

**Current Financing Issues in Today's Market:
What is Balance Sheet Management and Why is it Important?**

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Stability, But for How Long? Over the past two years, healthcare credits have achieved some degree of stability after several years of upheaval and instability. But one question persists: How long will it last? The attitude of the major credit rating agencies is summarized in a recent headline from the January 3, 2003 edition of *The Bond Buyer*: “Raters: Health Care Looks Good for 2003, But Dark Clouds Loom”.

Rating agency concerns center around Medicare and Medicaid reimbursement rate pressures, a possible push back from employers over increasing managed care premiums, and mounting pressure from higher wage rates for scarce nursing and other professional talent, pension and malpractice insurance costs, and a continuing bear market in equities that has robbed many hospitals of much needed investment income and reserves.

In the face of these concerns, an aging population and demographic growth have increased utilization and the demand for capital expenditures by health care entities continues to rise.

Access to Capital: Ratings are Critical. Not-for-profit hospitals and healthcare systems still rely on tax-exempt bonds as the primary source of external capital to finance the growing need for services, updated facilities and new technology. In order to access the credit markets, an appropriate credit rating is critical. Proper *balance sheet management* is one of the key factors in obtaining and maintaining a good credit rating. Good balance sheet management reflects positively on management when the rating agencies and potential bond investors review the creditworthiness of a health care entity.

As healthcare executives, we focus most often on operational management issues. From a financial perspective, this results in concentrating on the income statement. The most frequently asked question each month is “How did we do compared to the budget?” Many times the balance sheet receives little attention from top management – until something goes wrong, often with a cash flow crisis resulting from revenue cycle/accounts receivable problems!

So, What is Balance Sheet Management? Balance sheet management is achieving the proper balance of *liquidity*, *capital investment*, *debt* and *equity* that is appropriate for the specific entity. Sounds simple, doesn't it? But there are many moving parts to be managed.

Managing liquidity obviously involves managing cash and investments – good banking and custodial processes, proper asset allocation and investment policies, and good investment management.

But as important as cash and investment management is, revenue cycle management is even more important. Almost every hospital in the United States has faced some type of major accounts receivable or revenue cycle problem within the last few years. Many problems that show up as accounts receivable problems result from broken processes on the front end of the revenue cycle – inadequate data obtained from the patient, failure to obtain pre-certification, inadequate coding documentation, and the list goes on . . .

Successful hospitals have learned to devote adequate resources to managing the *entire* revenue cycle process. They think of it as “keeping the fish you already have in the boat!”, i.e., billing and promptly collecting correct amounts for services the hospital is entitled to be paid for goes a long way toward avoiding cash flow problems.

Volumes have been written on the topic of *managing capital investment*. The critical need is for *discipline* in the capital investment process. That discipline begins with a long-range strategic financial plan that is an integral part of the organization's strategic plan. Many hospitals develop nice sounding strategic plans that are embodied in illustrious PowerPoint[®] presentations but are never achieved because the key strategies are not grounded in financial reality. Developing a long-range financial forecast and plan that is articulated with the strategic plan helps ensure that key strategies will work in the real financial world. Using the long-range financial plan to then drive the annual operating and capital budgets helps ensure that the strategic plan is embedded in the day-to-day operations of the entity.

Discipline in managing capital investment also involves a process with real “teeth” to analyze and approve specific capital expenditures that fit the strategic and long-range financial plans, and saying NO to those that don't. Again, it sounds simple, but it is anything but simple in the real world of competing priorities and politics of most healthcare institutions.

And, finally, discipline in managing the capital investment process includes after-the-fact follow up of major capital projects to see if they did, in fact, meet the projections and plans upon which approval was based. This builds accountability into the process, and helps the organization learn from mistakes and improve its capital investment process.

