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## IDENTIFICATION AND EVALUATION OF FINANCING OPTIONS

COULEE COMMUNITY HOSPITAL  
GRAND COULEE, WASHINGTON

CASCADE MEDICAL CENTER  
LEAVENWORTH, WASHINGTON

NORTH VALLEY HOSPITAL  
TONASKET, WASHINGTON

March, 2003

**TABLE OF CONENTS**

<b><u>Section:</u></b>	<b><u>Page:</u></b>
<b>1. Executive Summary .....</b>	<b>3</b>
<b>2. Description of Study .....</b>	<b>10</b>
<b>3. Financial Position.....</b>	<b>14</b>
<b>4. District Financing Options .....</b>	<b>20</b>
<b>5. Summary of HUD Program Requirements .....</b>	<b>23</b>
<b>6. Organizational Structure/Legal Issues .....</b>	<b>26</b>
<b>7. Idaho Health Facilities Authority/Shoshone Medical Center .....</b>	<b>28</b>
<b>8. Washington Health Care Facilities Authority.....</b>	<b>29</b>
<b>9. Search for Other Financing Structures .....</b>	<b>30</b>
<b>10. Conclusions and Recommendation (“The 1-2-3-4 Solution”).....</b>	<b>35</b>

**Appendices**

- Appendix A - Initial District Questions**
- Appendix B - Coulee Community Hospital Financial Information**
- Appendix C - Cascade Medical Center Financial Information**
- Appendix D - North Valley Hospital Financial Information**
- Appendix E - HUD Financing Requirements, Handbook 4615.1**
- Appendix F - HUD Exceptions for CAH**
- Appendix G - USDA Direct Loans, Guarantees, and Grant Options**
- Appendix H - Analysis of “Cross Over Point”**
- Appendix I - Daily Journal of Commerce Article Re: Rural Hospitals/DOH  
Information Re: Financial Vulnerability Index**
- Appendix J - WA-CERT Information**
- Appendix K - Corrections to AWPFD “Guide to Capital Funding Options”**
- Appendix L - District Population and Income Information**
- Appendix M - Seattle Times Article Re: “Financial Picture ....”**

## Section 1

### EXECUTIVE SUMMARY

The purpose of this report is to document findings, conclusions, and recommendations related to possible capital financing options to support the replacement of existing hospital facilities for Coulee Community Hospital (which operates as part of Douglas, Grant, Lincoln, Okanogan Counties Public Hospital District #6), Cascade Medical Center (which operates as part of Chelan County Public Hospital District No. 1), and North Valley Hospital (which operates as part of Okanogan County Public Hospital District No. 4), all as referred to herein as the “Hospital(s)” or the “District(s).” The opportunity of total replacement of existing Hospital facilities is determined to be a major goal to meet future community healthcare needs for each District.

#### **1. Coulee Community Hospital**

The need to replace the existing 30+ year-old facility was documented in a comprehensive study that was concluded in September 2001 by Health Facilities Planning and Development, and Pacific Design Group P.S. Based upon discussions with District Administration, the estimated cost of such a replacement construction project is assumed to be \$10 million, without any additional related direct or indirect financing costs. For evaluation purposes, the assumed financing is about \$13.1 million through the Housing and Urban Development (“HUD”) program (also known as the FHA-242 program). This amount includes capitalized interest, debt service reserve fund, and all other costs of issuance.

#### **Findings and Conclusions**

Based upon 2002 debt limits with an estimated assessed valuation of about \$170 million, the District’s remaining non-voted debt capacity is about \$0.5 million and remaining total combined voted and non-voted debt capacity is about \$2.8 million. The District does not have sufficient legal debt capacity to undertake any meaningful form of tax supported general obligation borrowing, including either Unlimited Tax General Obligation (“UTGO”) bonds or Limited Tax General Obligation (“LTGO”) bonds to fully fund a replacement project. The possible use of HUD financing, as a single funding source for about \$13.1 million, is viewed as too large and too risky to undertake at this time. Further evaluation of other financing options is discussed herein.

#### **Recommendation**

Since neither general obligation nor revenue obligation capacity exists to serve as a sole source of funding for a total replacement project, the District needs to evaluate the various combinations described herein as the “1-2-3-4 Solution” to find possible components that may collectively generate sufficient funding and/or rethink smaller incremental projects that do not require total replacement.

## **2. Cascade Medical Center**

The District has been reviewing specific replacement options with architects for the existing 40+ year-old hospital and rural clinic facility. The possible replacement projects are each slightly under \$9.0 million, so the assumed financing for evaluation purposes is \$8.0 million of LTGO bonds, together with about \$1 million of equity contribution.

### **Findings and Conclusions**

Based upon 2003 debt limits with an estimated assessed valuation of about \$959.1 million, the District's remaining non-voted debt capacity is about \$6.0 million and remaining total voted and non-voted debt capacity is about \$22.8 million. While the District has statutory non-voted general obligation debt capacity to issue \$6 million of LTGO bonds, the remaining unencumbered portion of annual regular property taxes is only sufficient to support debt service on about \$3 million of LTGO bonds. In other words, while the statutory aggregate debt limitations cover the maximum legal amounts of general obligation indebtedness that may be issued, there are "practical" limitations that are imposed by the capital markets or lenders, which may reduce the amount of LTGO debt to be issued by the ability of the district to generate sufficient unencumbered regular property taxes to pay the annual debt service payments. However, there is sufficient voted capacity to cover the entire project with a voter approved UTGO bond issue with an estimated annual average tax levy of about \$0.70 per thousand (subject to further detail analysis and related assumptions). The District could also ask voters to increase the current regular tax levy from about \$0.38 per thousand to \$0.50 per thousand, which would increase the overall LTGO potential borrowing to about \$4.4 million. Further evaluation of other financing options is discussed herein.

### **Recommendation**

Since voter approved UTGO financing is the only single source of available funding, the District should either focus upon this preferred option, or seek a combination of options as described herein as the "1-2-3-4 Solution." While the tax levy impact of a voter approved UTGO bond issue is clearly within the range of favorable efforts by other Public Hospital Districts in Washington, the entire process would require very careful planning with the District's Commissioners to assure that this option was clearly understood. The combination approach of various funding sources should also be evaluated further.

## **3. North Valley Hospital**

The District has identified numerous problems with its current 40+ year-old hospital facility and wants to evaluate general financing options to fund a total replacement project for \$12 million, including \$2 million of equipment. For evaluation purposes, the assumed financing is \$15.2 million through the HUD program.

### **Findings and Conclusions**

Based upon 2002 debt limits with an estimated assessed valuation of about \$530.0 million, the District's remaining non-voted debt capacity is about \$0.9 million and remaining total combined voted and non-voted debt capacity is about \$10.2 million. The District does have sufficient legal debt capacity to seek a meaningful amount (probably

up to about \$6 million maximum, but not enough to fully fund a total replacement project) of tax supported UTGO general obligation borrowing. Remaining LTGO bond capacity is inadequate to provide any meaningful funding. The possible use of HUD financing, as a single funding source for about \$15.2 million, is viewed as too large and too risky to undertake at this time. Further evaluation of other financing options is discussed herein.

### **Recommendation**

While general economic conditions are clearly not favorable within the District's boundaries, the reality of taxpayer support for partial funding of a replacement project is currently the only reasonable option to generate any meaningful portion of the required funding. Under any combination of funding sources, the District needs to reconsider the project size to explore ways of reducing the overall project budget. While the original \$12 million project cost included \$2 million for new equipment, the entire project amount needs to be re-evaluated.

### **4. Annexation**

Annexing neighboring territory beyond existing District boundaries has also been evaluated with each District, however, it is extremely unlikely that such efforts would produce any material expansion to the above general obligation debt capacity.

### **5. Revenue Bond Options**

Based upon the size, location, and demographics and any other, and many other factors, the opportunity for most Public Hospital Districts to issue direct revenue bond obligations in an amount sufficient to cover a \$9 million to \$12 million construction project is unavailable, without some form of credit enhancement to improve the credit quality of the revenue supported borrowing obligation or a direct funding arrangement. This study evaluates the possible use of either the HUD program or the United States Department of Agriculture's Rural Development ("USDA-RD") as the only realistic sources of credit enhancement or direct funding. Other more typical credit enhancement structures, such as municipal bond insurance companies, bank letters of credit, or other related devices, are simply not available to rural or other hospitals under 100 beds. Even if a hospital is large enough to capture the interest of possible credit enhancement sponsors, the related costs and covenants are extremely marginal, if not totally prohibitive from a business viewpoint. For hospitals over the 100-bed size threshold, a hospital would also need to demonstrate investment grade (or near investment grade) bond rating characteristics that are clearly not available for 25 bed rural facilities.

Therefore, the best apparent financing approach would be to develop multiple sources from a variety of funding methods, including the use of some District equity funds, possibly some or all tax-supported general obligation remaining capacity, some joint venture, partnership, or grant funding, and the remaining balance to be supported by HUD or the USDA-RD (collectively, "The 1-2-3-4 Solution"). Table 1 illustrates the general process that leads to this conclusion.

## **Project Summary**

The purpose of this study is to evaluate a wide variety of factors and form conclusions related to the following initial questions:

Does the District have the resources to finance the total replacement of their current hospital facilities with the estimated project cost of \$9.0 to \$12.0 million in any possible financing structure? If so, what are the primary risks and does it make sense for the District to undertake such a project? What steps should the District follow to accomplish the replacement project?

