financing strategic healthcare facilities
the growing attraction of alternative capital

When considering options for financing strategic facilities, community health systems have less reason today than they did in the past to bypass third-party capital in favor of tax-exempt bonding.

When considering financing of strategic facilities, executives of not-for-profit health systems all too often conclude, based on conventional thinking, that bonding the transaction (using tax-exempt debt) is preferable to applying alternative (third-party) capital to finance the underlying asset. There are four common rationales for this conclusion:

> Tax-exempt debt is less expensive over the long term.
> Ownership makes the most sense if the asset is to be used for 30 years or longer.
> As long as the organization has sufficient debt capacity, there is no reason not to use it.
> Alternative capital could implicate the organization’s balance sheet in the eyes of the credit markets.

Not-for-profit health systems often simply dismiss use of alternative capital to finance strategic facilities as being too expensive and less strategically useful. Yet a strong case can be made that health systems can benefit from applying alternative capital to finance strategic facilities—specifically larger, complex ambulatory facilities. This case example derives from the prospects of proposed, and potentially sweeping, changes in accounting rules and standards, and by

AT A GLANCE

> Community health system leaders often dismiss use of alternative capital to finance strategic facilities as being too expensive and less strategically useful, preferring to follow historical precedent and use tax-exempt bonding to finance such facilities.
> Proposed changes in accounting rules should cause third-party-financed facility lease arrangements to be treated similarly to tax-exempt debt financings with respect to the income statement and balance sheet, increasing their appeal to community health systems.
> An in-depth comparison of the total costs associated with each financing approach can help inform the choice of financing approaches by illuminating their respective advantages and disadvantages.

For discussions of private-use limitations affecting the choice of financing options and control issues under leased facilities, including examples of customary ground lease terms and conditions, go to frauenshuh.com/wp-content/uploads/2013/05/Private-Use-Limitations.pdf and frauenshuh.com/wp-content/uploads/2013/05/Control-Issues-Under-Leased-Facilities.pdf.
In general, the current environment supports an expanded view of “cost of capital.”

reform-driven economic and policy pressures on healthcare providers that will likely make it increasingly important for them to execute strategy within compressed timeframes while preserving balance sheet capacity and balance sheet liquidity.

A Historical Perspective

In the past, the facility assets of most not-for-profit, community-based health systems were devoted predominantly to inpatient services delivered on a single campus. Whatever outpatient services a health system delivered typically constituted only a small proportion of the overall facility assets and clinical services.

Under these circumstances, facility assets were viewed as investments with longer-term useful lives, often extending beyond a typical financing cycle of 30 years. Consequently, the question of “cost of capital” was relatively straightforward, especially given the availability of preferential cost-of-capital treatments with tax-exempt debt, including preferential interest rates, 30-year amortization, and minimal negative effects on days cash on hand. Health systems tended to regard private capital as being “too expensive” when weighed against the benefits of tax-exempt debt. And a health system was particularly prone to hold this view if it owned, controlled, and occupied virtually all of the facility assets financed.

Private, third-party capital began to emerge as a viable financing option when community health systems began to diversify clinical services and move “off campus” with medical office buildings and related outpatient facilities strategies. The viability of this option was reinforced when the Financial Accounting Standards Board (FASB) and the International Accounting Standards Board (IASB) jointly issued accounting rules permitting favorable balance sheet treatment of such arrangements, such as off-balance-sheet treatment of third-party ownership and leases for a community health system. With off-balance-sheet treatments, community health systems’ income statements and balance sheets were relieved of related encumbrances. Most credit agencies, however, have viewed such arrangements as being “on credit” regardless of how prevailing accounting rules and conventions treated related lease arrangements.

Nonetheless, the proposed changes in accounting rules, if implemented as expected, will cause third-party-financed facility lease arrangements to be treated in a manner that minimizes income statement differences as compared with tax-exempt-debt-financed ownership models. Balance-sheet treatment will favor third-party lease arrangements, and aggregate differences in cash flow performance (favoring the ownership model) should be weighed against the strategic flexibilities provided by the third-party lease option.

