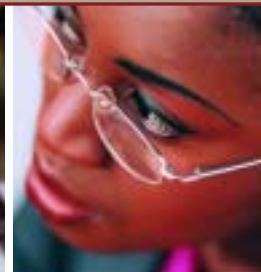


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How Are Hospitals Financing the Future?

Capital Spending in Health Care Today

**Financing the Future Report 2:
How Are Hospitals Financing the Future?
Capital Spending in Health Care Today**

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Report 2:

How Are Hospitals Financing the Future? Capital Spending in Health Care Today

Key Findings

Despite a double-digit increase in utilization, hospitals' aggregate capital spending increased only about 1 percent between 1997 and 2001, with the highest-spending hospitals being larger, urban hospitals with broad access to capital.

- Between 1997 and 2001, capital spending that resulted in fixed assets grew only 1 percent compared with 7.7 percent growth in number of hospital admissions and 19.6 percent growth in outpatient visits during that same period.
- Per-bed capital spending between 1997 and 2001 for hospitals defined as having broad access to capital is more than 13 percent higher than for hospitals defined as having limited access to capital.
- Between 1997 and 2001, the largest hospitals (400+ beds) spent nearly 63 percent more capital on a total per-bed basis than the smallest hospitals (less than 100 beds).

Between 1997 and 2001, spending on buildings increased at a more rapid rate than spending on equipment, and the two categories were almost equal as of 2001; spending on nonphysical assets appears to be increasing.

- Between 1997 and 2001, the cumulative increase in spending on buildings and fixtures was 3.0 percent, compared with a 0.5 percent increase for moveable equipment.
- Interviews with hospital financial executives suggest that hospitals are spending increasing amounts of capital for nonphysical assets in recent years.

Although most hospitals' capital acquisitions exceeded the amount of fixed assets they depreciated—an indicator of the sufficiency of capital spending—a significant minority did not stay ahead of depreciation. A large disparity exists between hospitals that are staying ahead of depreciation and those that are falling behind.

- Between 1997 and 2001, the capital acquisitions of 59 percent of hospitals exceeded the amount of fixed assets they depreciated. Conversely, the capital acquisitions of a significant minority—41 percent—did not keep ahead of depreciation.
- States with the highest percentage of hospitals not keeping up with depreciation were Hawaii, New Mexico, North Dakota, Florida, and New Jersey.
- States with the highest percentage of hospitals keeping up with depreciation were Idaho, South Dakota, Oregon, Iowa, and Minnesota.
- A higher percentage of facilities identified as keeping up with depreciation have positive operating margins, have positive total margins, and are designated as having broad access to capital.
- A higher percentage of facilities not keeping up with depreciation than facilities keeping up with depreciation were designated as limited capital access.
- Progressive organizations demonstrate a clear link between strategic and capital planning. In such organizations, the strategic plan drives capital planning and spending. Such a plan addresses community needs, competitive strategy, physician resources, workforce changes, and opportunities for improved profitability, and sets a clear financial path to achieving those goals.

1. Setting the Scene

The conventional wisdom says that aging plants, increasing demand, competitive pressures, and technological innovations are creating the need for significant healthcare capital investment. Skyrocketing costs also encourage capital spending, says the conventional wisdom, because hospitals must use capital to stem losses and invest in improved operating efficiency.

But is the conventional wisdom true?

Let's start with capital spending. Is hospital capital spending increasing?

The short answer in the aggregate is no. Capital spending on fixed assets has been relatively flat.

Are hospitals investing enough capital to keep up with needs?

A majority seems to be keeping up, but a significant minority apparently is not.

Are hospitals with limited access to capital, based on their financial performance, actually spending less capital than hospitals with broad access to capital? ¹

Yes, limited-capital-access hospitals are spending less, but many are keeping ahead of depreciation and maintaining a comparatively good average age of plant. (We will go into more detail on where and how limited-capital-access hospitals are getting their capital in a future report.)

These findings point to the great need for savvy organizationwide capital planning—planning that includes identifying strategic direction, improving financial performance, determining the amount of debt a hospital can and should assume, determining the amount of capital needed to achieve strategic goals, accessing that capital, and monitoring use of that capital. *Financing the Future*, led by HFMA in partnership with GE Healthcare Financial Services, is a year-long project whose mission is to help hospitals and other stakeholders understand capital needs now and in the future, and understand how to plan for, access, and invest capital to seize the opportunities that growing demand and technological innovation offer. The project is based on research conducted by HFMA and PricewaterhouseCoopers.

The first *Financing the Future* report—*How Are Hospitals Financing the Future? Access to Capital in Health Care Today*, released in November 2003—showed that the deteriorating financing position of hospitals is limiting their access to capital and could be increasing the cost of capital. Even more significant, the number of hospitals with limited capital access has grown significantly in recent years.

Couple that finding with this report's findings—that capital spending is flat, and 41 percent of hospitals are not keeping up with depreciation—and the potential for a downward spiral for some hospitals is apparent. The spiral would look like this: Hospitals increasingly struggle with their financial health...their deteriorating financial health makes them less creditworthy...their ability to access capital becomes limited...they must devote a larger proportion of their capital to keeping up with the demands of today...they are decreasingly able to invest in the future...and, as a result, their financial health drops significantly.

Findings from this second *Financing the Future* report suggest that the gap between the “have” and “have not” hospitals, when it comes to capital spending, is significant. Hospitals with a successful strategic capital planning process and an attractive enough balance sheet to make significant capital spending possible apparently are at least investing enough to keep ahead of depreciation. However, hospitals with a more challenging financial situation are not keeping up with the need to invest in the future.

This report answers key questions about the level and effect of capital spending:

- How much capital are hospitals spending?
- What kinds of hospitals are spending more, and what kinds are spending less?
- What are hospitals spending capital on? Are they spending on initiatives that will foster growth?
- Are hospitals spending enough to keep up with need?
- How do hospitals make their capital-spending decisions?