Accordingly, Table 1 represents a summary of the primary questions and conclusions:

**Table 1**  
**Primary Questions and Conclusions**

QUESTIONS	CONCLUSIONS									
<p>A) Current remaining legal debt capacity (\$ in millions):</p> <p style="padding-left: 40px;">General Obligations-  Voted UTGO  Non-voted LTGO</p>	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;"><u>Coulee</u></td> <td style="text-align: center;"><u>Cascade</u></td> <td style="text-align: center;"><u>North Valley</u></td> </tr> <tr> <td style="text-align: center;">\$2.8</td> <td style="text-align: center;">\$22.8</td> <td style="text-align: center;">\$10.2</td> </tr> <tr> <td style="text-align: center;">\$0.5</td> <td style="text-align: center;">\$6.0*</td> <td style="text-align: center;">\$0.9</td> </tr> </table> <p>*Only about \$3.0 per available regular levy</p>	<u>Coulee</u>	<u>Cascade</u>	<u>North Valley</u>	\$2.8	\$22.8	\$10.2	\$0.5	\$6.0*	\$0.9
<u>Coulee</u>	<u>Cascade</u>	<u>North Valley</u>								
\$2.8	\$22.8	\$10.2								
\$0.5	\$6.0*	\$0.9								
<p>B) Current capacity for revenue obligations, without credit enhancement?</p> <p>1. What would new project do to income statement?</p> <p>2. What if the District “unbundled” the hospital?</p> <p>3. Is there an “affordable” option, without credit enhancement?</p>	<ul style="list-style-type: none"> <li>- No meaningful capacity</li> <li>- Increase depreciation and interest expense only, no new volumes, no new revenues</li> <li>- Loss of existing tax benefits without gaining any the hospital? new benefits, couldn’t transfer District assets or working capital (without total repayment)</li> <li>- NO (although, Cascade could ask voters to approve UTGO bonds with an average levy rate of \$0.70)</li> </ul>									
<p>C) How about using the HUD program?</p> <p>1. Could HUD work?</p> <p>2. Project &amp; borrowing cost increases?</p> <p>3. Total borrowing amount?</p> <p>4. Mortgage requirements?</p> <p>5. Excessive “process” and conditions?</p> <p>6. DOES HUD MAKE SENSE?</p>	<p>Yes, but none of the Districts have sufficient cash flow to support any meaningful borrowing amount</p> <p>See Appendix B, C, and D; also Section 3</p> <p>Serious doubt if any amount makes sense</p> <p>Yes, but could structure through WHCFA with lease</p> <p>Mortgage problem, initial and ongoing fees, coverage tests</p> <p>ONLY AS A LAST RESORT and capacity is a major problem</p>									
<p>D) Any other viable financing options?</p>	<p>Only USDA, RURAL DEVELOPMENT, but only for a limited borrowing amount</p>									
<p>E) Any problems or limitations with USDA?</p> <p>1. Scope limits?</p> <p>2. Grant limits?</p> <p>3. Guarantee approach?</p> <p>4. Direct loan application</p>	<p>May work for \$3 million to \$5 million</p> <p>Typically around \$30,000</p> <p>Only taxable bonds could be issued</p> <p>Would require financial feasibility</p>									
<p>F) Final conclusion: “THE 1-2-3-4 SOLUTION”</p>	<p>Combination approach</p>									

**Overall General Recommendation** Subject to further analysis of this report, each District should continue to explore the merits of general obligations (to the extent that such an option is available, in part or in total), and possibly some PARTIAL financing support from either the HUD or USDA programs within the context of “The 1-2-3-4 Solution.” A workshop should be held with each District’s Board of Commissioners to address questions and evaluate any next steps in the overall planning process.

**An Additional Editorial Comment** While clearly beyond the initial scope of evaluating financing options for a replacement facility, it became apparent that a bigger problem must be discussed, which has to do with the ability of rural hospitals to maintain a reasonable level of ongoing financial viability. The interview with Mr. Bomi Bharucha (see Appendix I, page two) clearly addresses the heart of the problem. While CAH cost reimbursement represents a “godsend” over the prior Prospective Payment System (“PPS”), “the best that you will do is break even.” As illustrated on page 14 of this report, breaking even from operations may be a false point of security or comfort when measuring the TOTAL FINANCIAL NEEDS of any hospital’s operations. During periods of evaporating cash flow support from programs like Pro-Share and RHAP, CAH won’t serve as a long-term “godsend” or cure to basic economic survival. While the pro forma calculation of debt service coverage doesn’t look too bad, the overall cash flow positions suggest that the current budget position of each of these three hospitals is grossly inadequate to meet the TOTAL FINANCIAL NEEDS of each hospital. This somewhat contradictory information is a simple function of the underlying simplistic methodology in the debt service coverage calculation, which TOTALLY IGNORES the overall cash flow requirements for working capital and capital expenditures. In other words, CAH payments may be better than PPS, but the CAH payment system doesn’t cover the full financial needs in terms of overall cash flow requirements.

To further illustrate the issue of total financial needs that are not being met; the currently growing business practice of using leases or short-term financing devices (such as those identified in the AWPHD’s “Guide to Capital Funding Options”) is a perfect “leading indicator” of the underlying problem. Assuming that a hospital needs to replace an important piece of equipment, in theory, the historical depreciation (a non-cash operating expense) on the prior equipment should have been sufficient to generate positive cash flow through operations and be invested to serve as the source of funds to purchase the new replacement equipment. In fact, for far too many hospitals, the actual cash flow from the historical depreciation was used to subsidize the otherwise unmet total cash flow requirements during prior years. Since current operations are also deficient or inadequate to generate positive excess cash flow (after meeting the total current year cash flow requirements), the hospital may be forced into leasing or other short-term borrowing arrangements to acquire the necessary replacement equipment. In practice, this business action is only a temporary solution and will simply compound the future cash flow problems, since future cash flow will be reduced even more by the amount of annual payments on the equipment lease or financing arrangement. In addition, the cumulative impact of these decisions will also seriously dilute or eliminate any meaningful revenue obligation financing capacity in the future.

To fully understand the above differences, it may be helpful to review some history of hospital reimbursement issues back in the 1970's under the Washington State Hospital Commission (the "Commission"). While not intending to endorse their existence, it is appropriate to acknowledge the commission's understanding of certain general business fundamentals within the context of basic economics for nonprofit healthcare organizations. While initially chartered to control and assure "reasonableness" within the hospital rate setting process for all hospitals, the Commission learned that major problems existed in Medicare and Medicaid "cost reimbursement" methods (which were virtually identical to the current CAH system). The Commission found that even nonprofit hospitals couldn't meet their overall financial needs (including changes in annual working capital, certain portions of annual capital expenditures, annual principal payments, and certain other special funding requirements) on either a short-term or long-term basis with a break even budget, so the Commission authorized hospitals to generate necessary "profits" within guidelines (see subsequent discussion on page 13 herein). Since Medicare and Medicaid would pay only a portion of hospital cost (after A-8 cost report adjustments, most would argue that they didn't pay their fair share of costs), the Commission allowed all other total financial needs to be met from the "all other" payer category through allowed "cross subsidization" or "cost shifting" in the rate setting process. Under Commission rules at that time, the "all other" payer category didn't enjoy any level of discounts from billed charges, which meant that hospitals had some level of "pricing power" or payment leverage to generate sufficient cash flow (or at least a meaningful step towards that goal) to actually meet their overall financial needs. Today, that pricing power has been seriously diluted, since most major third-party payers negotiate (or demand) significant discounts from billed charges. The materiality of this problem is best demonstrated within the current budget numbers and related overall cash flow on page 14 herein, which shows that total financial needs aren't being met. Since current CAH payments are not covering the true financial needs of hospitals, their ongoing financial viability (even without any replacement project) is being seriously threatened.

There was an interesting period in the late 1970's when the Commission conducted a major experiment called the Prospective Reimbursement Project. For a portion of the selected hospitals, Medicare and Medicaid actually paid either a percentage of the total hospital's financial needs (as defined by the Commission) or on a percentage of charges basis that included their share of the calculated total financial needs of the hospitals. While that experiment didn't lead to any ongoing payment reforms, it is interesting to note that the Commission's policies and procedures recognized that **break even strategies would not maintain a hospital's financial viability**. With that history in mind, along with the general conclusions from this report about the inability of CAH hospitals to fund replacement projects with revenue obligations, the combined magnitude of these issues, absent any future improvements to reimbursement methods, must be carefully examined by all parties, before undertaking any serious commitment of current capital resources. Finally, as inflation and the high price of technology continues to rise, these challenges can only grow larger because each additional year of insufficient reimbursement and cash flow shortfall is compounding the financial problems to a point where basic economic survival may be jeopardized.

## Section 2

### DESCRIPTION OF STUDY

This study was authorized and funded by grants from the Washington State Office of Community and Rural Health and the Association of Washington Public Hospital Districts to conduct a financial analysis and related planning for the possible replacement of existing hospital facilities.

