA-approved mortgage lenders to complete the funding.

In 2007 changes were introduced to streamline the 242 process. The program was placed under the exclusive

control of the Office of Insured Health Care Facilities, a division of the Department of Housing and Urban Development. A select team experienced in health care processes the 242 applications.

The FHA Sec. 242 program is available to fund new facilities, acquisitions or the substantial

renovation and modernization of existing facilities. Systems may refinance debt through the 242 program as long as at least 20% of the funding pays for new projects.

The FHA 242 program offers borrowers the opportunity to issue bonds at a AAA-equivalent rating and take advantage of the lower interest rates that accompany these higher credit ratings. Interest rates are fixed,

which can be very appealing in a low long-term interest rate market. Borrowers have up to 25 years after construction completion to repay the principal of the FHA mortgage-insured loans. The FHA does not require the parent or affiliated entities to provide financial guarantees, and a high loan-to value ratio can minimize up-front cash requirements.

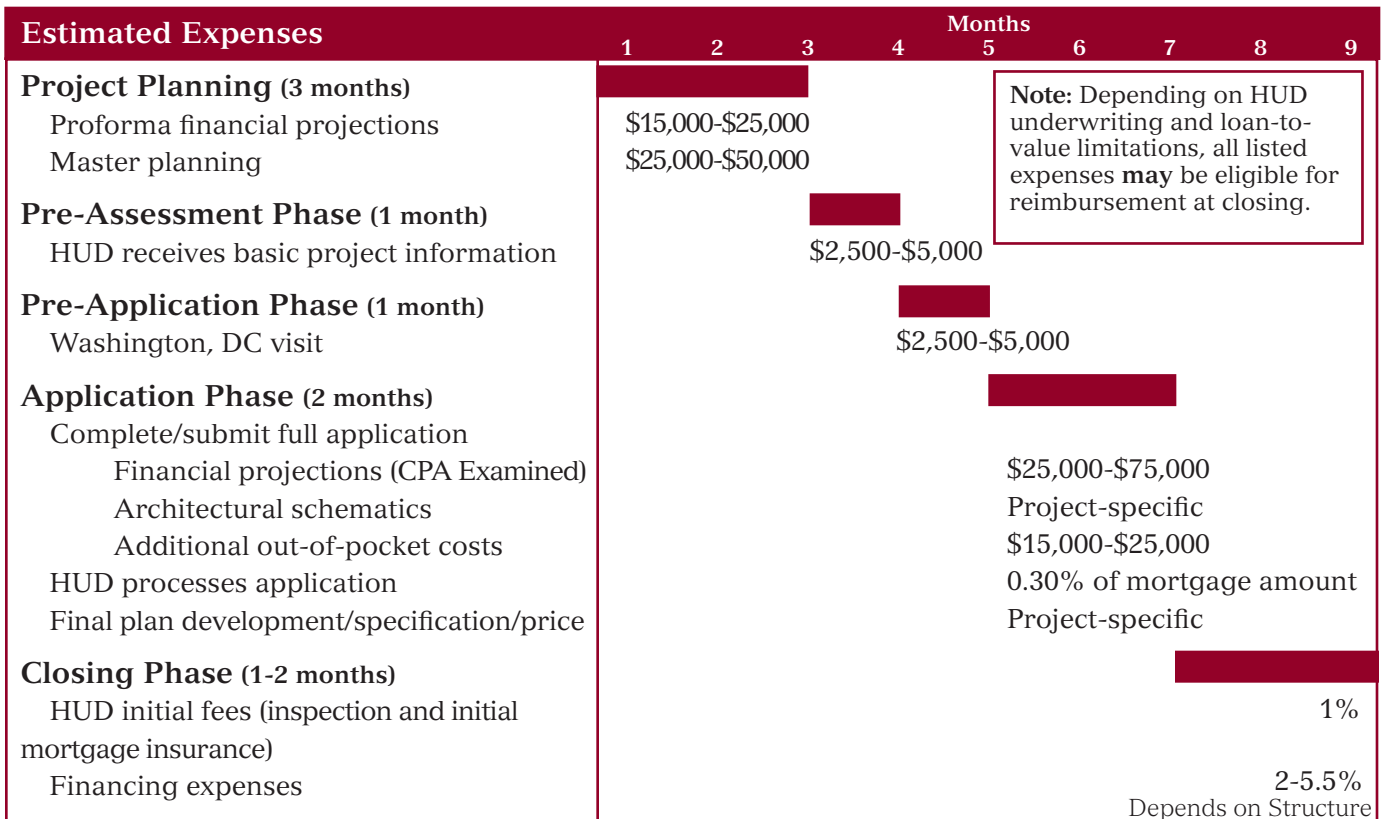
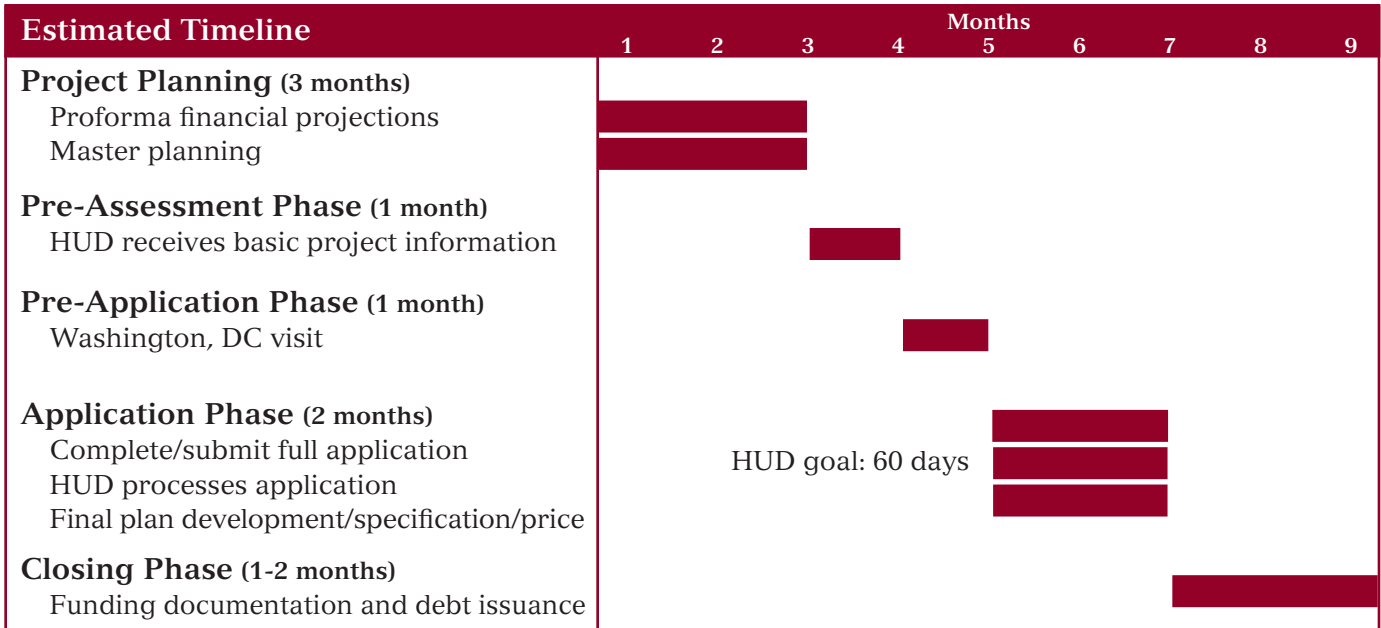
There is no limit to the amount of debt the program will insure, so long as the hospital can prudently support the debt repayment. The 242 program allows hospitals to borrow up to 90 percent of the value of the project; therefore, the debt available in some cases can meet 100 percent of the actual project cost. Project value calculations can include existing assets in addition to the actual project costs of new financing or construction.