In general, the current environment—with its uncertainties resulting from policy reforms, provider consolidations (especially physician integrations), volatile payment methods, and seen and yet-unforeseen niche players in the markets ahead—supports an expanded view of “cost of capital.” To gain insight into the relative merits of alternative capital financing in this environment, it is helpful to consider a comparison, under the proposed changes in accounting rules, of an alternative capital financing option with a tax-exempt debt option. A hypothetical case of an ambulatory care center is used because it represents a strategic priority for many community health systems.


Case Example: An Ambulatory Care Strategy

For our hypothetical case study, let’s assume that the ambulatory care facility in question is one of three large, clinically sophisticated ambulatory care centers that a large, not-for-profit health system—let’s call it Community Health System (CHS)—is contemplating developing in three distinct strategic, geographic regions as part of a 10-year strategy.

For most health systems, such a strategy does not exist in isolation. Rather, it will be part of the organization’s broader strategy aimed at securing its future in the emerging world of healthcare reform and should be understood in that context. Let’s also assume, therefore, that in addition to the ambulatory care facilities, CHS has the following plans to meet its strategic investment needs over the next five years:

- Recruiting and/or acquiring, and then integrating, up to 100 physicians as employees across a number of clinical specialties
- Acquiring and installing of an electronic health record (EHR) estimated at $90 million (not including anticipated downturns in productivity resulting from installation)
- Investing $95 million or more in upgrades of inpatient facilities
- Entering into various third-party contracting arrangements that will require CHS to assume financial risk for defined populations (with no clear idea of the total costs of related financial exposure)

For purposes of comparing financing approaches, however, focusing on a large-scale, clinically complex ambulatory facility is appropriate because developing such facilities often is the centerpiece of a community-based health system’s broad strategic plan, especially in tandem with pursuing complex physician alignment strategies (see the sidebar on page 4).

For the first ambulatory care facility, CHS expects to integrate employed and independent physicians, as well as other potential private lessee and joint venture partners including:

- A health system-owned primary care/urgent care clinic
- A joint-ventured ambulatory surgery center (ASC)
- Time-shared specialty clinic space
- A health-system owned comprehensive imaging diagnostic center, with a private radiology group on-site operating under an exclusive contract to read and interpret images
- A third-party owned and managed combination fitness and rehabilitation facility
- Community-use space available for rental and special functions, including dining facilities
- A therapeutic massage, complementary medicine, and chiropractic center, provided through a partnership between a third party and the health system

A Comparison of Financing Options

This case example involving CHS was developed comparing the costs of a tax-exempt financing with a model employed by a national third-party developer of healthcare facilities. The analysis assumes and incorporates adoption of the previously cited international accounting rules relating to income statement and balance sheet treatment of tax-exempt bonding versus alternative capital applications, including developer-owned and -financed facilities occupied by health systems under qualified lease arrangements.

For CHS’s leaders, the primary concern is to decide whether to bond and own the facility using tax-exempt debt or to finance the facility using alternative capital provided by a third-party developer through a lease arrangement. Therefore, assuming there are no regulatory restrictions on tax-exempt financing implicated by specific features of the strategic plan, the

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c. We have opted to use the “right of use” accounting standard, as described for lessees in International Accounting Standard (IAS) 17: Leases. IAS 17 is currently under study by the FASB and IASB, with their previously cited exposure draft, which was circulated for comment in fall 2010. As of press time for this article, the decision to adopt IAS 17, as currently written, had not yet been finalized. In their May 2012 meeting, the IASB and FASB reversed their position to use two approaches for lessees accounting and are currently recommending the “right of use” approach for lessees. This approach is referenced in this article because it aligns most closely with the credit agencies’ approach to addressing the credit impact of leases on credit ratings.
Ambulatory Care Facilities and Services Strategy

Integrated delivery systems (IDSs) that have organizational maturity tend to focus strongly on ambulatory care. It is conceivable that an IDS can earn upward of 60 percent of operating revenues in the outpatient services arenas and allocate 60 percent of facility assets to ambulatory facilities.