**Introductions** This study has been jointly prepared by Health Facilities Planning & Development (Jody Carona, Principal), and Harden Financial Services Incorporated (Dan Harden, President), both located in Seattle, Washington. A variety of other healthcare professionals supported certain portions of work that were necessary to complete this study, including:

- Beverly Court, Office of Community and Rural Health, Olympia
- David Berk, President, Rural Health Financial Services, Anacortes
- Brad Berg, Attorney, Foster Pepper & Shefelman PLLC, Seattle
- Charles Davis, HUD Representative, Washington, D.C.
- John Van Gorkom, Exec. Director, Washington Health Care Facilities Authority, Olympia
- Neil Moss, Executive Director, Idaho Health Facilities Authority, Boise
- Louis Weisman, President, APF West LLC (American Property Financing), Seattle
- Gary Alex, President, American Capital Resources Inc, Atlanta
- District Representatives: Mike Wiltermood, CEO and Debbie Bigelow, CFO; Doug Williams, CEO and Steve Clark, CFO; and Warner Bartleson, CEO and Bomi Bharucha, CFO
- Other Parties: see Section 9 for various contacts for other financing structures

**Background and Scope of Study** Based upon planning with District and Hospital representatives, this study was conducted to explore the availability of viable financing options to complete the possible replacement of each existing Hospital facility. After a comprehensive planning process that preceded this study for Coulee Community Hospital, the Hospital representatives had concluded that the existing 30+ year physical plant should be replaced in order to ensure that Coulee Community Hospital continue to provide access to quality healthcare within the Hospital's market and service area. Shortly thereafter, North Valley and Cascade were added into the study, since they were evaluating similar situations. Since the Hospitals have all recently been granted CAH status, there was reason to believe that financing options may exist that could allow the Districts to access HUD financing. In addition, the Coulee Community Hospital representatives prepared a detail listing of certain questions that needed to be answered within the scope of the study (see Appendix A). These questions included addressing other financing issues, such as legal debt capacity for Public Hospital Districts, particulars related to the HUD and USDA-RD financing structures, etc. With those

issues in mind, the study progressed through various interviews to collect a consensus set of opinions about available capital financing options and related problems.

The Hospital's CAH designation provides some support to the reality of capital financing options, since the related Medicare and Medicaid payment systems are significantly improved from their historical prospective payment methods. Rural hospital providers may be qualified for one of four special payment classifications, including Sole Community Hospital, Medicare-Dependent Hospital, Rural Referral Center, or Critical Access Hospital. The first three designations improve the resulting payment system (under very complicated payment terms) for both Medicare and Medicaid prospective payment systems, however, the CAH designation actually is the best for eligible Hospitals, since it provides the maximum possible amount of reimbursement, based upon reasonable costs. This factor is important because of the ability of the District's to predict the expected recovery of capital related costs (including depreciation and interest expense) resulting from a replacement facility. Since Medicare and Medicaid represent about 58% of Coulee's payment base for the entire hospital, about 28% (hospital portion is about 40% with an estimated 70% Medicare/Medicaid base, excluding the rural health clinic) for Cascade, and 65% for North Valley's hospital portion, the District's can collectively assume that these payers will be responsible for paying their share of the additional depreciation and interest expense associated with the new facility. Of course, the Districts would need to break even (or better) from operations to assure that the depreciation related cash flow is not reduced or eliminated by operating losses.

Discussions with Dave Berk confirm that this assumption is reasonable for the Medicare program (subject to future unexpected actions by Congress that could reduce current payment levels for CAH's). However, there is serious concern about the ability of the Medicaid program to meet current healthcare funding challenges, including possible future payment reductions or major adjustments to Medicaid eligibility, some of which have been included in Governor Locke's recent budget proposal. While it is impossible to predict the outcome of possible future reductions, if any, each District should be aware of the possible consequences resulting from that current uncertainty, as it could significantly alter certain underlying assumptions within this study. This concern about the ability of the Medicaid program to maintain current payment levels is supported by a recent weekly Healthcare Financial Management Association newsletter report as summarized below (the full text of the report is available at website: "<http://www.nga.org/cda/files/NOV2002FISCALSURVEY.pdf>"):

Providers looking to Medicaid for improved payments in the months ahead will be disappointed. The National Governors Association and the National Association of State Budget Officers released a report December 3, 2002 that concludes that many states have exhausted options for balancing their budgets and their most difficult decisions are still ahead. Tough times are the norm, rather than the exception, according to the report, as ‘nearly every state is in fiscal crisis.’ Medicaid has had to shoulder a significant part of the blame for the state condition, with program spending growing at 13.2 percent in fiscal FY’02, the fastest rate of growth since 1992. The number of states reducing FY’02 budgets after they were passed was almost twice the number of the previous year to 37 from 19; and those 2002 reductions were more than \$12.8 billion. States’ general fund balances have dropped from \$37.8 billion in FY’01 to a projected \$14.5 billion for FY’03.

In terms of the capital markets interest in funding loans or providing credit enhancement to rural providers, there has been very little or no such interest for anything other than tax-backed transactions. With over 40 Public Hospital Districts in the State, only a very few districts have any material amounts of outstanding revenue bond obligations (Evergreen in Kirkland, Valley Medical Center in Renton, Stevens in Edmonds, Affiliated Health Services in Mt. Vernon, and Kennewick General in Kennewick). When it comes to rural locations, there may be another 30+ facilities that share the same capital financing challenges as described herein, since they too are faced with replacement of aged facilities in the future. Since many of those rural facilities need a significant replacement, the need to design a suitable financing arrangement is becoming a very serious problem within the State. Discussions with Dave Berk indicate that there must be at least 1,000 hospitals with similar problems throughout the county. Using an assumed replacement cost of \$10-15 million each, this represents a \$10-15 billion problem. Hoping for some form of federal assistance with this problem may be wishful thinking, given other current priorities and problems with the federal budget. Congress is expected to at least explore this problem in the next few months; some are hoping that Congress may approve a new program like the old Hill-Burton Act, which funded the construction of many of the same hospitals that are now facing the need to replace those aged facilities. A national “capital funding” teleconference on strategies to seek federal grant funding was conducted by the National Rural Health Association on December 11, 2002. With over 100 participants from all over the country, it is very clear that new financing options need to be created for rural replacement projects, however, there simply aren’t many viable options to balance the need and related risk (see Section 9 for further discussion of other financing options).

The only known sources of meaningful revenue bond credit enhancement or supported direct funding would currently be the HUD or USDA-RD program. This judgment is based upon over 30 years of healthcare financial experience in Washington State, and is supported by discussions with experienced senior staff from the Washington Health Care Facilities Authority, the Idaho Health Facilities Authority, various bond counsel representatives and other healthcare financial consultants, all as identified herein. The

HUD program is complex and expensive. It also requires very restrictive covenants, including a clear first mortgage on the subject property. This mortgage requirement presents a serious challenge to Washington State Public Hospital Districts because this is prohibited under current State statutes. HUD may be willing to accept a long-term leasehold interest as a substitute for the mortgage security; however, this alternative creates other problems. To solve these problems, two options were evaluated within this study: 1) restructure the Hospital's future operations to a new 501(c)(3) organization that could provide either a mortgage or long-term leasehold interest; or 2) follow the Idaho Health Facility Authority model which will serve as a conduit tax exempt bond issuer with a long-term leasehold interest in the Shoshone Medical Center's new replacement facility in Kellogg, Idaho with the proposed issuance of about \$18.6 million in HUD supported bonds.

**Restructure the Hospital** This first approach creates four major problems. If a District released its Hospital to operate under a 501(c)(3) organizational structure, 1) the new organization would have no working capital (would need at least \$1+ million) because the District couldn't transfer any assets, per Washington statutes; 2) the HUD program limits its participation to 90% of the "replacement value" of the new facility, so the new organization would also need cash to cover the 10% shortfall, plus any other non-covered financing or project cost components; 3) each District currently has outstanding UTGO and/or LTGO bonds (original proceeds used for various Hospital and District purposes) that need ongoing tax support for debt service payments; and 4) since the new organizations wouldn't be a municipal corporation like the a District, they would need to seek assistance through the Washington Health Care Facilities Authority to issue tax exempt bonds with HUD support. Based upon these problems, together with the lack of revenue obligation capacity shown on page 14, this option has been ruled out of further consideration at this time.

**Idaho Health Facility** This approach appears to be workable. However, the problems with the HUD program are almost totally avoided by the possible use of the USDA-RD approach. As further described herein, this latter option is preferred, however, there are still very material questions about the appropriateness of trying to cover all of the replacement project costs within a single financing approach. The relative risks of such an undertaking are simply too large for the USDA-RD to support, subject to a confirming financial feasibility study.

**Purpose of Identifying Options: When reading this report, it should be understood that illustrated options, sample bond sizings, and discussions about certain options, are provided to evaluate each particular option, which may or may not actually exist for any individual District, either in part or in the total amount being evaluated. It is necessary to provide such sample options to properly contrast and evaluate the general features of each option, and to further analyze the POSSIBLE use of the options.**

## Section 3

### FINANCIAL POSITION

Each District has performed favorably during the past year, partially due to the financial benefits from CAH status. Future financial performance will be subject to the Medicare/Medicaid uncertainty discussed above. The amounts of special purpose support funds from Pro-Share and RHAP have been eliminated or reduced significantly in each 2003 Budget, which is creating a negative impact from previous levels of profitability. The analysis below will help to identify and quantify the degree of materiality that additional capital related costs would produce within the context of the overall financial position for each District's or Hospital's 2003 budget.