To qualify for the 242 program, a facility must principally

Figure 15: FHA Sec. 242 Mortgage Insurance

Sec. 242 Mortgage Insurance Characteristics	
Tax-Exempt	Yes
Fixed-Rate Option	Yes
Variable-Rate Option	No
Est. Max Term	25 Years
Est. Max Amortization	25 Years
First Mortgage Required	Yes
Non-Recourse	Yes
Debt Service Reserve Fund	Yes
Prepayment Penalties	Yes
Underlying Rating	No
Enhancement Renewal Risk	No
Ongoing Financial Covenants	No
Structuring & Closing Timeline	180 Days

Figure 16: FHA Sec. 242 Timeline & Expenses



Note: Depending on HUD underwriting and loan-to-value limitations, all listed expenses **may** be eligible for reimbursement at closing.

be an acute care hospital that derives less than 50 percent of its revenues from chronic convalescence, drug and alcohol treatment, epileptic treatment, nervous and mental deficiency and tuberculosis treatment. Average operating margins must be positive, and the average debt-service coverage ratio must be equal to or greater than 1.25 for the previous three years. Recently approved Critical Access Hospitals have the option of recasting their historical financial statements to enhance their qualifications.

Loans insured by the FHA program are secured by a mortgage and pledge of revenues related directly to the project. Subject to attaining the financial ratios listed in figure 17 and some other credit requirements, hospitals utilizing the program may transfer assets, including cash, to the parent health system or affiliate hospitals, which can be an attractive feature for those organizations. The ability to leverage hospitals in a system individually can be of great value to a system. Leveraging a facility individually or using the FHA 242 structure to fund a new hospital allows a system to segregate that debt in a non-recourse entity. This allows the system to borrow for other purposes, maintain conservative financial ratios and preserve credit ratings, while still maintaining the upside of realizing excess cash flows from the segregated facility. It is important to note that the segregation applies to real estate and accounting for that pledged real estate. There is no need to segregate operations and the FHA 242 hospital(s) can maintain their operational integration with the rest of a system.

Issuing debt through the FHA 242 mortgage insurance pro-

gram can save organizations a considerable amount of debt service over time, but initial costs and the time necessary to apply for the program should be taken into consideration as part of the funding option analysis. Borrowers must pay a one-time fee of .8% of the loan amount. Additionally, an annual premium of .5% of the remaining principal balance is required, a relatively small fee given the extent of the credit enhancement and AAA-rated debt. Organizations must also have the financial capacity to make monthly payments to a mortgage reserve fund, which must equal two years of debt service after ten years.

All FHA insured mortgages are guaranteed by the full faith and credit of the United States government. While an FHA insured mortgage carries essentially no credit risk to the bondholder, it does not guaranty timely, problem-free payment and is therefore not in and of itself ratable and marketable as a AAA security without additional upfront deposits. Under certain circumstances, an FHA insured loan may be wrapped into a GNMA mortgage-backed security, which carries a AAA rating and is a highly marketable debt instrument.

Hospital borrowers traditionally have accessed the tax-exempt bond market to reduce their overall borrowing costs. However, they have been limited by a 1980 amendment to the National Housing Act that prohibits the use of GNMA securities to secure tax-exempt bond financings for hospitals. As a result, tax-exempt financ-

Figure 17: Tier 1 Financial Benchmarks

Category	Ratio	Requirement
Liquidity	Days Cash on Hand	= or > 110 days
Profitability	Total Margin Ratio	3-year moving average = or > 2%
Profitability/Solvency	Debt Service Coverage	3-year moving average = or > 2%
Solvency	Equity Financing Ratio	= or > 25%
<i>Tier 1 Qualification requires meeting Days Cash ratio and 2 of 3 other ratios</i>		

ings for FHA insured hospitals have required intensive structuring around the FHA insured note to achieve a AA or AAA rating, including providing for upfront deposits to cover potential delays in paying insurance claims and differences between the note rate and the interest rate payable on an FHA insurance claim after an event of default. This structuring and the resulting reserve deposits impose costs on the transaction that would not be present with a GNMA security. Historically, the lower interest rates offered in the tax-exempt bond market have often been sufficient to justify these upfront structuring costs. However, when market conditions result in low reinvestment rates and relatively high yields on tax-exempt bonds (compared to Treasuries), FHA-insured transactions can become inefficient for many hospital financings, with the hospital required to post as much as 10% of the loan amount as additional security to receive a AA or AAA tax-exempt bond rating.

Additionally, the publicly-offered tax-exempt bond market expects and requires bonds to be issued in whole at closing. When reinvestment rates are very low, construction fund negative arbitrage produces an extreme drag on new construction tax-exempt bond transactions. By contrast, the taxable GNMA market is accustomed to draw-down funding in which purchasers of GNMA securities commit at the time of initial endorsement, to fund mortgage loan advances in installments as they are made, and interest only accrues on amounts previously funded. These factors can dramatically reduce construction fund carrying costs, though some up-front deposits may still be required in some situations.

On July 1, 2009, FHA introduced the 242/223(f) refinance option to assist borrowers who were negatively affected by the increasing capital costs during the 2008-2009 credit crisis. Under this program hospitals

are able to refinance outstanding debt by meeting certain criteria. Elements of the program will be finalized after a review period.

FHA Sec. 242 Mortgage Insurance for Critical Access Hospitals

Hospital systems that include Critical Access Hospital should be aware that these small, rural facilities are entitled to special underwriting provisions that increase their chances of qualifying for the program.

Critical Access Hospitals may qualify for FHA Sec. 242 insurance even if more than half of their services are dedicated to drug and alcohol treatment, chronic convalescence or other services described above that prevent general hospitals from using the FHA Sec. 242 program. The government also streamlines the application process to speed up consideration.

Critical Access Hospitals still, however, must meet the requirements that the average operating margin be positive over the past three fiscal years and the average debt-service coverage ratio exceed 1.25x for the same time. This is where the special provisions make a significant difference. Many systems can qualify a Critical Access Hospital for the FHA 242 program by judiciously managing transfer payments between the hospital and parent system.

Build America Bonds

As part of the 2009 American Recovery and Reinvestment Act (ARRA) government-owned hospitals are temporarily able to issue Build America Bonds (BABs) to finance capital expenditures. Unlike traditional tax-exempt bonds, interest on Build America Bonds is taxable to the bond investor and the federal government provides a subsidy equal to 35% of interest cost of the issue as either a direct payment to the borrower, or as tax credits to the investors. The direct payment (or direct subsidy) option, limited to new construction and

acquisition, allows the bond issuer to receive a cash subsidy from the federal government at the same time debt service payments are made, while the tax credit option provides the bond holders tax credit over the life of the bonds. Ultimately, tax credit BABs provide the issuer a lower subsidy than Direct Payment BABs, in part because holders must include the tax credit they receive in taxable income. The ability to issue BABs expires on December 31, 2010.