¹ In the first report in the *Financing the Future* series, *How Are Hospitals Financing the Future? Access to Capital in Health Care Today*, hospitals with relatively easy access to capital and hospitals with more limited access were identified based on two sets of criteria that analyzed profitability, liquidity, and debt burden. Facilities with operating margins > 2 percent, debt service coverage ratios > 3.5, current ratios > 2, and debt-to-capitalization of between 0 percent and 35 percent were classified as broad-access hospitals. Facilities with negative operating margins, debt service coverage ratios < 1.25, short-term days cash on hand < 5, current ratios < 1, and debt-to-capitalization of less than 0 percent or greater than 70 percent were classified as limited-access hospitals.

The report provides benchmarks and measures to determine the adequacy of hospitals' capital spending, and it offers tools to improve capital planning.

The findings also raise questions about the future of health care in America—about whether hospitals

will be able to keep up with demand for services, especially in a competitive, high-cost, low-margin, highly regulated environment. Look to forthcoming reports to shed more light on how hospitals will be *Financing the Future*.

2. How Much Are Hospitals Spending, and Who Is Spending the Most and Least?

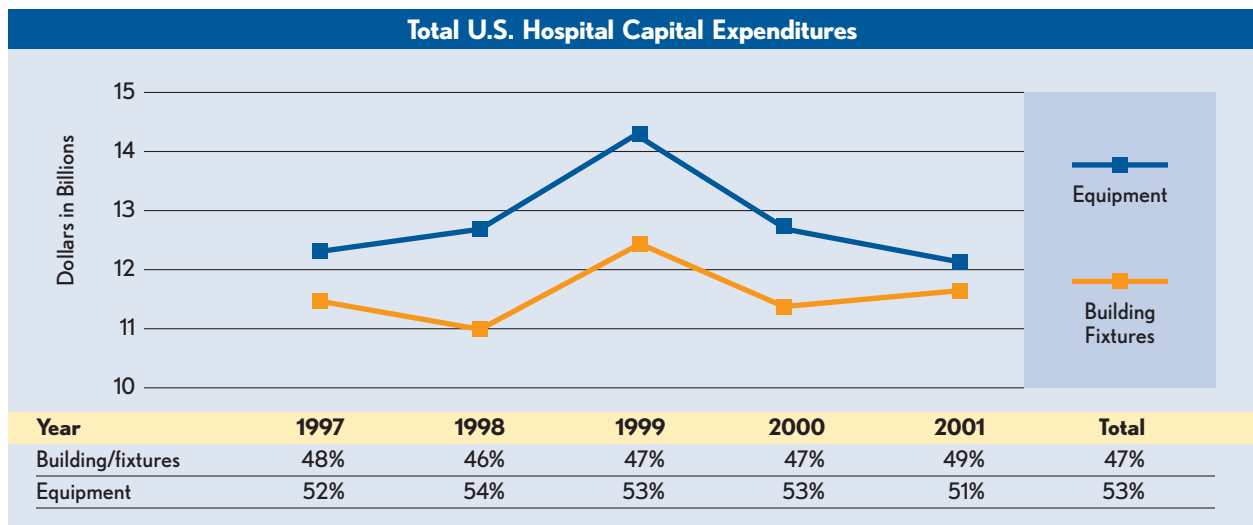
Despite a double-digit increase in utilization, hospitals' aggregate capital spending increased only about 1 percent between 1997 and 2001. And a closer look at spending shows significant gaps between hospitals related to capital spending, with a clear picture emerging of the characteristics associated with higher capital spending (large, urban, not-for-profit, more profitable, broad access to capital) and the characteristics associated with lower capital spending (smaller, rural, for-profit, less profitable, limited access to capital). Once we explore level of spending, we will look at what hospitals are spending their capital on and whether they are spending enough to keep up with demand.

Aggregate Capital Spending

Between 1997 and 2001, capital spending grew only 1 percent compared with a much higher level of growth in demand for services. Various sources (based on surveys of hospital CFOs) indicate that individual capital budgets may be increasing,² but in the aggregate, the total capital becoming operational between 1997 and 2001 stayed relatively constant.

Per-year spending on capital acquisitions that resulted in fixed assets, such as buildings or equipment, was \$23.5 billion in 1997. It was \$23.9 billion in 2001—the most recent year for which data are available. Thus, total capital spending increased only about 1 percent in that five-year period (see Exhibit 1).³

Exhibit 1



² *The Financial Health of the Healthcare Industry*, David Michaelson & Company, LLC, September 2002.

³ Data are from Solucient Database, which contains data reported by 5,713 hospitals in 1997, 5,587 hospitals in 1998, 5,545 hospitals in 1999, 5,022 hospitals in 2000, and 4,934 hospitals in 2001. The numbers represent most of the hospitals in the United States during these years. From 1997 to 2001, 94 percent of the hospitals in the database reported capital expenditures each year. While the data are representative of the sample of reporting hospitals, absolute dollar amounts of spending could be under-reported due to nonreporting of hospitals to Solucient in general and for these data elements for hospitals that do report to Solucient.

Although overall capital spending spiked from 1999 to 2000, the median spending was relatively flat through that period. This indicates that a small number of large projects was responsible for the spike in total spending. These projects appear to be related to clinic construction and Y2K.

The very limited growth in capital spending in this period was far outstripped by growth in demand for hospital services. Compare the 1 percent growth in capital spending with the 7.7 percent growth in hospital admissions between 1997 and 2001 (from 31 million to 33.4 million) and the 19.6 percent growth in outpatient visits between 1997 and 2001 (from 450 million to 538 million) (see Exhibits 2 and 3). Thus, aggregate capital spending appears not to be keeping up with demand as measured by utilization.

Who Are the Big Spenders?

By studying the characteristics of hospitals in relationship to their per-bed capital spending,⁴ a picture emerges of what kinds of hospitals appear to spend capital more plentifully than others. Perhaps not surprisingly, the highest-spending hospitals are the larger, urban hospitals with broad access to capital.

The gap between the big spenders and their counterparts suggests a significant polarization of the country's hospitals.