**2003 Hospital Budget and Pro Forma Analysis** Note: this sub-section deals with the formatted financial analysis shown on page 14 for each District. To begin the analysis of financing options, the Table 2 represents the District's/Hospital's portion of the District's 2003 operating budget (excluding the clinic and skilled nursing facility for Coulee). The purpose of this evaluation is to quantify the resulting impact of new facility financing within the context of the District's/Hospital's adjusted 2003 operating budget. This methodology has been selected, since the nature of the proposed replacement project is not intended to add any meaningful new patient volumes, add any new patient services, or new or increased revenues, improve existing staffing patterns, or otherwise significantly alter the general revenue, cost, and volume relationships in the 2003 budget. For these reasons, this approach is preferred over the typical "financial feasibility" forecast which would project the next four or five years of financial performance, based upon many assumptions about the future. This method is also useful because everything is stated in 2003 dollars, and the replacement hospital is assumed to be fully operational for the entire 2003 year. **Finally, it is extremely important to focus upon the very material assumptions related to the continuation or discontinuation of existing depreciation in this type of pro forma analysis. As shown below, individual circumstances will dictate whether the existing plant will be kept in some form of operations to justify continuing reimbursement for depreciation expense.**

**Cash Flow Considerations** Overall cash flow considerations must be added into the evaluation of relative financial strength to measure the degree of ongoing financial viability. This includes other cash flow obligations such as working capital, new and replacement equipment budget requirements, principal payments, and the payment of operating subsidies to other District operations, if any (such as the Clinic and Skilled Nursing Facility for Coulee). Without the benefit of a complete financial feasibility study, the following estimated cash flow requirements have been calculated (see additional calculations in Appendix B, C, and D for each District). These cash flow equivalents are beyond the normal calculation of estimated annual debt service coverage shown below (Note: cash flow may show interest expense as both a source and use of funds, alternatively, both amounts could be omitted, without changing the resulting net cash flow). This type of pro forma cash flow analysis takes the adjusted operating

expenses (with interest expense for the new debt, new project depreciation, and adjusted revenue deductions for CAH payments) to compute the overall net income, then adds back depreciation (a non-cash expense, and ASSUMING NO “FUNDING” OF ANNUAL DEPRECIATION), and finally removes the annual capital expenditures, change in working capital for the year, and principal payments. This methodology is very consistent with the old Washington State Hospital Commission process of determining allowed net income or “profit” by what used to be called Planned Capital and Service Component (PCSC) or “Growth and Development” which included the sum of net changes in annual working capital, certain amounts of capital expenditures and other special funding, and the amount of principal payments during the period. It is important to note that the Hospital Commission’s methodology actually encouraged the full funding of annual depreciation to assure that future capital would be available for the future replacement of depreciable assets. **Therefore, by not providing for the funding of depreciation in the analysis contained within this report, the resulting treatment is EXTREMELY CONSERVATIVE (and perhaps technically inappropriate), since this cash probably should be preserved for future capital needs and not used for current operating purposes.**

**Cash Flow Considerations** Overall cash flow considerations must be added into the evaluation of relative financial strength to measure the degree of ongoing financial viability, including other cash flow obligations such as working capital, new and replacement equipment budget requirements, principal payments, and the payment of operating subsidies to other District operations, if any (such as the Clinic and Skilled Nursing Facility for Coulee). Without the benefit of a complete financial feasibility study, the following estimated cash flow requirements have been calculated (see additional calculations in Appendix B, C, and D for each District) for analytical purposes beyond the normal calculation of estimated annual debt service coverage shown below (Note: cash flow may show interest expense as both a source and use of funds, alternatively, both amounts could be omitted, without changing the resulting net cash flow). This type of pro forma cash flow analysis takes the adjusted operating expenses (with interest expense for the new debt, new project depreciation, and adjusted revenue deductions for CAH payments) to compute the overall net income, then adds back depreciation (a non-cash expense, and ASSUMING NO “FUNDING” OF ANNUAL DEPRECIATION), and finally removes the annual capital expenditures, change in working capital for the year, and principal payments. This methodology is very consistent with the old Washington State Hospital Commission process of determining allowed net income or “profit” by what used to be called Planned Capital and Service Component (PCSC) or “Growth and Development”. This PCSC included the sum of net changes in annual working capital, certain amounts of capital expenditures and other special funding, and the amount of principal payments during the period.

**Table 2**  
**Analysis of Pro Forma 2003 Budget**

	<u>COULEE</u>		<u>LEAVENWORTH</u>		<u>TONASKET</u>	
Budget Scope:	Hosp. Only		Total District		Total District	
New Project Cost:	\$10 Million		\$9 Million		\$12 Million	
Type of Financing:	HUD		LTGO		HUD	
Amount of Borrowing:	\$13.1 Million		\$8 Million		\$15.2 Million	
Capitalized Project Cost:	\$11 Million		\$10 Million		\$13 Million	
Assumed Equity Contribution	\$0		\$1 Million		\$0	
Medicare/Medicaid "CAH" %	58% (100% hospital)		70% (40% hospital)		65% (100% hospital)	
<b>2003 BUDGET (\$ in Millions)</b>	<u>W/O Proj.</u>	<u>With Project</u>	<u>W/O Proj.</u>	<u>With Project</u>	<u>W/O Proj.</u>	<u>With Project</u>
Gross Revenue	\$9.8	\$9.8	\$4.7	\$4.7	\$13.2	\$13.2
Revenue Deductions	<u>2.0</u>	<u>1.6</u>	<u>0.7</u>	<u>0.5</u>	<u>3.2</u>	<u>2.4</u>
Net Patient Revenue	7.8	8.2	4.0	4.2	10.0	10.8
Other Oper./Nonoper. Income	<u>0.4</u>	<u>0.4</u>	<u>1.1</u>	<u>1.1</u>	<u>0.5</u>	<u>0.5</u>
Net Adjusted Oper. Income	8.2	8.6	5.1	5.3	10.5	11.3
Less Operating Expenses-						
Depreciation	0.5	0.4	0.2	0.5	0.7	1.1
Interest Expense	0.1	0.8	0.1	0.5**	0.2	1.1
All Other Expenses	<u>6.7</u>	<u>6.7</u>	<u>4.6</u>	<u>4.6</u>	<u>9.9</u>	<u>9.9</u>
<b>Net Income</b>	<b>0.9</b>	<b>0.7</b>	<b>0.2</b>	<b>-0.3</b>	<b>-0.3</b>	<b>-0.8</b>
<b>Cash Flow</b>						
Net Income	0.9	0.7	0.2	-0.3	-0.3	-0.8
Depreciation	0.5	0.4	0.2	0.5	0.7	1.1
New Capital Expenditures	-0.4	-0.4	-0.4	-0.4	-0.7	-0.7
Principal Payments	-0.1	-0.4	0	-0.3	-0.3	-0.6
Working Capital	-0.1	-0.1	-0.3	-0.3	-0.5	-0.5
SNF Subsidy	-0.4	-0.4	0	0	0	0
Clinic Subsidy	<u>-0.4</u>	<u>-0.4</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Net Cash Flow	<b>0.0</b>	<b>-0.6</b>	<b>-0.3</b>	<b>-0.8</b>	<b>-1.1</b>	<b>-1.5</b>
<b>Debt Service Coverage</b>						
Net Income Available for D.S.	0.7	1.1*	0.5	0.7	0.6	1.4
Debt Service	0.2	1.2	0.1	0.8	0.5	1.7
Coverage Ratio	<b>3.5x</b>	<b>0.92x</b>	<b>5.0x</b>	<b>0.88x</b>	<b>1.2x</b>	<b>0.82x</b>

\*Net of subsidy to SNF and Clinic

\*\*ASSUMES CAH PAYMENTS

Note: The above debt service coverage calculations for the budget year may be mixing both general obligations, if any, and revenue obligations, if any. If so, the resulting coverage doesn't reflect the fact that there is really only 1.0x coverage on outstanding general obligations, since tax collections are used dollar for dollar to make these payments. However, this "cash flow" measurement is still a meaningful tool to illustrate relative overall financial and cash flow relationships.

Discussions with Coulee Representatives have identified several developments to attempt to reduce the above "subsidy" for its clinic and skilled nursing facility operations. These developments include revised estimates that indicate that the net overall shortfall may be avoided to restore a positive cash flow.

**Evaluation of Pro Forma Impact** The entire financial burden of paying for the related project capital costs is assumed to be funded from operations within the same budgeted level for 2003 of profitability, (As adjusted for increase project related capital costs for CAH's). The resulting cash flow and estimated debt service coverage clearly suggest that further evaluation needs to be done prior to beginning any actual project. While some of the above estimates may be inaccurate by as much as \$100,000 to \$200,000 or more due to timing assumptions, interest earnings on borrowed funds, etc., it is doubtful that the correction of any of these estimates would materially change the general conclusion that any single revenue obligation is simply too risky (assuming that any such financing could actually be accomplished) to reasonably proceed with any proposed replacement projects.

**Selected Financial Ratio Analysis** Based upon Standard & Poor's Rating Services 2002 Not-For-Profit Median Healthcare Ratios and estimated District/Hospital performance using the above pro forma 2003 analysis, the following ratios are summarized.

**Table 3**  
**Selected Financial Ratios**

Ratio	Pro Forma Numbers				
	BBB	BBB-	Coulee	Cascade	No. Valley
Sample Size	58	72	1	1	1
Average Daily Census	85	65	3.0		5.5
Days of Cash	111	89			
Debt Service/Total Op. Exp. %	3.5%	3.7%	15.2%	14.3%	14.0%
Maximum Debt Service Coverage (x)	2.9x	2.6x	0.92x	0.88x	0.82x

It is also noteworthy to document the continuing trend of net downgrades within the past several years for larger hospitals that carry bond ratings. For example, Table 4 shows Moody's Investor Services hospital activity over the past two years:

**Table 4**  
**Hospital Performance Over the Past Two Years**

	<b>2001</b>	<b>2002</b>
<b># of Downgrades</b>	55	41
<b># of Upgrades</b>	22	22
<b>Ratio</b>	2.5:1	1.9:1

The purpose of the above bond rating comparisons is to focus upon the material differences between the general levels of what S&P considers to be the two lowest “investment grade” bond rating categories. From an investment viewpoint, the purpose of a bond rating is to obtain an objective and independent assessment of: 1) the probabilities of a potential payment default, and 2) if a default should occur, how material would the resulting losses be to the bondholders.