Build America Bonds were created by Congress because municipal bond issuers were effectively unable to lower borrowing costs through the issuance of tax-exempt bonds as a result of the financial market crisis that began in the Fall of 2008. The bankruptcy of Lehman Brothers and a major money market fund “breaking the buck” set off a financial panic in September, 2008, causing a broad array of investors to flee to the safety of US Treasury Securities, driving taxable yields to record lows. Simultaneously, the cost of credit and liquidity provided by banks and other financial institutions skyrocketed, forcing unwinds and liquidations of liquidity vehicles for billions of dollars of long-term municipal bonds that were ultimately returned to the marketplace. This in turn pushed long-term tax-exempt yields to record highs and resulted in a record inverse spread between long-term taxable and tax-exempt yields. State and local governments asked Congress for relief in the stimulus legislation when they were unable to use municipal bonds to lower borrowing costs.

The response to BABs has been very strong. BABs are expected to comprise 20% or more of the \$400 billion annual municipal bond market before the program expires. The potential market for BABs is much broader than the market for tax-exempt bonds, and the market for direct payment BABs has rapidly developed, narrowing their spreads to US Treasury Bonds over the first four months of the program. Issuers may choose to combine BABs for capital expenditures with tax-exempt bonds for working capital or to refinance existing debt. Another combination

that can be considered during a period with an inverse spread between long-term taxable and tax-exempt yields is to issue tax-exempt bonds maturing in the first ten years, where the tax-exempt yield curve is currently steep, and issue BABs for maturities longer than ten years where the difference between taxable and tax-exempt rates is currently minimal.

Rated governmental hospital borrowers, such as city and county hospitals, hospital districts, and any other governmental entities that own health care facilities may issue Direct Payment BABs to acquire or construct those facilities and secure the BABs with GNMA securities that might otherwise be sold in the conventional market.

After applying the BABs’ subsidy payment, these bonds could be structured to provide an effective cost of funds that is roughly equivalent to 65% of the rate otherwise available to the borrower in the conventional market. An example: Assume 30 year, AAA-rated municipal bonds could be sold at par at a 5.75% coupon and assume the same bonds could be issued on a taxable basis at a 7.00% coupon using direct payment BABs. After the 2.45% rebate from the US Treasury (35% of 7.00%), the net borrowing cost totals $7.00\% - 2.45\%$, or 4.55%. Compared to the 5.75% coupon of the traditional municipal bonds, the interest savings is $5.75\% - 4.55\%$, or 1.20%.

Another structuring alternative is to combine BABS, FHA Sec. 242 mortgage Insurance, and GNMA securities to eliminate many of the upfront deposits otherwise required in a traditional FHA insured tax-exempt financing (see FHA 242 section above) and reduce the net interest cost. For example, the typical up-front deposits required by the rating agencies for a new construction Section 242 tax-exempt hospital transaction amount to approximately 10% of the loan amount. These deposits could be reduced to zero if the BABs are issued as draw-down bonds. Although an up-front deposit for negative arbitrage may still be required

in certain situations, several structuring techniques are available to help reduce those amounts considerably. This structure will also reduce net interest cost. For example, the estimated coupon on tax-exempt bonds insured by FHA hospital mortgage insurance might total 6.25%. The estimated coupon on taxable notes insured by FHA mortgage insurance and wrapped with GNMA securities might total 7.00%. The estimated coupon on taxable notes using BABs, insured by FHA mortgage insurance and wrapped with GNMA securities would be 7.00% - 2.45% (35% of 7.00%), or 4.55%, a reduction of 1.70% versus the tax-exempt issue and 2.45% versus the FHA/GMNA alternative.

Alternative Sources of Capital

While the majority of capital finance for hospitals is funded via traditional sources of capital as described above, hospitals also have alternative funding options available for project finance. Two of the primary finance alternatives are Off-Balance-Sheet (OBS) structures and Real Estate Investment Trusts (REIT). These options are typically taxable and utilized in order to preserve balance sheet debt capacity or because of the inability to secure traditional financing.

A) Off-Balance-Sheet (OBS)

OBS financing involves a third-party investor who owns hospital-related property and leases the property to the hospital. This arrangement is described in an operating lease, typically with a long term and an option for the hospital to retain ownership at the end of the lease.

The three primary forms of OBS financing are: (i) sale/leasebacks, (ii) synthetic leases, and (iii) master leases. Each form offers a different balance between hospital control of the property and the hospital's ability to exit the arrangement.

A sale-leaseback involves an investor purchasing an existing hospital asset and leasing it back to the hospital. This transaction provides the hospital with cash from the sale, but still allows the hospital to continue operating the property. The hospital's lease payment is at least equal to the investor's debt service associated with funding the purchase. Ownership of the property reverts to the hospital at the end of the lease, which usually takes the form of a ground lease.

A synthetic lease is similar to a sale-leaseback, but offers shorter terms and interest-only lease payments. Because no principal is included in the lease payment, the purchase option at the end of the term equals at least the debt principal outstanding.

Finally, a master lease involves the funding of a new project by a third party in concerted effort with the hospital. The developer manages the construction of the project and can serve as the initial operator upon project completion, while the hospital is able to use the space to offer services.

Of note, while OBS financing can provide a short-term boost to a hospital's cash position and allow the hospital to continue operations or grow without accumulating traditional long-term debt on the balance sheet, it is important for hospitals to work closely with their accountant in evaluating the accounting classification of the OBS alternative, because some OBS structures will result in a contingent liability for the hospital.

B) Real Estate Investment Trust (REIT)

A REIT is a company that purchases real estate assets and leases the assets to one or more operators. Similar to an OBS financing, this allows a hospital to operate the facility without technically owning the property. REIT's are compensated through the receipt of lease payments made by the hospital and via the ultimate sale of properties.

¹The Bond Buyer Year End Reviews, 2003 - 2007

²Bloomberg & Lancaster Pollard Research

Summary

The financing options for large hospital and multi-hospital systems can be complex and are continually evolving. Each financing structure has a unique set of characteristics that will likely be perceived to have both desirable and undesirable qualities. Each option must be evaluated with input from a knowledgeable investment banker/financial adviser and in concert with the unique credit profile of the organization and its long-term strategic plans.

Part III Risk Management

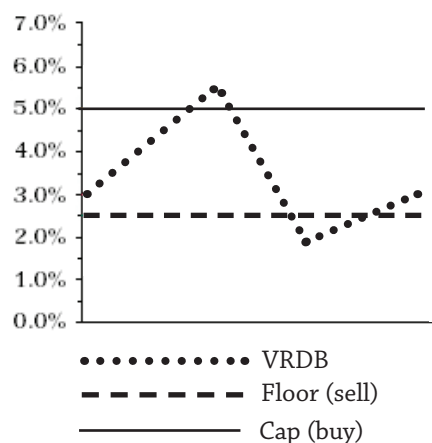
Interest Rate Risk Management

From 2003 through 2007, variable rate indebtedness accounted for 56% of municipal healthcare bonds¹. Variable rate debt structures provide healthcare borrowers access to a low cost of capital because the interest rate on the bonds is determined on the short-end of the yield curve (i.e., daily, weekly, monthly, etc.). Assuming a normal up-sloping yield curve, this variable interest rate may be significantly lower than fixed rates. For example, over the last ten years the difference between tax-exempt weekly rates and 30-year fixed rates for A-rated healthcare providers has totaled 317 basis points (3.17%)². Variable rate debt also provides borrowers flexibility, as there are typically no prepayment provisions. This is counter to traditional fixed rate bond issues, which tend to have a combination of prepayment lockouts and prepayment penalties for the first ten years.