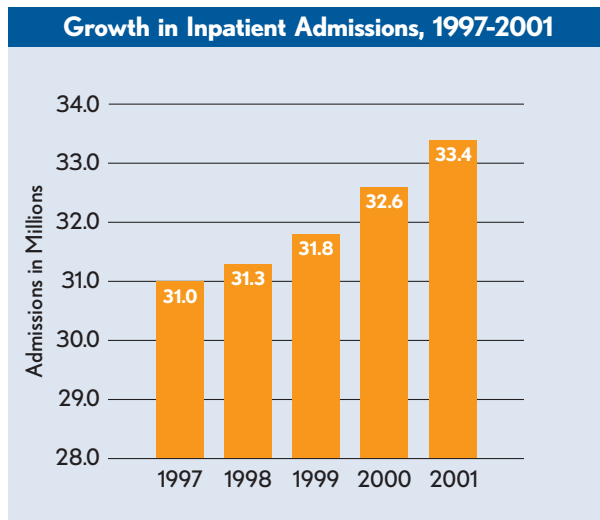
Capital Access and Capital Spending

A closer look at hospitals' capital spending shows that hospitals with broader access to capital are spending significantly more per bed than those with limited access to capital (see Exhibit 4). Per-bed capital spending for hospitals defined as having broad access to capital is more than 13 percent higher than for hospitals defined as having limited access to capital:

- For hospitals defined as having *broad* access to capital, the five-year total spending per bed was \$245,000 from 1997 through 2001.
- For hospitals defined as having *limited* access to capital, the five-year total spending per bed was \$216,000 from 1997 through 2001.

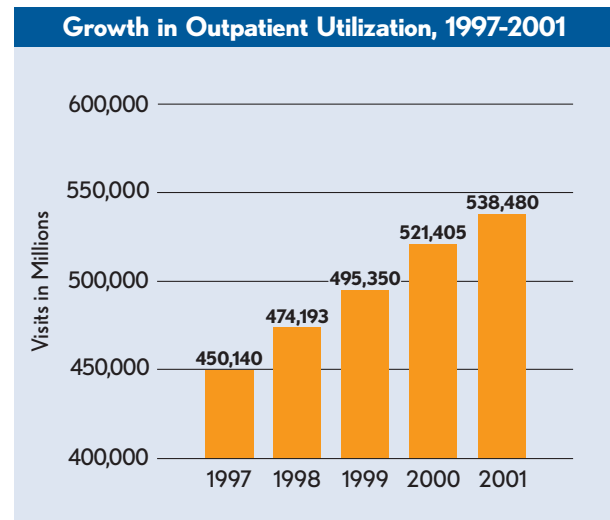
These categories of access to capital are based on the kinds of financial indicators traditionally used to determine creditworthiness. (See the first *Financing the Future* report for a full explanation of these categories.) The findings show a link between creditworthiness and amount of spending.

Exhibit 2



Source: Hospital Statistics, American Hospital Association, 2002.

Exhibit 3



Source: Hospital Statistics, American Hospital Association, 2002.

Organizational Characteristics and Capital Spending

Size, sponsorship, location, and teaching status all were linked to significant differences in capital spending, with large, not-for-profit teaching hospitals spending the most (see Exhibit 4).

- Bed size.** For the five-year period between 1997 and 2001, the largest hospitals (400+ beds) spent nearly 63 percent more capital on a total per-bed basis than the smallest hospitals (less than 100 beds). Of hospitals that spent more than \$100 million on capital projects in a given year between 1997 and 2001, 54 percent had a bed size of more than 400.⁵
- Teaching status.** For the five-year period between 1997 and 2001, teaching hospitals spent more than 58 percent more capital on a total per-bed basis than nonteaching hospitals. Of hospitals that spent more than \$100 million on capital projects in a given year between 1997 and 2001, 92 percent were teaching hospitals.
- Sponsorship.** For the five-year period between 1997 and 2001, not-for-profit hospitals (non-religious) spent nearly 70 percent more capital on a total per-bed basis than for-profit hospitals. Of hospitals that spent more than \$100 million in a single year between 1997 and 2001, 80 percent were not-for-profit.
- Urban versus rural.** For the five-year period between 1997 and 2001, urban hospitals spent 32 percent more capital on a total per-bed basis than rural hospitals. About 94 percent of facilities that spent more than \$100 million on capital projects in a given year between 1997 and 2001 were located in an urban area.

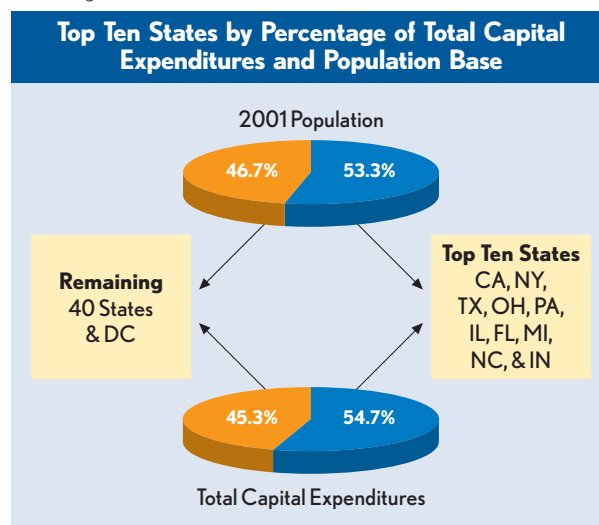
As would be expected, total capital spending was highest in states with the largest populations (see Exhibit 5). Of the total spending across the United States, ten of the most populous states in the country (containing 53.3 percent of the total U.S. population) accounted for more than half (54.7 percent) of the total spending between 1997 and 2001. No pattern could be discerned in a state-by-state comparison of per-bed capital spending.