**Who Should Pay For Capital Costs?** For many years, Public Hospital Districts have been challenged by the major policy issue of “who should pay the capital costs to provide community healthcare services?” While some argue that the payers of the actual services rendered should pay all related costs, others have argued that the taxpayers need to support capital costs for the benefits of having immediate access to modern healthcare facilities and services. Since the legal limits of tax supported general obligation debt may not permit the tax-supported alternative (or voters may not approve additional taxes, if a vote would be required), then the only possible approach would be for the “revenue” supported approach with some form of credit enhancement or direct funding to permit access to the capital markets. Of course, each District is responsible to make these difficult decisions, based upon existing payment or reimbursement methods that may very well change over the future.

In addition, each District needs to consider the sufficiency of funds to complete a replacement project (including possible construction delays, change orders, etc.), as well as the viability of future operations. If future payment or reimbursement reductions (including changes to Medicaid eligibility which will certainly reduce future reimbursement) produce material shortfalls, then the resulting impact could prove to be devastating to the District’s/Hospital’s ability to operate. If a District structured a hospital related financing through a 501(c)(3) organization, then an event of financial default on an outstanding HUD or USDA revenue obligation could result in the liquidation of Hospital assets, including some or all facilities, to satisfy payment shortfalls or extinguish the entire outstanding indebtedness, (all subject to negotiated covenants within any such financing agreements).

**Recent Newspaper Articles Regarding Rural Hospitals:** To illustrate the current thinking about the difficulties for rural hospitals maintaining favorable financial operations, one need only refer to the articles recently published in Washington State, including the Daily Journal of Commerce (see Appendix I) in December 2002. Since two of the mentioned Districts are also participants of this study, further discussion seems

appropriate. Part of the story has to do with the State's financial evaluation of rural hospitals in terms of measured financial vulnerability, using an index methodology, which reports that 25 of 44 rural hospitals were considered financially vulnerable in 2000 or 2001. Given the current post-Enron attitudes towards full disclosure, each District may want to carefully evaluate an appropriate approach in treating this possible disclosure item to satisfy legal requirements associated with any financing structure. The mere fact that the State has identified certain hospitals in this manner, also suggests that all Board members should be advised before they authorize any new commitments.

**“Cross Over Point” Question** Based upon the current CAH designation, assuming no future adverse changes to payment or reimbursement methods, the Coulee Community Hospital representatives have asked about the ability to generate excess annual cash flow from depreciation and interest expense to cover principal and interest payment obligation. Since the debt service payment structure from a HUD or similar revenue supported bond issue would be based upon level annual debt service payments, the annual depreciation base would be on a “straight-line” basis, assuming that the replacement facility costs are depreciated over an average of depreciable lives. Therefore, principal paid during the early years would be less than annual depreciation and the short-term cash flow resulting from depreciation should be favorable. However, the following factors must also be considered:

- 1) While annual depreciation is a non-cash expense, the Hospital's annual net positive cash flow is the sum of both depreciation and net income, as adjusted for other total financial needs. If net income or overall net cash flow is negative, then the resulting sum of cash flow will be insufficient to produce any favorable result, (see the cash flow analysis on page 17 for each Hospital – Table 2).
- 2) If the resulting positive cash flow is larger than the necessary principal payments, there are also several other possibilities with the net surplus, if any
  - a) Working capital may consume the excess funds;
  - b) New and replacement equipment may consume the excess funds; and/or
  - c) The excess funds may be spent for other operating or non-operating purposes.
- 3) The prudent management approach would be to invest any specific excess amounts of equivalent remaining depreciation, after payment of principal and meeting other financial needs, to assure that there will be sufficient funds to cover future shortfalls in years where principal will certainly exceed the annual depreciation. Sample calculations of these relationships are illustrated in Appendix H, which computes the “cross over point” to be around 5, 12, or 18 years into assumed 20, 25, and 30-year debt repayment structures. Finally, given the above cash flow analysis, none of the Districts would be experiencing an overall positive net cash flow, so the concept of investing surplus amounts is purely academic.

## Section 4

### DISTRICT FINANCING OPTIONS

As further described in Appendix B, C, and D, the District's have several financing options, including general obligations which are limited by State statutes (and may be further reduced by the "practical" limitations of available unencumbered regular tax levies to meet new annual debt service requirements) and revenue obligations which are not limited by State statutes.

**Legal Debt Capacity** Based upon State of Washington statutes and using 2002 information, each District's statutory legal maximum debt capacity and estimated remaining capacity, excluding revenue obligations which are not limited by statute, is shown in Table 5 (\$ in millions):

**Table 5**  
**Legal Debt Capacity**

Current Year Assessed Valuation (based upon prior year assessments)	<u>Coulee</u> <b>\$170.0</b>	<u>Cascade</u> <b>\$ 959.1</b>	<u>No. Valley</u> <b>\$530.0</b>
<u>Maximum Non-voted Capacity @ 0.75% of A.V.</u>	\$ 1.3	\$ 7.2	\$4.0
Less: Outstanding LTGO Bonds	0.6	1.2	2.6
Other Non-voted Obligations	<u>0.2</u>	<u>0.0</u>	<u>0.5</u>
<b>NET REMAINING NON-VOTED CAPACITY</b>	<b>\$ 0.5</b>	<b>\$ 6.0*</b>	<b>\$0.9</b>
<u>Maximum Voted and Non-voted Capacity @ 2.5% of A.V.</u>	\$4.3	\$ 24.0	\$13.3
Less: Outstanding LTGO Bonds	0.6	1.2	2.6
Other Non-voted Obligations	0.2	0.0	0.5
Outstanding Voted UTGO Bonds	<u>0.7</u>	<u>0.0</u>	<u>0.0</u>
<b>NET REMAINING VOTED AND NON-VOTED CAPACITY</b>	<b>\$ 2.8</b>	<b>\$ 22.8</b>	<b>\$10.2</b>

\*Note: available regular levy would currently support about \$3.0 million.

Note: LTGO means Limited Tax General Obligation bonds that are paid from regular property tax levies and UTGO means Unlimited Tax General Obligation bonds that are paid from excess property tax levies.

**Tax Levy Limitations** Remaining legal capacity is insufficient to cover the total amount of new project borrowing, (except for Cascade with sufficient UTGO capacity), that would be needed for each proposed replacement facility. See Appendix B, C, and D for a more detailed description of excess property tax and regular property tax levy limitations for each District.

**Revenue Obligations** Since “revenue” obligations are not limited by State statutes, the “practical” debt capacity for such borrowings are limited only by:

- A) The District’s willingness to be involved in such a financing transaction, given the related costs and associated risks; and
- B) The lender’s willingness to enter into such a financing transaction with risks above what might otherwise be available with “stronger” financial situations.

In other words, revenue obligations are negotiated between willing parties with interest rates, fees, terms, and conditions built into the overall transaction on a “best efforts” basis. Depending upon the credit strength or weakness of the issuing district, these transactions may be issued as private placements to a bank or institution, or sold to an underwriter for a public bond sale. To support a public bond sale, the underlying credit typically needs some form of credit enhancement device, such as municipal bond insurance, bank letter of credit, or other form of guarantee of debt service payment. HUD is a financing structure, which provides a payment guarantee arrangement that assures sufficient credit strength to encourage potential bond purchasers to buy bonds, either in the form of a public bond sale or private placement transaction. The overall costs and benefits of revenue obligations, in any form, need to be carefully considered by the issuing district. Given the above pro forma debt service coverage calculations, the Districts need to recognize that revenue obligations almost always have some form of continuing coverage covenant that requires a minimum of 1.10x to 1.25x coverage. These coverage covenants cannot which can’t reasonably be met by any of the District. Therefore, violation of such a coverage covenant would probably result in a default on the borrowing.

**General Financial Impact Resulting From the Issuance of New Debt Obligations**

Recognizing that each District has different circumstances, the following section illustrates the material planning points related to the issuance of new debt (**NOTE: the following discussion assumes that Medicare and Medicaid do not pay their share of new interest expense because of the possible offset resulting from excess or regular property tax levies that may be restricted solely to the payment of the new interest expense. EACH DISTRICT SHOULD EVALUATE THIS ASSUMPTION DURING THE COURSE OF FURTHER DETAIL PLANNING**):

- A. **Issue UTGO Bonds**- while this approach requires voter approval. (which may be difficult to obtain) it results in new tax revenue sources to totally offset dollar for dollar increases in principal and interest payments. CAH reimbursement is improved because of Medicare and Medicaid paying their share of new project depreciation, so the resulting overall net cash position is improved with the new project, assuming no adverse changes in operating expense relationships.
- B. **Issue LTGO Bonds Backed by Current Regular Tax Levy**- to the extent that there are available unencumbered regular levy dollars to accomplish this funding source, the regular tax levy collections are offset against the new interest expense, while Medicare and Medicaid won’t pay any incremental new interest expense,

they will pay their share of the new project depreciation. Therefore, the overall net cash position may or may not be improved, depending upon how the regular levy has been previously treated in the cost report, and depending upon whether or not the District can maintain a favorable overall net cash flow position. In addition, the issuing District needs to consider the fact that the commitment of existing regular tax collections to cover new debt service means that those tax funds will no longer be available to be used for capital purposes or to support operating cash flow.