A) Interest Rate Cap

An interest rate cap is created when a hospital enters into a contract with a financial counterparty to ensure the variable rate the hospital pays to bondholders will not exceed a certain interest rate level. The financial counterparty agrees to assume that interest rate risk in exchange for an

Figure 18: Rate Caps and Floors



upfront fee. The fee paid by the hospital to the counterparty is determined by the interest rate cap level and the term of the cap. The higher the probability the cap will be pierced, the higher the fee. For example, a 5% cap for 20 years will be more expensive (higher fee paid to counterparty) than a 7% cap for three years.

B) Interest Rate Floor

An interest rate floor is created when a hospital enters into a contract with a financial counterparty that gives the counterparty the right to benefit from interest rates below a certain rate level. The financial counterparty pays an upfront fee to a hospital for this sale. The higher probability the floor will be pierced, the higher the fee. For example, a 3% floor for 20 years will be more expensive (higher fee paid to hospital) than a 1% floor for three years.

Although there are many benefits to variable-rate indebtedness, funding capital projects via variable rate debt exposes organizations to interest rate risk. Specifically, if variable rates rise, the organization's interest expense will increase. A hospital will only be able to adequately tolerate a limited amount of interest rate risk depending on the hospital's liquidity position and net cash flows. Therefore, it is often

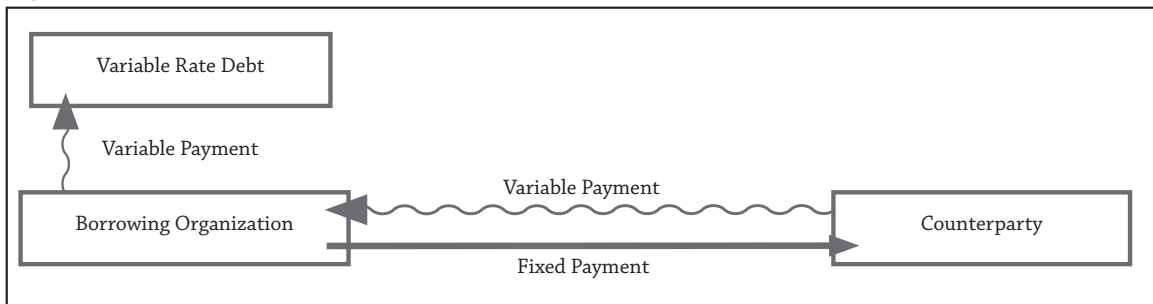
in the best financial interest of a hospital to mitigate interest rate risk through the use of derivatives.

Derivatives are financial instruments designed to trade away interest rate risk to other financial counterparties. Those financial counterparties primarily include investment banks and commercial banks. There are three primary types of interest rate derivatives: (i) caps, (ii) floors, and (iii) swaps.

the debt with a swap, the borrower pays a fixed amount each month to a counterparty in exchange for receipt of a variable-rate payment that approximates the borrower's interest payment. The variable-rate payment from the counterparty to the borrower is based on either of two interest rate indices, SIFMA (Securities Industry and Financial Markets Association, formerly Bond Market Association) or a percentage of LIBOR (London Interbank Offered Rate).

The variable cash flow received by the borrower roughly offsets the borrower's variable payment. The counterparty

Figure 19: The Pieces of an Interest Rate Swap



A common motivation for a hospital to sell a floor is to raise the capital to purchase a cap. As illustrated in figure 18 this transaction (sell floor, buy cap) creates an interest rate “collar”. In this scenario, the hospital is protected from paying interest rates above the interest rate cap level but has given up access to variable rates below the interest rate floor.

C) Interest Rate Swap

Swaps are financing vehicles that can synthetically “fix” a floating interest rate, thereby stabilizing cash flow and mitigating susceptibility to interest rate swings.

How Does an Interest Rate Swap Work?

An organization with variable-rate debt pays a different amount in interest each period as rates reset. In hedging

then receives a fixed payment from the borrower, thereby synthetically fixing the interest rate. There is no exchange of principal; only payment of net interest expense is impacted.

How Much, For How Long?

Interest rate swaps can be arranged for any term as they are independent of the underlying debt and are very flexible. They can be independent of letter of credit enhancements, or banks that issue letters of credit. Swaps can be restructured or retired at any time to match the organization's hedging strategy, and they carry no direct prepayment penalty. However, swaps do have value (as measured by the mark-to-market valuation), and therefore, borrowers can receive or pay the value if the swap is terminated early.

Understanding how much to swap, and when, means working with an investment banker to determine how much variable-rate risk exposure a hospital has over a period of time, and at what point variable-rate levels would become too high and too risky to maintain in light of debt covenants, the operating budget and other factors. A hospital does not need to hedge more, or longer, than the time and amount necessary to ensure appropriate risk exposure. For example, a hospital with \$20 million in cash and short-term fixed income securities and \$100 million in variable-rate debt potentially has only \$80 million of exposure to variable interest rate risk; the risk on the other \$20 million in debt would be roughly canceled out by investment returns of the cash and fixed income securities.

The keys to most effectively utilizing swaps are:

- 1) Identifying variable interest rate risk exposure and determining whether, and how much, to hedge, and
- 2) Tapping into a swap's flexibility and tailoring it to specific cost, timing and existing debt limitations.

Asset-Liability Management

Asset-liability management is a critical component of financial risk management. Hospitals too often manage their assets and liabilities in separate silos, and do not consider the impact of one on the other. In doing so, losses in the investment portfolio can trip debt covenants, which can negatively affect the hospital's operations. In order to reduce this risk, hospitals can implement a liability-driven investing approach, which requires hospitals to identify liabilities, determine risk tolerance, and develop an asset allocation strategy that matches the risk tolerance.

All institutions, including hospitals have embedded liabilities and for those with outstanding debt, embedded liabilities are comprised of the hospital's debt covenants. Debt covenants are financial or operational tests that a hospital agrees to meet

during the life of a financing transaction, are negotiated during the debt structuring process, and are different for every transaction; examples include financial covenants such as maintaining a minimum number of days cash on hand, or a maximum debt-to-capitalization ratio. Operational covenants may include the placement of a negative pledge on certain assets or the requirement to report financial and operational statistics within a specific timeframe. To protect investors, many bond and loan agreements contain provisions for corrective action and/or fees in the event a hospital violates a debt covenant (e.g., requiring a defaulting hospital to engage a management consultant and implement any recommended strategies). These covenants represent embedded liabilities; as such, the hospital should manage its assets relative to its liabilities to avoid potentially tripping a debt covenant.

Despite the importance of asset-liability management, hospitals often manage assets without considering the impact on liabilities. For example, a hospital might increase its exposure to equities in order to increase returns within its investment portfolio; however, if the stock market collapses, the hospital's liquidity may decline leading to a debt covenant violation, such as the minimum number of days cash on hand required. A liability-driven investing approach provides hospitals with a framework necessary to manage assets relative to liabilities.

In order to implement a liability-driven investing approach, hospitals must first determine their risk tolerance, which defines how much fixed income-like volatility is required based on their embedded liabilities. Although each asset class has certain characteristics that make it unique, all asset classes display one of two types of volatility: equity-like volatility or fixed income-like volatility. The primary purpose of assets with equity-like volatility, such as equities, commodi-

ties, real estate investment trusts, and non-investment grade bonds, is to increase returns within the investment portfolio. Conversely, the primary role of assets with fixed income-like volatility, such as investment grade bonds and Treasury Inflation-Protected Securities (TIPS), is to reduce the volatility of returns within the investment portfolio. Once a hospital determines its risk tolerance (e.g. how much fixed income-like volatility its liabilities demand), it can develop a specific asset allocation policy that provides an acceptable level of return volatility within the aggregate investment portfolio.