Exhibit 4

Capital Spending Per Bed	
Total five-year spending, 1997 through 2001 (Dollars in thousands)	
Location	
Rural	\$ 180.1
Urban	\$ 237.9
Bed Size	
0-99	\$ 173.7
100-249	\$ 223.1
250-400	\$ 231.6
400+	\$ 282.7
Sponsorship	
Governmental	\$ 230.9
For-profit	\$ 143.7
Not-for-profit (other)	\$ 243.1
Not-for-profit (church)	\$ 222.0
Teaching status	
Teaching	\$ 278.0
Nonteaching	\$ 175.4
Access to Capital	
Limited	\$ 216.4
Broad	\$ 245.1
Total U.S.	\$230.3

Source: Financing the Future project analysis, Solucient database

Exhibit 5



Source: Financing the Future project analysis, Solucient database

⁵ We conducted additional analysis of the hospitals that spent more than \$100 million in any given year, by operating characteristic and by type of project. The states that contained the highest number of these projects were California, New York, and Ohio. While this finding seems obvious from the perspective that these states are among the most populous and have the most hospitals, what is surprising is that these states also rank high on the list of states having limited access to capital. Several of these projects appeared to span multiple years, with spending in excess of \$100 million in each of those years. Nearly half of the projects were characterized by the hospitals themselves as "new" or "replacement" hospitals.

3. What Are Hospitals Spending Capital On?

Hospitals spend capital to ensure the viability of ongoing operations and remain as up-to-date as possible by replacing aging physical plants and equipment, and upgrading technology. And hospitals spend capital to invest strategically in the future, which involves physical reconfiguration and technology upgrades that support investment in or expansion of lines of service that promote growth.

Capital also can be used to clean up liabilities or exit operational strategies that have not worked. Hospitals cited the expenditure of their scarce capital dollars on the exiting of previous business strategies that had not worked, as well as the payment of growing liabilities in pension and malpractice funding.

Later in this report we will explore whether hospitals' capital spending is keeping up with demand. To lay a foundation for that discussion, we will describe what kinds of projects hospitals are investing their capital in.

Construction

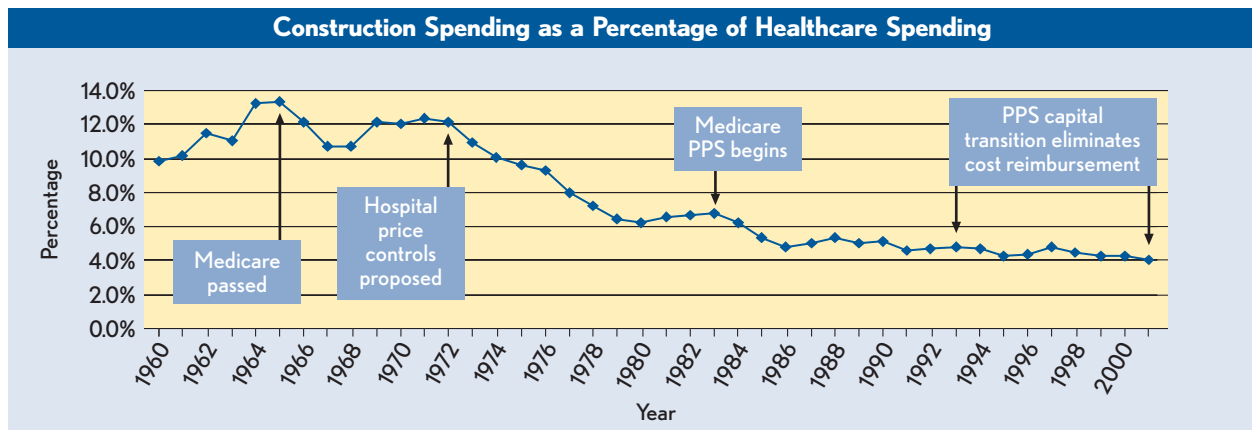
Although construction spending is increasing as a total dollar amount, it is decreasing as a percentage of total healthcare spending, a fact made tangible by the rising age of plant in American hospitals.

Between 1997 and 2001, spending on buildings increased at a more rapid rate than spending on equipment, and the two categories were almost equal as of 2001. Between 1997 and 2001, the cumulative increase in spending on buildings and fixtures was 3.0 percent, compared with a 0.5 percent increase for moveable equipment.

These findings suggest that hospitals are dedicating more resources to construction in recent years. And while that may be true as a percentage of capital spending, construction spending as a percentage of total healthcare expenditures decreased substantially over the last 40 years (see Exhibit 6) and was at its lowest point in 2002. While the figures in Exhibit 6 include all healthcare construction spending (e.g., spending for long-term care construction), it is likely that the majority of this spending has occurred in hospitals.

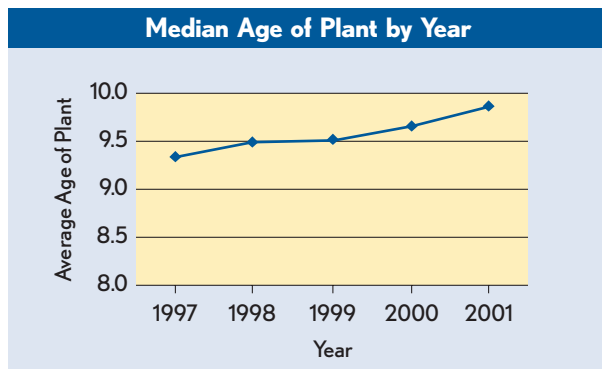
Construction spending as a percentage of total spending was at its highest in the mid-1960s and the early 1970s, when Hill-Burton funds were still available. Between 1947 and 1975, the Hill-Burton Act of 1946 authorized more than \$4.6 billion in grant funds and \$1.5 billion in loans for nearly 6,800 healthcare facilities in more than 4,000 communities.⁶ The Federal Housing Authority (FHA) program for the insurance of healthcare mortgages also began during this time

Exhibit 6



Source: CMS

Exhibit 7



Source: *Financing the Future* project analysis, Solucient database

period (in 1968) and has since insured more than \$9.4 billion in mortgages for more than 300 hospitals. Capital spending as a percentage of total spending declined throughout the 1970s and began to level off in the early 1980s at about the time the Medicare prospective payment system was enacted.

Medicare prospective payment for capital began its ten-year phase in 1992, but the hospital industry did not experience a precipitous drop in spending as a result. Rather, construction spending has hovered around 5 percent of total hospital spending in the last ten years, although this percentage has declined fairly steadily during that time period.