- C. **Issue LTGO Bonds Backed by New Regular Tax Levy-** while also requiring voter approval to raise current levy amounts, it results in new cash flow source to offset dollar for dollar increases in interest expense and principal payments. CAH reimbursement is improved because of Medicare and Medicaid paying their share of new project depreciation, so the overall net cash position is improved with the new project, assuming no adverse changes in operating expense relationships.
- D. **Issue Any Form of Revenue Obligations-** as evaluated throughout this report, the resulting cash flow consequences of this debt source are very serious and it requires very careful analysis before committing to this approach.

## Section 5

### SUMMARY OF HUD PROGRAM REQUIREMENTS

The HUD program provides mortgage insurance for hospital loans to build new facilities or modernize existing facilities. Since HUD is only providing insurance to the loan, the hospital still needs to select an underwriter for a public bond sale or arrange for a private placement financing arrangement, all based upon the credit worthiness resulting from the HUD loan guarantee. The initial HUD housing program was modified in the 1970's to supplement the Hill-Burton Act which provided hospital grants for one-half of specific construction projects to treat the medical needs of the financially distressed (uninsured or under-insured) general population. The following summary is provided to focus upon the key provisions of the HUD program which are considered to be unique or noteworthy and may be in contrast to typical revenue obligations for general Public Hospital District financing purposes (see Appendix E for a complete copy of HUD Handbook 4615.1, Mortgage Insurance for Hospitals). In addition, there are certain additional HUD provisions that were provided by Charles Davis, HUD Representative, and from Neil Moss, Executive Director, Idaho Health Facilities Authority.

**Selected Points from HUD Handbook 4615.1** The following is a summary of material points contained in the HUD Handbook 4615.1.

- A) Clear first mortgage must be provided to secure HUD's insurance commitment, or similar long-term leasehold interest.
- B) Loan prepayment must be approved by HUD.
- C) HUD may require "operating fund" security to cover any anticipated deficits.
- D) Financing commitment may cover both a construction loan and the permanent financing.
- E) Federal National Mortgage Association (FMNA) may participate in construction advances.
- F) Mortgage/loan terms: maximum of \$50 million with loan limit of 90% of "replacement" cost of subject property, including equipment.
- G) Various "rehabilitation" limits to existing structures.
- H) Maximum loan term: 25 years from date of initial amortization (post-construction) with level monthly payments.
- I) Mortgage insurance premium paid with monthly loan payments, plus initial financing charge not to exceed 2% of loan and 1% annual fee during construction.
- J) Limitations on future financing require HUD prior approval on any second mortgages, including cross default provisions.
- K) All projects must meet CN requirements as determined by each state.
- L) Construction standards must meet all federal guidelines.

- M) General flow of process:
- a. Initial Application
    - i. Initial Application Fee (\$1.50 per thousand dollars of loan coverage), plus similar amount upon issuance of Commitment Letter
    - ii. Project description
    - iii. Description of services, programs, department functions, staffing, etc.
    - iv. Financial feasibility report (NOT REQUIRED FOR CAH HOSPITALS IN STATES WITH CN REVIEW)
    - v. Probable site visit
  - b. Project Requirements (after approval of Application and Commitment Letter issued)
    - i. Predesign Conference
    - ii. Review of Schematics
    - iii. Preliminaries- full scope of project with cost estimates
    - iv. Working drawings
  - c. Contracting/Construction
    - i. Competitive bidding
    - ii. Davis-Bacon Act (prevailing wage requirements)
    - iii. Pre-construction conference
    - iv. Site visits
    - v. Post-construction inspection (plus fee of \$5 per thousand of loan)
- N) Debt may be taxable or tax exempt.
- O) Need Title Insurance Policy.
- P) No “shell” space in project.

**Selected Points from Charles Davis, HUD Representative** Based upon specific questions about HUD financing, the following information was provided:

- A) While there are no exceptions to the HUD mortgage requirements, 501(c)(3) organizations may have a reversionary clause (a very complex arrangement where title is held by a municipal entity) or a lease arrangement for 50 years or longer with certain terms and conditions.
- B) When asked what the financial impact may be from the Davis-Bacon Act prevailing wage requirement, he was not aware of any estimates to overall project costs. Subsequent discussions with Brad Berg, Foster Pepper Shefelman PLLC and Bill Badger, Sellen Construction Company, Seattle office project manager, have indicated that the State of Washington prevailing wage requirements are virtually identical to the Davis-Bacon Act requirements for Public Hospital Districts. A community 501(c)(3) hospital could avoid both of these requirements and reduce overall project costs by about 5%.
- C) Related financing costs include: costs of origination, processing, underwriting, closing and delivery, mortgagee’s legal fees, escrow monitoring, permanent placement, title insurance, etc.

- D) The hospital would be required to Trustee a mortgage reserve fund to contain one year of debt service within five years and two years of debt service within 10 years (note: public bond sale would probably require the debt service reserve to be fully funded from bond proceeds).
- E) Interest during construction is a project cost.
- F) HUD will insure 90% of replacement costs and a Debt Service Reserve Fund is not an allowable cost. Costs of issuance are allowable costs.
- G) A financial feasibility study would not be required for some Critical Access Hospitals.

**Selected Points from Neil Moss, Executive Director, Idaho Health Facilities Authority** Based upon discussions with Neil Moss about the current \$18.6 million HUD financing for the Shoshone Medical Center in Kellogg, Idaho, the following information was provided:

- A) The lead-time to move the initial Application to final form took over three and one-half months, including the involvement from lawyers in Idaho, Oregon, and Washington D.C.
- B) While not specifically a HUD condition, the Shoshone Medical Center has already completed the total project design and negotiated a guaranteed maximum price construction contract, which is critical to know how much debt to borrow.
- C) HUD will require the Shoshone transaction to include a letter of credit to cover any arbitrage losses during the construction project. The scope of “arbitrage losses” seems to be related to any shortfalls resulting from actual interest earnings during the construction period being less than originally estimated at the time of bond issuance.
- D) An estimated bond sizing is not available at this date.

## Section 6

### ORGANIZATIONAL STRUCTURE/LEGAL ISSUES

Before starting this study, Coulee Community Hospital representatives prepared a series of detail questions that they wanted addressed within the scope of the study (see Appendix A for the full text of these questions and answers provided by Brad Berg, Foster Pepper Shefelman PLLC). A summary of responses to these questions is detailed below.

**“Unbundling of a District’s Hospital”** Since providing a mortgage on a District’s hospital facilities can’t be accomplished under Washington statutes, the concept of “unbundling” the Hospital into a new or existing community based 501(c)(3) organization was explored. In the process of evaluating this type of alternative organizational structure, the Districts should also consider the operations of the clinic and skilled nursing facility, overall reimbursement, and tax levy (for existing and future excess and regular property tax levies) consequences, if any, with input from Bond Counsel. From the District’s perspective, it would seem sensible to keep the clinic and/or skilled nursing facility as healthcare operations within the District’s structure. This may or may not permit the continuation of current regular or excess property tax levies, subject to confirmation with Bond Counsel. The “unbundled” Hospital could then legally provide a mortgage; however, it couldn’t issue its own tax-exempt debt obligations without going through the Washington Health Care Facilities Authority (the “Authority”). Furthermore, the District couldn’t transfer any assets (without future repayment); including needed working capital in the estimated amount of \$1+ million, and the Hospital would also have no assets to meet the “non-covered” portion of an assumed HUD borrowing. This shortfall would include both the 10% of project costs that aren’t covered under the HUD 90% limit to replacement value, as well as non-allowed financing or project components, such as debt service reserve funding. There are also issues related to the existing \$1.1 million of UTGO and LTGO Bonds that won’t mature until 2011 (note: both Cascade and North Valley have outstanding general obligation bonds in different amounts and with different maturity dates). Finally, since the Authority would require a guaranteed maximum price (“GMP”) construction contract to support a bond issuance, the Hospital would need to pay the pre-construction project costs for the initial project planning, architectural costs, etc. before a permanent Authority transaction could be completed. The hospital could arrange for a construction loan, which would be refinanced by a permanent transaction through the Authority.

**Annexing of Additional District Property** This concept resulted from an interest in exploring the possibility of expanding the assessed valuation tax base and therefore to expand the general obligation debt capacity of the District. Since we failed to identify any viable options in any geographic direction, this option was ruled out.

**Entering Into a Long-term Lease Arrangement with the Authority** Similar to the Shoshone structure described below, the District could possibly enter into a long-term lease arrangement with the Authority. Mr. Van Gorkom, Executive Director, has been evaluating such a structure and is continuing his review of the merits and related problems. The GMP requirement would still exist, unless the District was willing to negotiate the HUD structure in two phases, with the first phase to serve as a construction loan (possibly on a taxable basis) to finance the initial preparation costs, including architects, together with all project construction. The second phase would cover the permanent long-term financing (including the refinancing of the initial construction loan). The HUD program provides for this two-phase approach (or alternatively as described below in a single phase). However, the Authority will need more time to evaluate its policy position related to any form of HUD financing.