Managing debt and equity really involves achieving the right balance of debt and equity, as well as determining the right debt structure for the organization. Not-for-profit healthcare organizations obtain their equity capital from two primary sources: operations

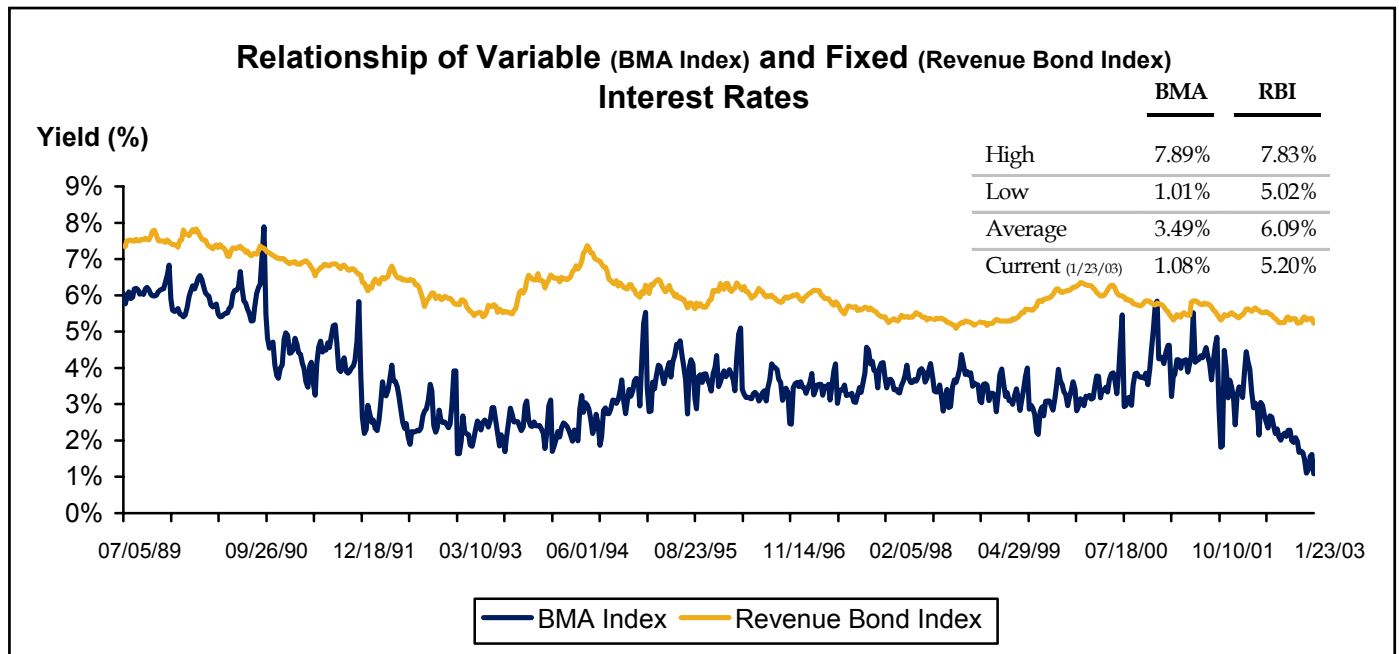
(i.e., operating cash flow) and philanthropy, with operations supplying the bulk of the equity capital for most non-profits. That is why operating profitability measures such as operating margin, operating cash flow margin, debt service coverage, and the ratio of debt-to-cash flow are among the important financial measures evaluated by the rating agencies.

Managing debt involves achieving the optimal balance of liquidity, debt and leverage (debt to equity relationship). That is why the rating agencies place so much importance on measures such as days cash on hand, the ratio of cash-to-debt, and the ratio of debt-to-total capitalization.

Managing debt also involves analyzing and managing financial assets of the entity in relation to the types of debt used, which leads to decisions about capital structure allocation and the appropriate mix of fixed-versus-variable rate debt.

How Much Variable Rate Debt is Enough? Long-term fixed interest rates are near historic lows, but variable rates are even lower and many hospitals are increasing the use of variable rate debt in their financing arsenals. Another headline from *The Bond Buyer*, on November 21, 2002, gave an ample description: “Hospitals Like Variable Rate, Despite Low Long-Term Interest”.

The affinity for variable interest rate debt is understandable because variable rates have consistently outperformed fixed rates over time. The historical spread between variable and fixed rates is illustrated in the following table.