Over the years, various academic studies have shown that asset allocation is the key driver of return volatility. A study of the asset allocation of 91 large pension funds, published in 1986 by Gary Brinson, Randolph Hood, and Gilbert Beebower, found that, “Investment policy dominates investment strategy (market timing and security selection), explaining 93.6% of the variation of total plan returns.” Additionally, Roger Ibbotson and Paul Kaplan’s 2000 study of the asset allocation of 94 U.S. balanced mutual funds and 58 pension funds found that “asset allocation explains about 90% of the variability of a fund’s return over time.” As a result, hospitals should focus on asset allocation, including the allocation to fixed income-like volatility, as a means to reduce the volatility of returns within their investment portfolio.

Volatility can be reduced within an investment portfolio by adding asset classes that have a low correlation with asset classes already held in the portfolio. Correlation, which ranges from negative one to positive one, is a statistical measure of how two assets move in relation to each other. For example, two assets with a correlation of positive one move in lockstep in the same direction, so that if one asset gains 5%, the other asset will gain 5% as well. Conversely, two assets with a correlation of negative one will move in the opposite direction, so that if one asset gains 5%, the other asset will lose 5%. Although correlations can change

over time, research has shown that investments such as commodities, Treasury Inflation-Protected Securities (TIPS), real estate investment trusts (REITs), emerging market stocks, and high yield bonds have historically had relatively low correlations with U.S. stocks and bonds. Given that many hospitals currently have investment portfolios comprised mostly, if not entirely, of U.S. stocks and bonds, adding assets with low correlations should reduce the volatility of returns within the investment portfolio.

Hospitals can lower the volatility of returns within their investment portfolios by developing an asset allocation policy linked to its embedded liabilities. As such, this application of liability-driven investing (i.e. asset-liability management), can reduce the likelihood of the hospital violating a debt covenant.

Recognizing the need to address the liabilities in the development of an asset allocation plan is the first step to reducing the risk in the organization. The second step is to know that the needs of each hospital are unique, and that an asset allocation plan is different from one hospital to the next. When it comes to managing a risk budget, there is no “one size fits all”. The last step is knowing that asset-liability management within any organization is a fluid process, and must be monitored continuously to reflect the hospital’s changing capital needs, the interest rate environment, and the risks and opportunities in investment markets.

Summary

Managing risk is essential to a hospital’s financial health, and can be achieved through the use of derivatives and asset-liability management. A knowledgeable investment banker/financial advisor can help an organization determine its risk tolerance and develop strategies to mitigate it.

Appendices

Appendix A: Definition of Ratios

Liquidity

<u>Days Cash on Hand:</u>	Unrestricted cash and investments / daily cash operating expenses
<u>Cushion Ratio:</u>	Unrestricted cash and investments / maximum annual debt service (MADS)
<u>Cash to Debt:</u>	Unrestricted cash and investments / (long-term debt - current liabilities)
<u>Current Ratio:</u>	Current assets / current liabilities

Profitability and Operational

<u>Operating Margin:</u>	(Total operating revenues – total operating expenses) / total operating revenues
<u>Excess Margin:</u>	(Total operating revenues – total operating expenses + non-operating revenues) / (total operating revenues + non-operating revenues)
<u>Cash Flow (EBIDA) Margin:</u>	(Total operating revenues – total operating expenses + interest expense + depreciation + amortization) / (total operating revenues + non-operating revenues)

Capital Structure and Cash Flow

<u>Debt Service Coverage*:</u>	(Total operating revenues – total operating expenses + non-operating revenues + interest expense + depreciation + amortization) / MADS
<u>Debt to Capitalization:</u>	(Long-term debt - current liabilities) / (long term debt – current liabilities + unrestricted net assets)
<u>MADS as % of Total Revenue:</u>	MADS / total revenue

* The most widely used ratio in the capital markets, this measures the ability to make debt payments from ongoing operations. The denominator is always the maximum annual debt service, but the numerator can be known by several different terms including “net operating income,” “net income available for debt service” or simply “net available.”

Appendix B: Factors in a Hospital Credit Analysis

Financial Operating History: Generally, three to five years of audited financial statements are necessary for an accurate credit evaluation, which will include margin, trend and debt service coverage analyses. Stable or growing profitability from operations is desired with minimal reliance on non-operating revenues to meet the ongoing and routine capital needs of the organization. Significant deviations from year-to-year performance or within specific accounts will need to be addressed by management. Non-operating revenues evidencing community support (either tax-supported or charitable contributions) are viewed favorably.

Financial Position: Particular attention is given to liquidity and capital structure. Highly leveraged organizations will be perceived as being a higher credit risk. Organizations with little or no liquidity will be viewed negatively even in the absence of long-term debt. Hospitals with balance sheet liquidity will be assessed to determine the scope of investment policies and adherence to them. Investment strategies that produce more consistently stable returns will be preferred. The quality of accounts receivable will be reviewed by aging and payor source, as will the hospital's procedures for accounting of contractual allowances, bad debt allowances and write-offs.

Financial Feasibility: Financial projections will be important for those projects that may substantially impact revenues or expenses, including but not limited to the impact on Critical Access reimbursement. Underlying feasibility assumptions will be reviewed against historical operating metrics, and substantial variances between the two will need to be well supported.

Organization Background/Strength of Management & Board: The organization's history and length of service to the community will be evaluated. The industry experience of key management personnel will be considered, as will their tenure with the organization. Evidence of proactive efforts to address facility challenges or opportunities will be viewed favorably. The quality of management's financial and operational reports and frequency of review by management and the board will be evaluated. The educational and professional background of board members will be reviewed, with a diverse make-up and active participation in strategic initiatives viewed positively.

Service Lines and Medical Staff Characteristics: A review of the primary and specialty service lines and how they have changed over time in response to market demands will be conducted. The admitting characteristics of medical staff will be evaluated over a two- to three-year period. Although more challenging in smaller hospitals, heavy concentration of admissions among one or two physicians may be viewed negatively. The active medical staff's age, board certification (if any), length of practice and association with the hospital will be evaluated. New physician recruitment programs will be assessed for their ability to improve long-term retention and their impact on hospital financial results.

Utilization and Payor Mix: A three- to five-year historical review of utilization metrics by service line will be conducted with stable or growing trends viewed favorably. Adverse utilization trends will need to be addressed by management with plans to improve market share or implement facility downsizing. The payor mix will be reviewed over a similar period to identify favorable or negative trends. Managed care contracts with commercial payors will be reviewed to determine pricing power.

Physical Plant and Market Area Characteristics: The age and physical and functional obsolescence of the facility will be considered along with any plans for improvement. Projects involving rehabilitation of existing structures will need to demonstrate a plan to minimize disruption to operations. Construction risk due to potentially rising construction costs and change orders will need to be minimized through contractual arrangements and/or adequate balance sheet reserves. The site of the existing or proposed facility will be evaluated for ingress/egress, opportunities for expansion, marketing visibility, proximity to ancillary services and profile of the surrounding community. The primary and secondary market demographic and socioeconomic characteristics will be evaluated to determine opportunities for profitable growth. The market share of the hospital versus competing area hospitals will be determined as well as comparisons by size, physical plant, service lines, and active medical staff. Referral, patient transfer and other relations with larger tertiary hospitals

will be reviewed.

Litigation History and Claims Exposure: A review of historical and pending claims as well as management plans to mitigate future claims will be conducted. The types and amounts of liability coverage will be reviewed to determine adequacy to meet pending or potential future claims.