A look at trends in the average age of plant across the country reinforces the relatively low level of spending on construction. The average age of plant has increased in the industry over the last five years (*see Exhibit 7*).

Some evidence suggests that, since 2001, there has been an upswing in construction spending. In 2002, construction contracting for hospitals was up 11 percent and for clinics/ nursing homes, up 5 percent.⁷ *Modern Healthcare's* 24th Annual Construction and Design Survey showed a 16 percent increase in completed construction projects over that same timeframe. However, according to CMS, construction spending represents less than 50 percent of capital spending. Report 3 in the *Financing the Future* series, to be released in March 2004, will predict future spending trends to provide greater insight on this issue.

Equipment

Annually, spending on equipment exceeded spending on buildings, with spending on equipment making up 51 percent of capital spending for fixed assets in 2001. Equipment includes fixed equipment (such as elevators and air conditioning systems), major movable equipment (such as diagnostic imaging apparatus and information technology), and minor equipment (such as dictating equipment and surgical instruments).

This pattern of spending a higher proportion of capital on equipment shows the importance of equipment investment to keeping up with health and safety code requirements, efficient and high-quality practice of medicine, efficient operations, and strategic business expansion.

However, the amount spent on equipment in 1997 was roughly the same as spending in 2001, a remarkable finding considering the high cost of and high need for equipment related to compliance, medical technology, and information technology. For just one example, an x-ray device that cost \$175,000 is likely being replaced by a CT scan that costs \$1 million, and that will eventually be replaced or supplemented with a PET imaging machine that costs more than \$2 million.⁸

A survey by the National Association of Public Hospitals and Health Systems (NAPH) gives some sense of how at least one segment of hospitals is divvying up its capital dollars for equipment. The survey showed that in 2001, 14 percent of NAPH member hospitals' capital budgets was spent on medical equipment, 14 percent was spent on information systems, 5 percent was spent on other equipment, and 3 percent was spent on code compliance. Major modernization constituted 41 percent and new programs 14 percent of capital expenditures, both of which involve equipment investment.⁹

A survey of capital needs of small rural hospitals by the Health Resources and Services Administration showed that 38 percent of respondents were aware of deficiencies within their hospitals requiring renovation, most of which would require expenditures for equipment. The respondents identified their highest

⁷ Dodge Construction Outlook, Midyear Update, McGraw Hill, 2003.

⁸ The State of Hospitals' Financial Health, American Hospital Association, 2002.

⁹ Singer, Ingrid, and Carrier, Betsy, *Capital Investment in America's Safety Net: Results of the NAPH Capital Expenditure and Financing Survey for FY 2001*, National Association of Public Hospitals and Health Systems, September 2003.

priorities for capital spending as new radiology equipment (46 percent), a new information system (34 percent), a new roof (24 percent) and a new sprinkler system (16 percent). In addition, 51 percent said major renovation or addition was a high priority, and 28 percent needed to replace a major piece of mechanical equipment such as a boiler. These findings highlight the mix of strategic and nonstrategic purposes for equipment that healthcare executives must weigh in their capital allocation.¹⁰

Information Technology

The purchase and upgrade of information technology and information systems (IT and IS) remain a constant concern for hospitals. Of nearly 900 hospital executives surveyed in February 2003, 62 percent said their hospitals will increase their IT spending in 2004, and 23 percent said their budgets would remain the same as for 2003.¹¹ Additional industry sources anticipate IT spending to increase from \$34 billion in 2001 to \$48 billion by 2006, with healthcare IT growth second only to that anticipated for governmental agencies.¹²

Despite these large projected increases, healthcare IT spending remains low when compared with IT spending by other service-oriented industries, at only slightly more than 2 percent of total revenue.¹³

Why is spending expected to increase? The industry executives surveyed explained the increase as a result of HIPAA compliance, healthcare provider connectivity, and a shift from content management to business intelligence.¹⁴ Research cites poor information recording and transmission as a key component of the inter-related operational issues facing the healthcare industry.¹⁵ And it is clear from Institute of Medicine reports and other patient-safety-inspired mandates that continued automation and electronic accessibility of clinical information are vital to the expanding list of safety initiatives.

Size of Projects

A look at spending by size of project per hospital shows a slight increase in the number of large, expensive capital projects, and a continuing large proportion of small projects.

The vast majority of hospital capital projects in any year between 1997 and 2001 were smaller than \$10 million. This proportion decreased over time, while gains were made in the proportion of slightly larger projects. Only a handful of hospitals spent more than \$50 million on capital acquisitions in any given year. More than 15 percent of the capital in each year was spent by slightly more than 1 percent of the hospitals.

Nonphysical Assets

Interviews with hospital financial executives suggest that hospitals are spending increasing amounts of capital for nonphysical assets in recent years. CFOs cited many competing needs:

- Increases in funding of pension, self-insurance, or other benefits plans
- Exit strategies for non-core investments, such as managed care organizations and physician practices
- Process improvement initiatives designed to increase patient satisfaction and enhance productivity

Many hospital executives are forced to focus on short-term operating margins to survive. Cash-strapped facilities have a difficult time focusing on long-term capital investment.

The following section takes on this question of short-term versus long-term focus with a look at whether hospitals are spending enough capital to keep up with demand.

¹⁰ Stensland, Jeffrey, Schoenman, Julie, Mueller, Curt, and Singer, Andrew, *Capital Needs of Small Rural Hospitals: Final Report*, Rockville, Md.: Office of Rural Health Policy, Health Resources and Services Administration, May 2002.

¹¹ Brown, Eric G., Holmes, Bradford J., and Yuen, Esther H., *2003 Hospital IT Spending Lures Tech Vendors*, Forrester Research, March 2003.

¹² Cruz, Geraldine, *In Unforgiving Times, the U.S. Healthcare Market Boosts IT Spending*, Gartner, Inc., August 2003.

¹³ *Spending Our Money Wisely: Improving America's Healthcare System by Investing in Healthcare Information Technology*, The Health Technology Center, Manatt, Phelps & Phillips LLP, May 2003.