When large ambulatory facilities are principal components of the strategic plans of not-for-profit health systems, these plans tend to share common objectives and characteristics:
> Multiple facilities are developed to stake out key geographic locations.
> Facilities often are multispecialty in design, incorporating complementary clinical services to facilitate referral and care of patients within the facility.
> Ancillary diagnostic and therapeutic services are developed to high levels for the sake of patient convenience and site revenue and margin productivity (e.g., imaging diagnostics, outpatient surgery, and laboratory diagnostics).
> Primary care and urgent care are often provided to draw patients to the site.
> Employed and independent physicians often are integrated into the facility, providing a “seamless” clinical experience.
> In many cases, highly sophisticated retail services are provided with the ambulatory centers, including pharmacies, fitness centers, therapeutic spas, personal training centers, dining facilities, and community education programs.
> All services exist together under the health system’s brand.

Health systems that have pursued “ambulatory destination strategies” to their highest levels have, as a central goal, positioned the ambulatory facilities as “community magnets” — a place to receive more than just care of illness.

Basic Ambulatory Center Developmental Costs
Almost without exception, larger-scale, sophisticated ambulatory centers are operated for their strategic and financial returns value. They are often designed to attract and retain strategic geographic and clinical populations while operating at a profit.

Sizing typically runs in a range of from 50,000 to 300,000 square feet. As an example, a health system whose strategic plan is to build a “class A” ambulatory care facility might develop and fund a 250,000-square-foot ambulatory care center using third-party capital and structure the facility under a long land lease with 10-year space leases. Assuming the health system is pursuing a mixed-use strategy that involves both employed and independent physicians as well as third-party lessees and joint-venture partners, such a facility will likely encompass diverse programs, including ambulatory surgery, imaging, urgent care, oncology, rehabilitation, and occupational health. Physician services might include cardiology, antenatal, obstetric/gynecology, pediatric urology, otolaryngology, pediatrics, endocrinology, primary care, sleep lab, and wound care. Such a facility also might include a medical spa, a fitness center, and a health food café.

Total development costs for such “class A” facilities, in general, range from $325 to $360 per square foot. Full clinical “floor planning”—comprising all furniture, fixtures, and equipment (FF&E)—can run an additional $125 per square foot (including application of the electronic health record, for a consolidated cost of upwards of $450 per square foot for the more clinically and strategically sophisticated centers.

Related Physician Strategies
As is implied in the example of a “class A” ambulatory facility described in the preceding paragraphs, community health systems often pursue ambulatory strategies not only to increase market share, but also to “integrate” employed and independent physicians within a common facility to present a unified clinical “brand” and programming. Such facilities have been used successfully for “markets in transition”—that is, markets where a health system needs to accommodate independent physicians (and other providers) as partners while building an employed group.

When this mixed-use model is employed, facility financing options are implicated. In many instances, the sponsoring health system will need to accommodate physicians under one roof as employees, joint venture partners, independent lessors of clinical space, and “visiting” specialists. Accordingly, related tax code and regulation addressing “permitted use” governs (or at least affects) facility financing options, which means use of tax-exempt funding to finance the facility may not be permitted and the health system may be required to use cash or alternative capital to finance the underlying facility asset. (For a discussion of such private-use limitations, go to frauenshuh.com/wp-content/uploads/2013/05/Private-Use-Limitations.pdf.)

On a related note, some not-for-profit health systems permit ownership in strategic ambulatory sites by employed and independent physicians. Such ownership opportunities are not permitted with health system ownership and tax-exempt facility financing.
initial question CHS’s leaders should consider is, Which form of capital is more advantageous, with due consideration paid to an in-depth examination of all related “costs”?

Two additional questions follow from this initial question: What are the total costs associated with the financing of a large-scale ambulatory care facility? And, given healthcare market dynamics and potential accounting rule changes ahead, is a broader perspective on evaluating “total cost” required?

CHS’s initial ambulatory care facility is expected to be 140,000 square feet in size with total costs of construction estimated at $50 million, not including required clinical and information technologies, furniture, and other equipment, which are estimated to be an additional $17.5 million.

Additional assumptions related to this project are as follows:

> Under a third-party ownership model, a 10-year, renewable lease is assumed at a total, aggregate lease cost of $41.06 million.

Community health systems also may find it preferable to transfer long-term facility risk to a qualified third party, thereby ensuring future strategic and financial flexibilities.