Collateral: The type, amount, and quality of security that can be provided to creditors (bond investors or lenders) will be evaluated in light of other credit characteristics. Priority revenue pledges will be preferred, as will first lien mortgage and security interests in real estate and personal property of the hospital. Parity security interests with other creditors will be viewed less favorably, although not as poorly as subordinated lien positions.

Appendix C: Rated Bonds

Ratings on bonds can be achieved in several ways. Bonds can be rated based on the strength of the borrower, or they can be rated because they are backed by another organization that has a published credit rating. The most common example of a backing by another organization is a bank letter of credit. If a rated bank agrees to stand behind a hospital's bonds, the bonds will receive the same rating as the bank.

Ratings fall into two general categories: investment-grade and non-investment-grade. These groupings are significant because many institutional investors can purchase only investment-grade securities. Thus, there is a broader market for distribution of a bond with an investment-grade rating. This results in a lower interest rate for the borrower.

Issues rated in the four highest categories, "AAA," "AA," "A" and "BBB," generally are recognized as investment-grade. Debt rated "BB" or below generally is referred to as "high yield," "speculative-grade" or "junk bonds." The following chart identifies the relative credit strength of each possible rating category.

	Explanation	S&P	Moody's	Fitch
Investment-grade	Highest rating, capacity to repay extremely strong, highest quality	AAA	Aaa	AAA
	Very strong capacity to repay, differs slightly from AAA, high quality	AA	Aa	AA
	Strong capacity to repay/more susceptible to change in circumstance/economic conditions, upper medium grade	A	A	A
	Adequate capacity to repay, adverse economic conditions may lead to weakened capacity to repay, medium grade	BBB	Baa	BBB
NON-Investment-grade	Speculative characteristics, less near-term vulnerability to default	BB	Ba	BB
	Capacity to meet payments, greater vulnerability to default, speculative, low grade	B	B	B
	Current identifiable vulnerability to default, poor to default	CCC	Caa	CCC
	Highest speculation	CC	Ca	CC
	Lowest quality	C	C	C
	Payment in default, default	D		DDD
	In arrears			DD

Appendix D: Typical Costs in a Bond Issuance

Time of Costs	Type of Cost/Description
<p>Up-Front Issuance/Closing Costs</p>	<p>Attorney Expense:</p> <ul style="list-style-type: none"> ■ Bond Counsel ■ Borrower’s Counsel ■ Underwriter’s Counsel ■ Credit Enhancement Counsel <p>Up-Front Fees:</p> <ul style="list-style-type: none"> ■ Underwriter’s Discount ■ Printing Costs for Disclosure Documents and Bonds ■ Trustee Acceptance Fee (if applicable) ■ Issuer’s Fee (if applicable) ■ Credit Enhancement Origination Fee (if applicable) ■ Bond Rating Fee (if applicable)
<p>Periodic Costs</p>	<ul style="list-style-type: none"> ■ Annual Trustee Fee ■ Annual Credit Enhancement Fee (if applicable) ■ Annual Remarketing Fee (if variable-rate debt) ■ Rating Fees (if applicable) ■ Annual Issuer Fees (if applicable)

Appendix E: Notable Requirements for Tax-Exempt Bonds

Requirement	Details of Requirement
95% Test	At least 95% of the bond proceeds must be used for land costs and depreciable property.
3-Year Spend-Down	Bond proceeds must be substantially spent within three years of issuing the bonds.
Maximum Allowable Weighted Average Maturity	Maximum allowable weighted average maturity. The weighted average maturity of the bond issue may not exceed 120% of the reasonably expected weighted average economic life of the assets financed.
2% Maximum for Issuance Costs	No more than 2% of bond proceeds may be used to pay bond issuance costs.
25% Maximum to Acquire Land	Except for 501(c)(3) bonds, no more than 25% of the bond proceeds may be used to acquire land.
Required Inducement Legislation	501(c)(3) Bonds – A similar, but less stringent, requirement applies to 501(c)(3) bonds. In fact, nonprofit organizations may adopt their own internal resolution (referred to as a reimbursement resolution) to preserve the eligibility of incurred expenditures prior to receiving a formal inducement resolution.
Annual Dollar Limits by State and Accessing Allocation from State Volume Cap	501(c)(3) and Refunding Bonds – Allocation is generally not required for these bonds.
Required Public Hearing	<p>Except for certain refunding bonds, there must be a public hearing on a proposed financing before the bonds can be issued.</p> <p>14-Day Notice – Generally, notice of the public hearing must be published in a local newspaper at least 14 days prior to the hearing.</p>

Appendix F: Key Players in Hospital Financings

Asset Manager: This position is sometimes referred to as an “Investment Manager” or “Money Manager” and is responsible for assisting an organization in properly investing financial resources to gain consistent returns over time based on a particular investment allocation and strategy.

Bond Counsel: An attorney retained by an issuer to provide a legal opinion that the issuer is authorized to issue the proposed securities, has met all legal requirements necessary for issuance, and that interest on the proposed securities will be exempt from taxation. Bond Counsel also prepares many legal documents related to the proposed issuance and will advise the issuer regarding authorizing resolutions, the trust indenture, official statements, validation proceedings and litigation.

Bond Insurer: Provides bond insurance to assure the full and timely payment of all interest and principal over the life of the bonds. These organizations typically are paid an up-front fee that is calculated on total interest and principal over the life of the bonds.

Bond Trustee: Usually a bank trust department that acts on behalf of the bondholders. The trustee controls specific funds created for the bond issue, controls disbursement of bond proceeds, and is responsible for enforcing remedies and taking actions on behalf of bondholders in the event of default. The trustee also receives debt service payments from the borrower and acts as paying agent. The trust indenture outlines the trustee’s fiduciary responsibilities and bondholders’ rights.

Borrower’s Counsel: Represents the borrower in the transaction, frequently drafts necessary disclosure statements about the borrower, and issues opinions on behalf of the borrower and on the legality of its actions regarding the bond issue. Additionally, borrower’s counsel ensures that the appropriate documentation of board approval is obtained and that properly authorized individuals are executing the necessary documents. Finally, borrower’s counsel issues the opinion regarding the borrower’s compliance with any outstanding regulations and/or laws.

Commercial Banker: Also referred to as a commercial lender or relationship manager, this person works for the letter of credit bank offering a number of commercial banking products (checking and saving accounts, cash management services, payroll services, lines of credit, etc.) and may suggest term loans as an alternative to tax-exempt bond financing.

Credit Enhancer: Institutions willing to use their credit and financial strength to enhance the financial strength of a bond issue or mortgage loan. The typical credit enhancer is a letter of credit bank (most common), bond issuer, or governmental agency.

Financial Adviser: May be retained by either the borrower or issuing authority to assist in developing a plan of finance and to evaluate the pricing and final structure of the bond issue. A financial adviser can become involved in a financing at any point in the process. In most instances, the investment banker will generally act in this capacity.

Investment Banker or Underwriter: Responsible for structuring and managing the financing and selling the bonds or mortgage loan. The underwriter buys the bonds from the issuer or issuing authority and sells the bonds to investors. Although these terms frequently are used interchangeably, a distinction should be made between investment banker and underwriter – investment bankers structure the financing while underwriters distribute the securities to the investing public.

Issuer or Conduit Authority: This entity is specific to municipal or tax-exempt bond financings. Usually a governmental division, or at least a quasi-governmental agency, it issues the tax-exempt bonds for a project. These bonds are exempt from certain taxes depending upon where they are issued, who issues them, and the tax status and residence of the bondholder. The issuer can either be a special government entity created solely to issue tax-exempt bonds or be the city, county, or state in which the project resides.