## Section 7

### **IDAHO HEALTH FACILITY AUTHORITY / SHOSHONE MEDICAL CENTER**

The following discussion about the Shoshone Medical Center's ("SMC") pending HUD arrangement with the Idaho Health Facility Authority is presented to understand the structure and approach for the transaction and look for possible similarities for a Washington State Public Hospital District. It is important to understand that SMC operates as an Idaho "District Hospital" within Idaho State statutes. Similar to Washington State Public Hospital District statutes, SMC could not offer a mortgage on its property, so the Idaho Health Facility Authority agreed to work with them to structure a 99 year lease arrangement where in the Authority holds a leasehold interest. This leasehold interest could be used to satisfy HUD's mortgage requirement by securing the Authority's leasehold interest, all of which currently appears to be permitted under Idaho statutes. Since Idaho has six Hospital Districts none of which appear to be "investment grade" candidates, the HUD approach with SMC is being viewed as a possible model to assist in providing funding sources that otherwise wouldn't exist. Accordingly, the creation of the SMC model is being done with a great deal of interest by the other Idaho Districts, including significant national attention from many other hospitals that are facing some or all of the same financing issues related to mortgages.

SMC already has a GMP construction contract, so neither the Idaho Health Facilities Authority nor SMC will need to speculate about the amount of bonds to be issued for total project and financing related costs. None of the parties involved with a major financing, including the Hospital board and management, underwriters, lender, etc., would ever want to enter into a major permanent borrowing without the comfort of the GMP contract. This means that hospitals looking at this model may have to "front" the project design and development costs, including the competitive bidding and contractor selection, either with equity funds or some form of pre-construction loan financing. This situation may create a challenge in getting the hospital's board to spend this amount of equity capital, or arrange for a temporary pre-construction loan, with or without the absolute assurance that the borrowing support will ever be granted by HUD, an issuing authority, or other parties that would be needed to complete any long-term permanent financing.

## Section 8

### WASHINGTON HEALTH CARE FACILITIES AUTHORITY

Mr. John Van Gorkom, Executive Director, Washington Health Care Facilities Authority (the “Authority”) has been involved in certain discussions about the scope of this study. He has also had independent discussions with the Idaho Health Facility Authority and other parties that have shown an interest in working with Washington Public Hospital Districts to resolve the problems with providing a HUD mortgage or a leasehold interest. It currently appears that the solution to the HUD mortgage requirement would require Districts to use the Authority, since this is the only identified approach under current Washington State statutes. In using the Authority, Districts need to understand the variety of requirements that need to be satisfied. Since the economics of using a HUD financing does not appear to be in the Districts best interest (per the above analysis) the details of other Authority policies, procedures, and requirements are not presented within this report.

Mr. Van Gorkom has shared his current thinking about the use of the HUD approach on a very preliminary basis, all subject to further evaluation by the Authority. He believes that the costs are very high and the degree of complexity is very demanding. He seems to prefer the use of a private placement transaction or some other financing option to eliminate the HUD involvement, however, there are very few interested lenders for such transactions and the maximum borrowing amount might be limited to around \$7 million (note: some casual inquiries to a few lending organizations and banks have found absolutely no such potential interest for small hospitals in any material amount). Of course, any private placement lender would have to satisfy themselves regarding the ability to repay debt service, this would be reflected in their proposed interest rates, fees, and covenants. Whenever greater repayment risk is present, a willing lender will either choose not to participate or elevate the rates, fees, and covenants to levels that may not be attractive enough for the borrower to accept.

## Section 9

### SEARCH FOR OTHER FINANCING STRUCTURES

Given the somewhat disappointing findings of the prior work, it was decided to expand the scope of this study beyond the HUD financing structure. Accordingly, the following additional parties were contacted to seek new options, if any:

Prior Experiences in Washington, Oregon, Alaska and Idaho -  
Lower Umpqua Hospital District, Reedsport, Oregon  
Selected Bond Counsel Attorneys

Research with Selected Local, Regional, and National Healthcare Investment Bankers and Other Financing Specialists -  
American Property Financing  
American Capital Resources Inc.  
Salomon Smith Barney  
UBS Paine Webber  
RBC Dain Rauscher  
U.S. Bank (Government Banking)  
Bank of America  
Seattle-Northwest Securities  
Cashmere Valley Bank

Other Contacts –  
National Rural Health Association  
Association of Washington Public Hospital Districts  
Idaho Health Facilities Authority  
Washington Health Care Facilities Authority

As a result of the investigation of alternative financing options with the above parties, the only other possible source of funding or credit support identified was the United States Department of Agriculture-Rural Development (“USDA-RD”), operating under a variety of different USDA sub-divisions and/or agency titles. One USDA transaction was completed by Umpqua District Hospital in Reedsport, Oregon, which issued \$3.6 million in December 1996 directly with USDA for a major construction project and related costs. A review of the financing transcripts indicated that most of the identified problems (costs, mortgage, covenants, approvals, schedule, etc.) with the HUD structure were avoided or minimized in the USDA transaction.

**USDA-RD Options** Accordingly, the Wenatchee USDA-RD office was contacted and its representative, Mr. Jim Wehrer, indicated a very strong interest in certain potential rural hospital construction projects. Appendix G contains the three types of project support that may be of interest, including grant funds (typically only about \$30,000, could be expandable under certain circumstances), guarantee arrangements for taxable lending

agreements, and direct loan support. This latter option may include fixed rate loans up to 40 years (subject to the maximum asset lives that are being financed) at current interest rates ranging from 4.5% to 4.75%, depending upon the size of the District's population (must be under 20,000 total population, which works for all of the Districts), and based upon average household income levels (see Appendix K for individual District information).

While there are a variety of initial requirements to move towards a direct loan from USDA-RD, it does appear that this possible funding source could be the most promising revenue obligation approach for the Districts, assuming that the USDA-RD route is probably only a partial source of project funding (maybe in the range of \$3 million to \$5 million). This would be dependant on the District's ability to produce a "feasibility study" which demonstrates the District's capacity to repay debt service on the borrowing. An initial debt service reserve fund isn't required, but deposits are expected over a ten year period to build the reserve account (although, the District could "borrow" from the fund to make needed capital expenditures from time to time). This financing vehicle does not need to be processed through the Authority, since it is directly funded through the government with interest rates that are much more favorable than tax exempt borrowing rates from either a public bond sale or private placement.

**Joint Ventures, Partnerships and Grants** Each District should explore the following areas to evaluate potential capital support. In the way of joint ventures and partnerships, Empire Health Services, Spokane, may have interests in certain business propositions, including shared services, funding of certain types of equipment to link its Spokane presence with rural locations, etc. Indian tribes may be suitable candidates to discuss joint venturing or partnerships in clinic services or other special programs. Some federal government agencies have agreed to provide capital for selected projects in lieu of property tax payments that they don't pay. Any hospital that is receiving material number of patients from the District's service area may be worth consulting to see if there are possible areas for financially sound arrangements. An example of this strategy would include the possibility of either North Valley or Cascade discussing possible joint ventures or partnerships with the Wenatchee Valley Clinic. If nothing else, each of these parties, including ALL governmental agencies, state and federal departments, cities, counties, etc., should be asked to support the District's pending financing plans, including providing letters of endorsement, etc. The District's can also post their plans and financial needs on the internet with a website called "WA-CERT" to capture potential interest from a wide range of entities and organizations that seek potential service arrangements, etc. (see Appendix J for additional details).

The Association of Washington Public Hospital Districts published “A Guide to Capital Funding Options” in April 2002. This should describe financing options (see Appendix K for certain corrections to page # 103 of the Guide) and a wide range of possible grant funding sources, including the following:

Ben B. Cheney Foundation  
Economic Development Administration, U.S. Dept. of Commerce  
M.J. Murdock Charitable Trust  
The Norcliffe Foundation  
Office of the Advancement of Telehealth  
Office of Community and Rural Health, Washington Dept. of Health  
Office of Special Programs, Health Resources and Services Administration  
PACCAR Foundation  
The Seattle Foundation  
Union Pacific Foundation  
U.S. Dept. of Agriculture  
U.S. Dept. of Agriculture, Rural Utilities Telemedicine  
Washington Health Foundation  
Washington State Dept. of General Administration  
Washington State Treasurer’s Office  
Other website resource: The Foundation Center @ “[fdncenter.org/funders](http://fdncenter.org/funders)”

In addition, the National Rural Health Association published “Capital Funding Options for Rural Community Health Centers” in August 2002 which is a guidebook and resource listing that can be ordered at its website: [www.nrharural.org](http://www.nrharural.org). This should be a very useful document for locating new grant sources, including the following partial listing (excluding a wide variety of foundation resources, publications, guides, fundraising campaigns, creation of foundations, useful website addresses, Washington State Rural Development Council, Capital Link offices, etc):

Bureau of Primary Health Care  
Health Resources and Services Administration (Congressional appropriations)  
National Library of Medicine  
Office of Community Services, Admin. for Children and Families  
Office of the Advancement of Telehealth  
Rural Business Enterprise Grants Program  
Rural Health Outreach Program  
U.S. Dept. of Commerce

One other potential source of grant funding is the Kresge Foundation.

**Other Possible Solutions/Legislative Initiatives** Besides the need for another Hill-Burton Act, or similar financial support device from the federal government such as incentive tax credits, which seems doubtful in the near future (if ever, but who knows?), the following concepts have been considered as possible solutions for the 40+ rural hospitals in the State. Given the uncertainty and unknown lead-time for relief from any of these ideas, they may only serve as long-term remote possibilities.