> Under both financing options, the health system owns the land for the facility.
> Under the lease arrangement, land is conveyed to the developer by way of a “ground lease” (For examples of customary ground lease terms and conditions, go to frauenshuh.com/wp-content/uploads/2013/05/Control-Issues-Under-Leased-Facilities.pdf.)

For purposes of comparison, underlying case assumptions set the tax-exempt interest rate at 5 percent over a 30-year term. (Costs related to debt issuance are considered in the debt amortization model.) Expected return rates to the

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**PRIMARY SIZE AND DEVELOPMENT COST ASSUMPTIONS FOR A HYPOTHETICAL AMBULATORY CARE FACILITY**

**Key Assumptions**

> The land for the facility is owned by the fictitious Community Health System.
> The arrangement involves an operating lease.
> The facility is fully leased.

**Building Information**

<table>
<thead>
<tr>
<th>Building Information</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rentable square footage</td>
<td>140,000 sq ft</td>
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<tr>
<td>Hospital square footage</td>
<td>140,000 sq ft</td>
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<tr>
<td>Term of lease</td>
<td>10 years</td>
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<td>Annual rent inflationary factor</td>
<td>2% per year</td>
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<tr>
<td>Development cost per rentable square foot</td>
<td>$357</td>
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<tr>
<td>Total project cost*</td>
<td>$50 million</td>
</tr>
<tr>
<td>Aggregate NNN lease payments (not including operating expenses)†</td>
<td>$41,061,454</td>
</tr>
<tr>
<td>Present value of lease payments at 5 percent‡</td>
<td>$31,455,396</td>
</tr>
</tbody>
</table>

* The figure for total project cost represents cost associated with a complex, clinically sophisticated ambulatory care center. Programs within this center include surgery, radiation oncology, imaging, rehabilitation, primary, and specialty services. It does not include embedded technologies and furniture, fixtures, and equipment (estimated at 35 percent of building cost).
† With an NNN, or “triple-net” lease, the tenant is responsible for three major expenses associated with commercial real estate ownership: property tax, insurance, and maintenance.
‡ Five percent represents the hospital’s assumed cost of capital.
developer/owner are set at 7.5 percent, in accordance with industry standards (e.g., CBRE, the international corporate real estate services company, in its Fourth Quarter 2010 National Medical Office Update, supported a national benchmark for a 7.5 percent return on capital for third-party owners).

Summary Case Analysis
The exhibit above depicts how a third-party lease arrangement, over an assumed 10-year term, converts to health system accounting practices under the proposed rule changes. With such a lease, payments made to the developer are scheduled for the proposed 10-year term. The accounting treatment causes the health system to recognize an imputed, fixed, annual amortization charge reflective of the “right to use” balance sheet treatment under the rules and an annual, imputed interest expense charge based upon the health system’s assumed incremental borrowing rate (assumed to be 5 percent for the case example).

An analysis of the income statement effect of an expected 10-year lease model compared with that of a 10-year period of ownership by CHS discloses a $1 million total advantage over 10 years with the tax-exempt financing option, (see the exhibit on page 7).

The exhibit on page 8 shows that cash flows favor the tax-exempt financing option by $8.5 million (net present value of $6.3 million). Balance sheet treatment favors the alternative capital lease model by preserving $18.5 million in balance sheet capacity, given that with application of expected accounting rule changes, there is recognition of a $31.5 million “right to use” asset with a corresponding equivalent liability booked for the third-party-owned option, whereas with the tax-exempt bonding option,
a $50 million asset is booked against a corresponding $50 million liability.

Conclusions and Discussion

Before discussing the financial analysis implications of CHS’s case, it is useful to revisit the “permitted use” issue. For the CHS example, it is unlikely that a tax-exempt financing option is available for comparison, in that the strategic plan for the ambulatory care facility contemplated eliminates tax-exempt financing as an option under the “permitted use” analysis. Given that larger, clinically sophisticated ambulatory care facilities often house “mixed strategies,” including independent physicians and other for-profit partners, a comparison of tax-exempt and alternative capital financing options is, in fact, often irrelevant.