Over the past thirteen-plus years since the inception of the BMA Index (an indicator of variable interest rates), floating rates have averaged about 250 basis points (2.5 percentage points) lower than fixed rates as indicated by the Revenue Bond Index – which can translate to millions of dollars of interest savings for most health care institutions.

Generally, over the last few years the proportion of variable rate debt has increased for higher rated-credits, while it has decreased for lower-rated credits. According to a report by Fitch Ratings at *The Bond Buyer* Health Care Finance Conference held last November, “AA” rated hospitals increased their variable rate debt from 24% of total debt in 1994 to 31% in 1999. During that same period, “BBB” rated hospitals decreased their variable-to-fixed rate debt ratio from 34% to 18%. This reflects the greater ability of stronger credits to withstand the higher risks associated with variable rate debt. These risks include interest rate, credit and liquidity risk. Strong ratings or credit enhancement are required for variable rate market access.

In addition, a variety of new variable rate structures including auction rate securities, other non “puttable” structures, and interest rate swaps are becoming more prevalent forms of variable rate debt. These types of transactions require greater education of management and the board to ensure proper fiduciary understanding of these more complicated structures.

As a rule of thumb, the rating agencies consider “unhedged” variable rate debt in the range of 20% to 30% of total debt to be acceptable. However, the amount of variable rate debt must be considered in relation to short-term investments on the asset side of the balance sheet, which provide a natural “hedge” against rising interest costs on variable rate debt. As variable rates rise, the organization’s cost of capital will rise due to the variable rate debt but investment income will also rise due to its short-term fixed income investment portfolio.

For example, an analysis of the balance sheet of Hometown Hospital shows the following financial assets and liabilities:

**Hometown Hospital
Analysis of Balance Sheet**

| Financial Assets: | \$ Millions | Liabilities: | \$ Millions |
|--------------------------|--------------------|-----------------------|--------------------|
| Short-term fixed income | \$25 | Variable rate debt | \$20 |
| Long-term fixed income | 20 | Fixed rate debt | 80 |
| Equities | 30 | | |
| Total investments | \$75 | Total debt | \$100 |
| | | Percent variable rate | 20% |
| | | Percent fixed rate | 80% |

Based on this analysis, 20% of Hometown Hospital’s debt is variable rate – well within the rating agencies’ acceptable range of 20% - 30%. But, the hospital’s short-term fixed income investments (defined as securities with a maturity of less than three years) total \$25 million. Assuming the hospital reasonably expects to maintain that level of short-term investments, they can be considered as a partial hedge against its variable rate debt. Thus, the hospital could restructure its debt to have approximately 45% - 50% variable rate debt, calculated as follows:

**Hometown Hospital
Analysis of Restructured Debt**

| Liabilities: | \$ Millions |
|--------------------------------------------------|--------------------|
| Variable rate debt | \$45 |
| Fixed rate debt | 55 |
| | ----- |
| Total debt | \$100 |
| Calculation of un-hedged variable rate exposure: | |
| Variable rate debt | \$45 |
| Less, Short-term fixed rate investments | -25 |
| | ----- |
| Un-hedged variable rate exposure | \$20 |
| % of total debt | 20% |

So after restructuring its debt, Hometown Hospital has an un-hedged exposure to variable rate risk of 20% of its total debt – again well within rating agency norms. And the interest savings on \$25 million of variable rate vs. fixed rate debt would be significant - \$2.5 million in the first year assuming the savings averaged 1% below what the hospital would have paid for fixed rate debt.

We have used a simple analysis in our example to demonstrate the concepts of “hedged” and “unhedged” variable rate exposure. In today’s market, a variety of analytical tools are employed to carefully review both the asset and liability side of the balance sheet for asset allocation targets and risk tolerance using an approach known as comprehensive asset liability management. This approach allows health care systems to evaluate fixed and variable rate exposure in the context of an efficient frontier, and to develop a capital structure that meets their overall objectives.

Conclusion. Maintaining a credit rating is critical to ensure access to capital. Good balance sheet management is not only important to maintaining a credit rating, it can also ensure good cash flow and save significant interest costs. Health care executives must focus not only on managing operations and the income statement, but equally on managing both sides of the balance sheet if their institutions are to survive and thrive in the challenging environment facing healthcare institutions today.