4. Are Hospitals Spending Enough to Keep Up?

Our findings show that while a majority of hospitals appears to be spending enough capital at least to stay ahead of depreciation, a significant minority is not. Hospitals with the most effective capital spending appear to be larger, rural, not-for-profit, and profitable. Our findings also show that certain states appear to be facing significant shortfalls in effective capital spending.

One way to measure whether hospitals' capital spending is keeping up with need—specifically, aging facilities and equipment—is to compare the acquisition of fixed assets with ongoing depreciation expense.¹⁶

We will call this the future investment index. If the index is less than 1, average age of plant increases over time, and if the index is greater than 1, average age of plant decreases. In other words, hospitals with an index of greater than 1 are more likely to have newer plants and equipment and not need as much capital investment in the future.

A small majority of hospitals—59 percent—had an index greater than 1, indicating that their capital acquisitions between 1997 and 2001 exceeded the amount of fixed assets they depreciated, resulting in lower age of plant and growth in net fixed assets (see Exhibit 8).

Exhibit 8

Relationship between Organizational Characteristics and Future Investment						
Distributions		Greater than 1			Less than 1	
Total Facilities	Total	%	Avg. Index	%	Avg. Index	
Total	100%	59%	3.28	41%	0.64	
Location						
Urban	56%	56%	3.15	44%	0.64	
Rural	44%	64%	3.44	36%	0.64	
Bed Size						
0-99	54%	60%	3.70	40%	0.61	
100-249	32%	58%	3.08	42%	0.65	
250-399	11%	59%	3.55	41%	0.69	
400+	4%	64%	1.88	36%	0.72	
Sponsorship						
Governmental	25%	62%	3.57	38%	0.62	
For-Profit	15%	47%	2.37	53%	0.56	
Not-for-Profit (Church)	14%	59%	4.29	41%	0.69	
Not-for-Profit (Other)	46%	62%	3.04	38%	0.67	
Teaching Status						
No	76%	59%	3.02	41%	0.63	
Yes	26%	60%	4.03	40%	0.66	

Source: Financing the Future project analysis, Solucient database

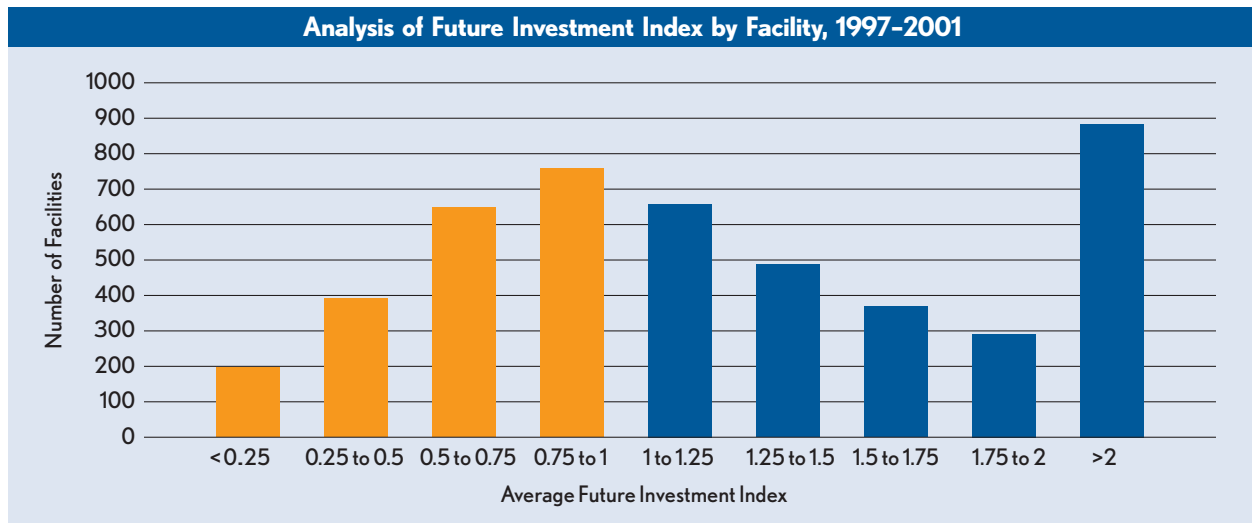
An index greater than 1 indicates the hospital is spending capital at a level sufficient to keep ahead of depreciation; an index less than 1 indicates the hospital is not spending enough to keep ahead of depreciation.

¹⁴ Brown, Eric G., Holmes, Bradford J., and Yuen, Esther H., 2003 Hospital IT Spending Lures Tech Vendors...

¹⁵ Spending Our Money Wisely: Improving America's Healthcare System by Investing in Healthcare Information Technology...

¹⁶ The index was calculated as new spending on buildings and fixtures and major moveable equipment as a percent of reported depreciation and amortization expense from Medicare cost report data through the Solucient database for the period 1997-2001. The analysis used an average five-year amount to account for non-reporting facilities and to smooth out the effect of years of large capital spending versus years of limited capital spending. The data were also culled to remove obvious reporting errors.