Issuer's Counsel: Represents the issuer (issuing authority). Bond counsel frequently acts as issuer's counsel.

Letter of Credit Bank: Provides a letter of credit (usually a "direct pay letter of credit") that is drawn on by the trustee to make principal and interest payments to bondholders.

Letter of Credit Bank Counsel: Represents the letter of credit bank by preparing and reviewing all documents involving the letter of credit bank and the reimbursement agreement between the borrower and the bank.

Mortgage Banker: A mortgage banker originates, sells and services mortgages in the mortgage market. This entity is necessary when utilizing some of the government enhancement programs.

Purchaser's Counsel: Represents institutional investors or purchasers on certain unenhanced and unrated issues that are considered riskier by the investor community. Counsel reviews all documents and may occasionally negotiate terms, covenants and other items on behalf of the investor.

Rating Agency: Makes an independent determination as to the likelihood the bond will be repaid in accordance with its terms. The most well-known rating agencies are Moody's Investor Services, Standard & Poor's and Fitch IBCA. The intent of ratings established by the agencies is to allow investors to quickly assess a borrower's financial strength without having to personally study financial statements.

Trustee's Counsel: Represents the bond trustee and often is the Bond Counsel in a transaction.

Underwriter's Counsel: Represents the underwriter and prepares the official statement. Drafts the bond purchase agreement.

Appendix G: Security and Covenants

Bondholders almost always expect some security for their investment. This means that the payment of interest and principal is based on more than the borrower's promise to pay and is supported or secured by additional items. The underlying credit of the borrower will be the primary determinant of the types of security that will be required for a financing. An investment banker's skill, reputation in the financial community, and the ability to negotiate on behalf of the borrower can affect those requirements. Security normally includes a first mortgage and security agreement, a pledge of gross revenues, a debt service reserve fund and additional loan covenants.

Security:

First Mortgage and Security Agreement: Bondholders generally expect a first mortgage on the project being financed with tax-exempt bonds. The mortgage is similar to a home mortgage and provides the bondholder certain rights, including foreclosure in the event of default. The lien is documented through a first mortgage and security agreement filed in the county in which the property is physically located. On some higher-rated transactions, a first mortgage may not be required. In this case, a negative lien (where the borrower agrees not to encumber the facility with other liens) will be given as security.

Pledge of Gross Revenues: The borrower must pledge all of its gross revenues for payment of debt service on the bonds. This pledge is considered an important part of the security package. Most tax-exempt bond issues are called revenue bonds rather than mortgage bonds because the revenues of the project being financed are the primary source of bond repayment.

Debt Service Reserve Fund: It is customary for a bond issue without credit enhancement to include the funding of a debt service reserve fund that can be used for principal and interest payments to the bondholders if the borrower is unable to pay. It normally equals the maximum annual debt service of principal and interest to be paid in any year during the life of the bonds.

Additional Covenants:

The legal documents associated with a bond issue include an agreement ("covenant") by the borrower to pay all interest and principal due on the bonds. In addition to this fundamental repayment requirement, other business terms provide added security for the bonds. Covenants, like other components of an issue, are negotiable. It is important to balance the interests of the parties involved so as to give the bondholder some degree of control and allow the borrower enough flexibility to operate.

Ratio or Financial Covenants: These covenants refer primarily to the financial performance of the borrower and some of the more common are listed in Appendix A: Definition of Ratios. These usually are set at minimum standards and generally are the easiest way to provide early warning of financial trouble. Covenants related to liquidity ensure that the borrower always has cash available for operations and debt service in the event of a revenue shortfall or cash flow shortage. The debt service coverage ratio is probably the most widely used ratio covenant because it measures the ability to make debt payments from ongoing operations.

Additional Indebtedness: Bondholders do not want borrowers to incur additional debt indiscriminately and thereby weaken their ability to pay debt service on the bonds. Therefore, borrowers usually must agree to covenants restricting their actions in this area. Guidelines or formulas can be negotiated in the covenant that will allow the borrower to incur some additional indebtedness without the bondholders' permission.

Insurance Covenants: These covenants will require that minimum standards for insurance be maintained on assets on which the investor is holding a security interest and/or are relied upon by the borrower to generate revenue. This enables the borrower to rebuild/replace damaged assets, make available sufficient funds to service debt, and ensure that the bondholder is protected with respect to its reliance on value of the collateral.

Maintenance Covenant: A maintenance covenant refers to the continuous upkeep of a facility or property to help maintain the value. Again, this is important during a bond issue when the investor is holding a first mortgage on the property as a guarantee for the loan.

Financial Statements: There always will be a need to review the borrower's audited financial information to ensure compliance with ratio covenants.

Appendix H: Terms and Participants Associated with Financing Alternatives

All-in Interest Cost: Representation of the total true cost of the financing including all interest rates and fees paid.

Arbitrage: Generally, transactions where the same security is bought and sold in different markets at the same time for the sake of the profit arising from a price difference in the two markets. Arbitrage, with respect to the issuance of tax-exempt debt, usually refers to the difference between the interest paid by the borrower and the investment income earned by acquiring higher-yielding securities.

Asset: Any valuable item that is owned by an organization and is available to generate income or cash.

Balance Sheet: Often referred to as the “Statement of Financial Position,” it is a snapshot in time and shows the accumulated values in dollars of assets and liabilities as of a given date. It is important because of its ability to track the balance of assets, liabilities and net assets (equity). The strengths and weaknesses of an organization are easily ascertained from this financial statement.

Basis Point: Short reference to 1/100 of 1 percent. For example, the difference between 5.25% and 5.50% is 25 basis points.

Bond: Proof of an issuer’s obligation to repay a specified principal amount and interest – at a predetermined rate or in accordance with a formula — on certain dates. Bonds do not represent ownership, but rather are a type of loan and thus considered senior securities. Interest on a tax-exempt bond is exempt from federal income taxation and may be exempt from state or local taxation in the jurisdiction where issued.

Bond Buyer Revenue Index (BBR): A tax-exempt market index composed of highly rated tax-exempt, fixed-rate, revenue bond obligations with an average maturity of 30 years. The index serves as a benchmark that is accepted industry wide. The index allows for an efficient way to regularly monitor the long-term, tax-exempt, revenue bond market.

Bond Purchase Agreement: This is a legal document between the borrower, underwriter, and issuing authority that obligates the underwriter to purchase the bonds at agreed-upon interest rates and with specific terms.

Bond Transcript: All legal documents associated with the offering of a new tax-exempt bond issue.

Callable Bond: A bond permitted or required to be redeemed before the stated maturity date at a specific price, usually at or above par, by giving notice of redemption in accordance with the terms in the trust indenture.

Cap: The highest interest rate that can be paid on a floating rate bond over a specified period of time.

Capitalized Interest: A portion of the proceeds of an issue set aside to pay interest on the bond or loan during the construction period. Capitalization refers to the treatment of the interest cost because it is added to the basis or cost of the asset for accounting purposes.

Closing: The meeting of concerned parties involved in a new bond issue during which the requisite legal documents are executed and proceeds are delivered for use by the borrower.

Collar: An upper and lower limit on the interest rate that can be paid on a floating rate bond over a specified period of time.

Conduit Financing: Bonds, usually tax-exempt, issued by a governmental unit to finance a project to be used primarily by a third party engaged in private enterprise. The taxing authority of the governmental unit does not secure the bonds. The bonds do not constitute an obligation of the governmental unit. Reliance for repayment is placed on revenues generated from the project.