- A) Some form of self-imposed tax to all hospitals in Washington: since all Washington hospitals currently pay 1.5% “business and occupation” (“B&O”) taxes, some of this existing tax money or perhaps “new tax money” resulting from a higher rate could be used to help rural facilities.
- B) State and/or local sales taxes or general B&O taxes: As is done with a variety of special purpose funding arrangements throughout the State, special allocations of existing or new sales tax could be allocated to direct fund or support funding. The City and Borough of Juneau, Alaska had voters approve a five-year, one cent increase to the local sales tax to fund \$20 million of capital improvements for the Bartlett Regional Hospital. King County arranged a variety of tax changes to fund a baseball stadium, which voters had previously defeated. Other special purpose projects have included the Key Arena for basketball and a new football stadium from creative taxing sources.
- C) “Securitize” Medicare and/or Medicaid payments: to serve as “first dollar” designation to cover annual debt service payments. While this “solution” would only result in the ability to channel initial amounts of Medicare and/or Medicaid payments into a secured debt service structure, to a possible lender may see a more solid security package to support a lending transaction. As a practical matter, the hospitals would still have the ongoing challenge of covering operating costs and other cash flow needs. See February 2003 HFMA monthly magazine for an interesting related article about securitization.
- D) Create some form of State Bond Bank: like many other states, Washington could create a bond bank to enhance the credit worthiness of rural hospital debt obligations. Alaska has a bond bank (currently being used by the Bartlett Regional Hospital for a \$25 million tax exempt bond issue) to support a wide-variety of municipal and special purpose financings, including healthcare organizations.
- E) Modify the scope of the Washington Health Care Facilities Authority: empower the Authority with some form of “moral obligation” capacity, like a bond bank.
- F) State and/or federal supported incentives to encourage “hub and spoke” affiliations between rural and urban healthcare organizations.
- G) Seek to restore the 6% annual growth increases for rural (and urban?) facilities (limited to Public Hospital District’s with CAH facilities or apply to all rural

locations?) to regular property tax levies that were cut to one percent by the recent “I-747” tax proposition. This would restore a meaningful source of annual financial support for operating and/or capital purposes, and “grow” the practical financial capacity for Public Hospital District’s to issue and service the payments on LTGO’s within existing statutory debt limitations. This consideration also raises a general business and reimbursement issue related to the manner in which Public Hospital Districts with CAH facilities may or may not be “offsetting” their annual regular property tax collections against operating expenses for purposes of calculating Medicare and Medicaid reimbursement under the CAH payment system. If the offset occurs, this treatment raises a variety of implications ranging from an investors’ concern for true dollar-for-dollar coverage on a LTGO (if LTGO bonds are outstanding or may be proposed for issuance), to the intent of taxpayers’ financial support, and to the purposes or objectives of Medicare and Medicaid reimbursement.

- H) In addition to any legislative attempts mentioned above or not, the AWPHD’s may consider some form of public relations program to counter the types of newspaper articles contained in Appendix M. Any state-wide financial performance information should be divided into categories of rural, public hospital districts, and/or some form of “all other” to properly measure actual results. The unsupported conclusion in this article that there should be less pressure upon taxpayers to support public hospital districts is totally without merit. While the Daily Journal of Commerce article (Appendix I) may go too far in the direction of rural vulnerability, this Times article is going too far in the other direction.

Assuming that there are 40 rural facilities that need capital projects ranging from \$10 to \$15 million each, somewhere in the range of \$400 to \$600 million for possible capital purposes is required. If each rural facility could generate the legislative support of three or four members, then the resulting number of members could be significant energy to influence new legislation. Since each rural facility is a major employer in its respective community, the ability to orchestrate a possible legislative solution seems to be worth pursuing. Of course, since the rural hospital is a critical component to the future viability of rural communities, there may be many other approaches to consider.

## Section 10

### CONCLUSIONS AND RECOMMENDATIONS

As illustrated throughout this analysis, none of the initial financing strategies, on a revenue obligation basis, are realistic as a sole financing source. Only Cascade Medical Center has sufficient remaining general obligation debt capacity to fully fund a replacement, but access to that source would require the voters to approve an excess tax levy to pay the debt service on a UTGO bond issue. The other two Districts do not have enough capacity to support the issuance of general obligations, either voted or non-voted, to totally fund a replacement project. Without some form of credit enhancement and based upon the lack of availability from any private lender, the Districts do not have any reasonable single funding option, other than perhaps a portion of replacement project financing from: A) the existing HUD program, but probably as an absolute last resort; B) finding another federal agency such as USDA-RD to provide partial credit or funding support; or C) wait for some future program that doesn't exist at this time.

Accordingly, it is recommended that the Districts begin to develop what shall be called "The 1-2-3-4 Solution". This solution, with the following preliminary components, assumes that the total replacement project budget is about \$9 million to \$12 million for direct project spending purposes (excluding indirect borrowing costs, debt service reserve funding, capitalized interest, etc. which need to be added to the borrowing component):

**Table 6**  
**1-2-3-4 Solution**

<b>Component Number</b>	<b>Source of Funds</b>	<b>Range of Dollars</b>
<b>1</b>	District Equity, including foundations	\$0 million to \$2 million
<b>2</b>	General Obligation Borrowing	\$0 million to \$10 million
<b>3</b>	Joint Ventures, Partnerships and Grants	\$0 million to \$5 million
<b>4</b>	Revenue Obligations	\$0 million to \$5 million (plus indirect costs)

While the 1-2-3-4 Solution is purely a conceptual framework to establish a package of funding sources, (instead of focusing upon any single approach that appears beyond the reasonable levels of most Public Hospital Districts to accomplish), it is a solid and logical place to begin an organized process. This solution may take one year, a few years, or many years to implement. Without creating any notion about whether a rural Public Hospital District's priority is to create growth (expand population and attract new business), maintain current population and business activity, or even shrink the size of existing rural areas, this conceptual framework is intended to accommodate any situation.

In addition, while the 1-2-3-4 Solution lays out the sequence of logical steps to take towards a combined financing plan, it also “sums” to a total of 10, suggesting that a total of a \$10 million could fund the direct costs to support a total facilities replacement project. While the actual direct costs of such any such project may prove to be higher than \$10 million, it probably wouldn’t be lower than \$10 million. Further analysis of creative design and construction approaches should also be undertaken, however, that effort is beyond the scope of this study.

**Component #1: District Equity** Subject to the amount of general obligation capacity below, District equity funds may need to be committed as the base or starting point for the entire plan (could be from existing cash reserves or generated from a Foundation’s activities). An assumed \$1 million would represent 10% of the overall direct replacement project cost and would serve as the “foundation” to the combination of funding sources. The maximum amount of this component needs to be based upon the necessary amounts of existing cash and investments that must be retained to support reasonable working capital and future levels of reserve funds. The remaining cash reserve level should represent at least 50 to 60 days of operating cash expenses (excluding depreciation and amortization), although, further work needs to be done with each District to confirm a reasonable general target level of liquidity funds.

**Component #2: General Obligation Borrowing** To the extent that there is available legal general obligation debt capacity, the taxpayers/voters should be asked to participate in the overall funding strategy, either in part or in total, but only after the District’s Commissioners fully understand all options and agree with the strategy to approach the public. This exercise with the voters will also help the elected District Commissioners to gain the positive or negative feedback from their constituents. If this effort is unsuccessful, then the Commissioners may wish to re-think the entire concept of a full replacement facility and begin re-thinking the remodeling or “piece-meal” approach to the existing facilities.

**Component #3: Joint Ventures, Partnerships, and Grants** The joint ventures, partnerships, and grant support component is based upon the absolute need to “close the gap” between available general obligation or revenue obligation debt, which may be very nominal, if any, and equity support to the project.

**Component #4: Revenue Obligations** As detailed above, none of the Districts have any meaningful revenue obligation capacity; however, there may be opportunities to include revenue obligations as a component to an overall financing plan within a multiple source plan. The cash flow benefits resulting from a new project may be sufficient to cover a modest amount of debt service payments on a much smaller scale than those measured within the above analysis for revenue obligations, but only if it is a minor portion of the total funding. The District’s also need to be aware of the “hidden” amounts of indirect financing costs, such as capitalized interest, debt service reserve accounts (initial and subsequent, if any) that will further eroded revenue obligation borrowing capacity.

**The Next Steps** If District Commissioners and the administrative team are willing to move forward with a possible voter approved general obligation, if available, or to create a multi-phase funding plan with a draft planning work program and schedule, then the next steps may include some or all of the following:

- A) Conduct a workshop with the District Commissioners to confirm that all of the above issues are known and understood before progressing any further;
- B) Retain District Special Legal Counsel to evaluate and confirm legal issues;
- C) Confirm or reject assumptions related to the possible approach with the Authority for both existing and possible modified approaches, as discussed herein;
- D) Begin conceptual project definition, site requirements, and possible discussions with architects to review construction options;
- E) Discuss possible financing plans with an investment banking firm to begin some preliminary and conceptual financial structuring plans;
- F) Capture written conceptual support from all organized public entities, including County Commissioners, any City Councils, all State or Federal Rural Agencies;
- G) Post project concepts on WA-CERT to seek possible support;
- H) Arrange planning with Washington State agencies to coordinate local planning and support strategies;
- I) Coordinate possible legislative initiatives venture with the Association of Washington Public Hospital Districts and Washington State Hospital Association; and
- J) Begin full grant writing/capital campaign effort.

Of course, each District will need to further assess its own situation and build related strategies accordingly. The above ideas are presented to support the planning process, and encourage further development or modification to meet the particular strategies.

While not directly related to capital financing matters, each District should consider the possibilities of seeking an Emergency Medical Services (“EMS”) tax levy, which may be approved by District voters in an amount up to fifty cents per thousand dollars of A.V. The term of this type of tax support may vary from one year to a permanent status. The proceeds of this tax levy may be used for certain emergency services, including a variety of related ancillary functions. Approval of an EMS levy would enhance the operating cash position of any District with or without any new financing.