Returning to the financial comparisons in the CHS example, over the 10-year comparison period, income statement effect differences between the two financing approaches could be seen as negligible, and the leasing option provides for greater balance sheet capacity. So from a purely financial (cost of capital) perspective, the decision whether to bond or lease rests with the analysis of cash flows, which is $6.3 million (NPV) favorable to the tax-exempt bonding option.

In the final analysis, providing that both financing options are truly available, health system leaders should focus their discussion more on strategic scenarios and financial and strategic risk management, and less on traditional methods of evaluating costs of capital in a lease-versus-own decision for a strategic facility asset. Three questions are relevant to consider:

> Is it prudent to retain tax-exempt debt capacity for “core assets” on-campus (e.g., inpatient facilities with the potential for an extended useful life)?
> How likely is it that one or several locations will exhibit continuing useful strategic value after 10 years have passed?d

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d. It is useful to note here that negotiations for a ground lease often will explore a variety of end-of-lease terms, including rights to exit the facility at the end of the initial lease period, to remain a tenant for a successive lease term, and to purchase the facility from the owner at a predetermined price (a take-out provision).

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**INCOME STATEMENT EFFECT OVER 10 YEARS**

<table>
<thead>
<tr>
<th></th>
<th>Health-System-Owned Model</th>
<th>Third-Party-Owned Model</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Depreciation</td>
<td>Interest Expense</td>
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<tr>
<td>Year 1</td>
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<td>$1.7</td>
<td>$2.5</td>
</tr>
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<tr>
<td>Year 4</td>
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</tr>
<tr>
<td>Year 5</td>
<td>$1.7</td>
<td>$2.3</td>
</tr>
<tr>
<td>Year 6</td>
<td>$1.7</td>
<td>$2.3</td>
</tr>
<tr>
<td>Year 7</td>
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<td>$2.2</td>
</tr>
<tr>
<td>Year 8</td>
<td>$1.7</td>
<td>$2.2</td>
</tr>
<tr>
<td>Year 9</td>
<td>$1.7</td>
<td>$2.1</td>
</tr>
<tr>
<td>Year 10</td>
<td>$1.7</td>
<td>$2.1</td>
</tr>
</tbody>
</table>

Total = $40.0

* Dollars in millions.

Note: Interest expense for the health-system-owned model assumes annual bond payments at 5 percent. Interest expense for the third-party-owned model applies the proposed changes and assumes a 5 percent annual interest payment on the unamortized balance of the net present value of the 10-year lease payments. Also, the conveyance of ground lease payments from the third-party developer to the hospital has no effect on the income statement, because this payment is made part of the operating expenses, which are 100 percent passed through to the health system under a NNN lease.
> What future strategies might be pursued in the facility, including the various partnership methods and models?

In short, despite the advantages of tax-exempt bonding, there are many reasons why alternative financing might be appealing to community health systems with strong balance sheets, including ample liquidity. Such health systems may opt to use alternative capital not only for the reasons cited in this article, but also because they are averse to being in the position of owner and landlord of a facility that will be occupied by private physicians and other partners. Community health systems also may find it preferable to transfer long-term facility risk to a qualified third party, thereby ensuring future strategic and financial flexibilities and mitigating financial and moral hazard risk.

The key point for health system leaders and financial strategists when deciding on the best course for strategic facilities financings is to examine the full scope of any related cost analysis, keeping in mind the analytical and judgment considerations presented in this article.

<table>
<thead>
<tr>
<th>Year</th>
<th>Health-System-Owned Model</th>
<th>Third-Party-Owned Model</th>
<th>Difference</th>
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<tbody>
<tr>
<td></td>
<td>Annual Debt Service</td>
<td>Annual Lease Payment</td>
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<tr>
<td>Year 1</td>
<td>$3.3</td>
<td>$3.8</td>
<td>$0.5</td>
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<td>Year 2</td>
<td>$3.3</td>
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<tr>
<td>Total</td>
<td>$33.0</td>
<td>$41.1</td>
<td>$8.5</td>
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Net Present Value
- Health-System-Owned Model: $25.1
- Third-Party-Owned Model: $31.5
- Difference: $6.3

*Dollars in millions; differences are inexact due to rounding.

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