Corpus: A term used to describe an income-producing asset, usually stocks or bonds, as contrasted to the income — such as interest — derived from it.

Cost of Capital: The financial expenditure required to borrow money. This includes, but is not limited to, issuance costs, attorney fees, credit enhancement (as applicable), and interest payments.

Costs of Issuance: The expenses associated with a financing transaction, including such items as printing, legal fees, rating agency fees, underwriter's discount and others.

Coupon: The interest rate on a fixed income security, determined upon issuance, and expressed as an annual percentage of the principal amount.

Credit Enhancement: An additional source of security for a bond or loan that comes in the form of a letter of credit from a commercial bank, private bond insurance, and government mortgage insurance and loan guarantees.

Debt Service: The series of payments of interest and principal required on a debt over a given period of time.

Debt Service Coverage: Expressed as a percentage, the amount of annual available cash flow divided by the annual debt service requirement. Debt service coverage is a primary indication of the safety or credit quality of an issue, or a borrower's ability to repay its debt.

Debt Service Reserve Fund: A fund created to cover a portion (usually one year) of debt payments on behalf of an organization should it not be able to pay out of regular revenues. This account usually is funded at closing from bond or loan proceeds to provide added security for the investor. Additional deposits may be required depending on the loan structure.

Defeasance: Termination of the rights and interests of bondholders, which usually occurs in connection with the refunding, refinancing or payoff of an outstanding issue.

Derivative: A financial instrument purchased or sold to manage the interest rate risk associated with an underlying security to protect against fluctuations in value. Borrowers utilize these instruments in the forms of caps, collars and swaps.

Discount: The amount by which a bond's par amount exceeds its market price.

Endowment: A permanent fund bestowed upon or created by an institution, made up of cash, securities and other investments to be used for a specific purpose. It is considered an asset of the organization, and income from investments is used to build the corpus and/or supplement operating expenses.

Feasibility Study: A report of the financial practicality of a proposed project and its financing, which should include estimates of revenues to be generated and expenses to be incurred and a review of the physical, operating, economic or engineering aspects of the proposed project.

Fixed Rate: A rate of interest that does not change during the entire term the debt is outstanding.

Floating (or Variable) Rate: A method of determining the interest to be paid on a bond by reference to an index, or according to a formula or some other standard of measurement, at stated intervals.

Interest Expense: Money a borrower pays a lender or investor for use of the loan or bond proceeds.

Investment-grade: A term used to define those bonds with a relatively high level of credit quality. Bonds rated Baa or higher by Moody's or BBB or higher by Standard & Poor's and Fitch are considered investment-grade bonds.

Issuer or Issuing Authority: Empowered under federal law to issue conduit tax-exempt bonds. The proceeds from the sale of these bonds can be used to provide low-interest loans to 501(c)(3) nonprofit organizations and other qualified borrowers/activities as allowed under the Internal Revenue Code.

Liability: A financial obligation, debt, claim or potential loss.

Liquidity: The ability of an asset to be converted into cash quickly and without any price discount.

Note: In contrast with a bond, a note commonly refers to a taxable security or loan.

Official Statement: The document prepared for or by the issuer that discloses to prospective investors material information on the security being offered for sale, including the purpose of the financing, how the debt will be repaid and the borrower's financial information.

Par Bond: A bond selling at its face value or maturity value.

Premium: The amount by which a bond's par amount is less than its market price.

Prime Rate: The interest rate that commercial banks charge their most creditworthy borrowers.

Pro forma: A presentation of data that reflects an "as if" scenario. A newly designated Critical Access Hospital can restate its financial statements for the three years previous to its designation as if it had been receiving cost-based Medicare reimbursement.

Put (or Tender Option) Bonds: Obligations that grant the bondholder/investor the right to require the issuer/borrower or a designated third party to purchase bonds, usually at par, either periodically, at certain times prior to maturity or upon the occurrence of specified events or conditions.

Qualified 501(c)(3) Bonds: Tax-exempt bonds can be issued for certain organizations. The most common qualified organization is a nonprofit entity that has been established for charitable purposes. If a project furthers the mission of such an organization, it generally qualifies for tax-exempt financing.

Ratings: Evaluations of the credit quality of securities and/or borrowers usually made by independent agencies. Ratings are intended to measure the probability of the timely repayment of principal and interest. Ratings are initially made prior to issuance and are periodically reviewed for confirmation or amendment if the borrower's credit position has changed.

Ratio: A formula used to compare different measures of an organization's performance. The three main types of ratios are profitability, liquidity and capital structure. Benchmark ratios are specific ratios that constantly are used

to measure performance of one organization against another.

Refunding: A procedure whereby an issuer refinances an outstanding bond (refunded bond) by issuing new bonds (refunding bond). There generally are two reasons for doing this: to reduce interest costs or to remove burdensome or restrictive covenants imposed by the terms of the bonds being refinanced. There are two types of refundings: current and advance. A current refunding refers to the ability to retire the refunded bonds within 90 days of closing the new issue. An advance refunding requires proceeds of the new issue to be used to purchase other obligations that are then deposited in escrow. These escrowed obligations mature in sufficient amounts and at appropriate times to provide funds to pay interest and principal of the prior issue when due or callable.

Reimbursement Agreement: An agreement between the borrower and letter of credit bank describing the reimbursement obligation of the borrower for draws on the letter of credit. Also contains other credit terms typically found in loan agreements.

Reimbursement Resolution: An official statement enacted by the directors of an organization that allows the organization to reimburse capital expenditures between the resolution date and the issuance of tax-exempt bonds. The earlier this is done the more reimbursements may be made out of the tax-exempt debt financing.

Remarketing: A formal re-underwriting/re-selling of a bond issue that has been “put” by an investor. The remarketing agent typically is responsible for periodically resetting the interest rate on floating/variable-rate transactions.

Revenue Bond: A type of bond in which the issuer pledges to repay the bondholders with revenues generated by the operations of the project financed.

Securities Industry and Financial Markets Association (SIFMA): A seven-day high-grade market index composed of tax-exempt, variable-rate debt obligations. The index serves as a benchmark that is accepted industry-wide. The index allows for an efficient way to regularly monitor the short-term tax-exempt market.

Serial Bonds: A series of bonds with individual annual maturities and individual interest rates. Usually these bonds mature in the first 10 to 12 years of a financing.

Sinking Fund: A structured plan to accumulate cash for the purpose of redeeming a fixed portion of bonds. This may comprise a portion of or the entire issue, and is in accordance with a fixed schedule detailed in the trust indenture or reimbursement agreement. This helps an organization create level debt service over time rather than having to pay it all off at the maturity.

Swap: An exchange of streams of payments over time according to specified terms. The most common type is an interest rate swap, in which one party agrees to pay a fixed interest rate in return for receiving an adjustable rate from another party.

Term Bond: A bond with a single final maturity date and single interest rate. All or a large part of an issue of bonds may be sold as one or more term bonds. Term bonds usually have mandatory annual payments called sinking fund payments.

Trust Indenture: A contract between the issuer and the bond trustee that sets forth the obligations of the issuer to the bondholders. Such contract includes specific repayment, collateral, default and bond fund provisions.

Yield Curve: A graph plotting market yields on bonds of equivalent quality but different maturities at a given point in time. The structure of interest rates as reflected by the yield curve will vary according to market conditions. A normal or positive yield curve results when short-term securities have a lower interest rate than long-term securities. An inverted or negative yield curve results when short-term rates exceed long-term rates. A flat yield curve exists when short- and long-term rates are approximately the same.

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