Exhibit 9



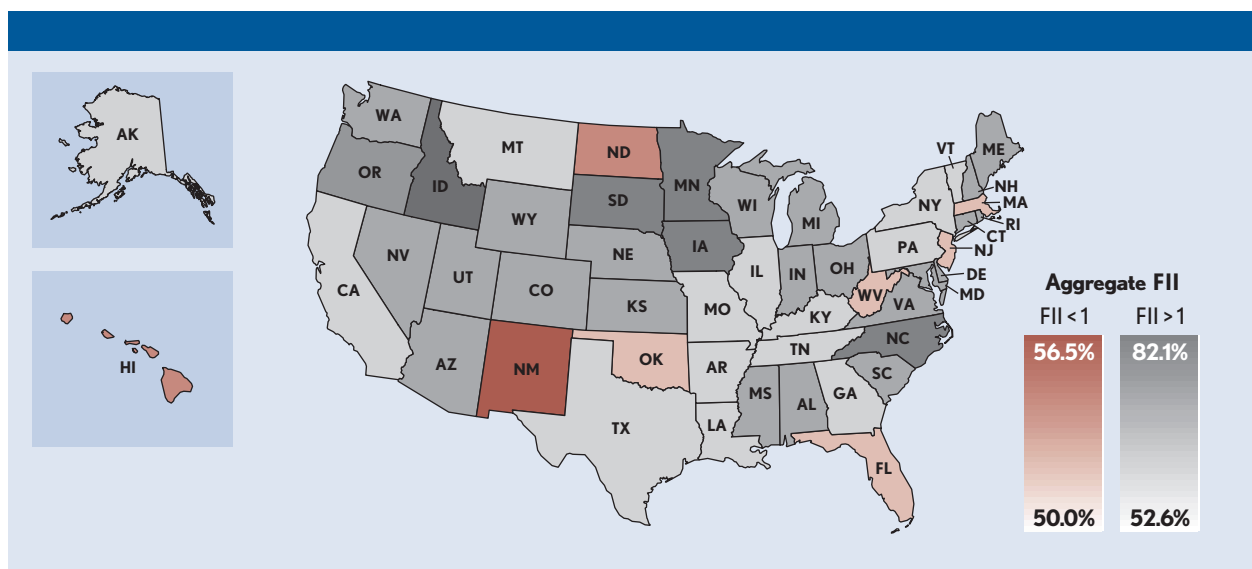
Source: Financing the Future project analysis, Solucient database

Conversely, a significant minority—41 percent—had an index of less than 1, indicating they are not keeping ahead of depreciation. A large disparity exists between hospitals that are staying ahead of depreciation and those that are falling behind. The average index for hospitals staying ahead of depreciation was 3.28, while the average index for hospitals not staying ahead of depreciation was 0.64. In addition, Exhibit 9 shows that when we distribute hospitals into groups based on how well they are keeping pace with depreciation, the largest group of hospitals is significantly ahead of

depreciation, and the second largest group of hospitals is just short of keeping up with depreciation.

The future investment index may not be routinely calculated by healthcare financial managers, and can be useful for boards and senior management to monitor their historical rates of future investment and to set goals for future needs. Many CFOs interviewed cited annual expected depreciation as their starting point for determining their capital budgets. Users should note, however, that this measure doesn't take into account all factors indicating wise capital spending, such as

Exhibit 10



Source: Financing the Future, based on Solucient data.

“whether the investments are helping the hospitals reach their long-term goals,” according to Jason Sussman, a partner at KaufmanHall.

A closer look at the findings shows the organizational and operational characteristics of hospitals that appear to be keeping up with aging facilities and equipment, and those that appear not to be keeping up.

Organizational Characteristics

Exhibit 8 (p. 9) illustrates organizational profiles of facilities that invested beyond current depreciation (index greater than 1) and those that did not (index less than 1). By and large, the majority of hospitals of all organizational characteristics had an index greater than 1, meaning they were staying ahead of depreciation. Rural, not-for-profit, and large hospitals tended to do the best job in this respect (although rural hospitals seem to have underspent on a per-bed basis between 1997 and 2001, as noted earlier).

Geographic Characteristics

Findings show a stark geographic distinction between hospitals that are and are not keeping up with capital needs. The “have’s” and the “have not’s” when it comes to both capital spending and capital access are clearly divided by state. Nine states had a majority of hospitals with indices less than 1 and, largely due to this ratio, the aggregate indices in all but one of these states were less than 1. Of the remaining 42 states where a majority of hospitals had indices greater than 1, there was significant variation in this percentage, from 53 percent to 82 percent (see Exhibit 10).

In addition, these findings show that capital spending and capital access, not surprisingly, are related. Levels of capital spending and capital access (as noted in Report 1) continue to vary according to state. Exhibit 11 suggests that in states where there is broader access to capital, there is also an increased ability to replace aging facilities and equipment.

Exhibit 11

Top 15 States Keeping Up with/Not Keeping Up with Depreciation			
States Keeping Up with Depreciation		States Not Keeping Up with Depreciation	
Rank (% of hospitals keeping up with depreciation)*	State	Rank (% of hospitals not keeping up with depreciation)†	State
1	Idaho	1	Hawaii
2	South Dakota	2	New Mexico
3	Oregon	3	North Dakota
4	Iowa	4	Florida
5	Minnesota	5	New Jersey
6	North Carolina	6	Oklahoma
7	Connecticut	7	West Virginia
8	Kansas	8	Massachusetts
9	Nevada	9	District of Columbia
10	Wyoming	10	Louisiana
11	Nebraska	11	Pennsylvania
12	Ohio	12	Texas
13	Delaware	13	Alaska
14	New Hampshire	14	New York
15	Rhode Island	15	California

* Score of greater than 1 on future investment index

† Score of less than 1 on future investment index

Conversely, in states where there is limited access, there is less ability to reinvest in physical plant.

Hospital analysts suggest that the remarkable differences by state may be a result of differences in:

- Regulatory approvals and barriers
- Managed care penetration and activity
- Physician admitting and treatment patterns
- Concentrations of illegal aliens and others with no health insurance
- Local or regional economic factors
- The “age” of the industry in the state

Exhibit 11 (p. 11) shows the top 15 states that are and are not keeping up with depreciation. This exhibit also compares these findings with findings of the percentage of hospitals in each state defined as having either limited or broad access to capital. The results show startling regional distinctions between states whose hospitals are and are not spending enough capital to keep up with need, as well as between states that have limited or broad access to capital.

Key findings include:

- Of the 15 states with the highest percentage of hospitals with an index of greater than 1 (keeping ahead of depreciation), seven are also among the top 15 states that have a high percentage of broad-access hospitals.
- Of the 15 states with the highest percentage of facilities with an index less than 1 (not keeping up with depreciation), eight are also among the top 15 states that have high percentages of hospitals with limited access to capital.
- Eight of the 15 states not keeping up with depreciation had major markets ranked in the top 20 of metropolitan areas for which health care is an important part of the economy. These states were

Exhibit 12

Relationship between Organizational Characteristics and Future Investment Index		
	Greater than 1 *	Less than 1
Profitability	%	%
Total	59%	41%
Operating Margin		
Positive	65%	35%
Negative	49%	51%
Total Margin		
Positive	64%	36%
Negative	47%	53%
Capital Access		
Broad	69%	31%
Limited	52%	48%
Moderate	55%	45%

Source: *Financing the Future* project analysis, Solucient database

* A future investment index greater than 1 indicates the hospital is spending capital at a level sufficient to keep ahead of depreciation; an index less than 1 indicates the hospital is not spending enough to keep ahead of depreciation.

Florida, New Jersey, Massachusetts, the District of Columbia, Pennsylvania, Texas, New York, and California.¹⁷ This finding suggests the potential for significant adverse effects on local economies should the area’s healthcare organizations not adequately invest in the future.

Operational Characteristics

It is, perhaps, no surprise that more profitable hospitals were able to invest in their futures more adequately than less profitable hospitals. What is surprising, however, is that more than half of hospitals designated as having limited access to capital are in fact replacing assets at a rate greater than their annual depreciation.

¹⁷The Milken Institute’s Health Pole Index combines the concentration of health care in a region’s economy with its share of national healthcare employment to show the importance of the healthcare industry to the region. Higher rankings indicate higher importance of health care to the regional economy. (*Financing the Future Report 1: How Are Hospitals Financing the Future? Access to Capital in Health Care Today*, November 2003; DeVol, Ross C. and Koepp, Rob, “America’s Health Care Economy,” Milken Institute, August 2003.)

This finding suggests that hospitals that would appear to be marginally creditworthy are finding sources of funding for capital expenditures, although it may be at a higher cost than more creditworthy hospitals.

Exhibit 12 highlights these relationships.¹⁸

Here are key findings related to profitability, capital access, and investment beyond depreciation:

- A higher percentage of facilities identified as keeping up with depreciation (an index greater than 1) have positive operating and total margins than facilities not keeping up with depreciation (an index less than 1).
- A higher percentage of facilities that are keeping up with depreciation than facilities not keeping up with depreciation also were designated as hospitals with broad access to capital.
- A higher percentage of facilities not keeping up with depreciation than facilities keeping up with depreciation were designated as limited access.

Findings also show a relationship between profitability and the average age of plant, supporting the conventional wisdom that newer facilities are related to better operational performance, although which is the cause and which is the effect is not clear. Average age of plant for various levels of profitability in 2001

shows, in most cases, an inverse relationship between average age of plant and operating margin: the lower the average age of plant, the higher the operating margin (see Exhibit 13).

Comparing each of these categories of operating margin and age of plant with several key financial indicators yields the following observations:

- The greater the annual capital expenditure, the lower the average age of plant and the higher the operating margin.
- The median debt per bed is lowest for the highest-performing hospitals, suggesting they have used debt less often to finance their capital expenditures.
- The median debt per bed is highest for the lowest-performing hospitals, indicating that (a) the debt burden of these hospitals may be hurting their operating performance and/or (b) they have had no option but to issue debt to acquire capital.

The relationships among these variables are strong, but the direction of cause and effect cannot be determined. Suffice it to say that hospitals that are able to invest in property, plant, and equipment, as evidenced through high annual capital spending and low average age of plant, seem to experience higher profitability.

Exhibit 13

Capital and Profitability Evaluation, 2001						
Operation Margin %	<(10)	(10) to (5)	(5) to 0	0 to 5	5 to 10	>10
Median Age of Plant	9.3	11.1	10.3	10.0	9.7	8.4
Median Debt/Bed*	\$172.8	\$136.9	\$155.6	\$171.7	\$159.8	\$79.2
Median Capital Expenditures/Bed*	\$19.1	\$21.4	\$21.6	\$29.7	\$33.6	\$28.8

* Dollars in thousands

Source: *Financing the Future* project analysis, Solucient database

¹⁸ Operating and total margins were calculated as based on a five-year average from 1997 to 2001 in order to analyze the relationship to the future investment index that was calculated as a five-year average. The designation of hospitals into capital-access categories, although not based on a five-year average, considered the classification criteria based on 1997-2001 data.

5. How Do Hospitals Make Capital Spending Decisions?

Capital fuels the continuation and expansion of business. Businesses need to change with market and external conditions, with advances in technology and invention of new products, with the demographics and desires of their customers.

Similarly, hospitals need capital to weather the changes that drive their businesses: market competition, technology or regulatory change, and shifting consumer needs. For each external driver, an organizational

goal may require a capital response (*see Exhibit 14*). Typically, the external factors drive the internal process of defining what needs to be spent on capital.

The hospital industry to a large extent remains not-for-profit or public, and certainly all hospitals continue to serve the mission of providing health care in their marketplaces. However, a common misconception among the public, payers, and sometimes even health-care professionals themselves, is that a hospital can

Exhibit 14

Responses to External Drivers of Capital Need			
Category	External Drivers	Internal Goals	Capital Responses
Competition	<ul style="list-style-type: none"> • Strategic efforts by other area hospitals • Emergence of specialty providers • Shift of volume to physician offices and other outpatient centers • Payer shifts of volume to lower-cost providers • Scarcity of medical professionals • Shifting regulated and negotiated payment incentives 	<ul style="list-style-type: none"> • Protect existing volume and market share • Create opportunities to expand market share • Avoid loss of profitable programs to specialty providers • Attract and retain valued employees and physicians • Retool programs that become unprofitable as a result of shifts in reimbursement 	<ul style="list-style-type: none"> • Facilities renovation or construction • Equipment purchases and upgrades • Automation and enhancement of digital capabilities • Information systems and technology upgrades
Technology/Regulation	<ul style="list-style-type: none"> • Advances in technology • Advances in pharmaceutical therapies • Shift in procedures to outpatient settings • Bio-terrorism preparedness • Privacy and security 	<ul style="list-style-type: none"> • Retain key physicians • Improve physician and patient satisfaction • Enhance quality of care and patient safety • Comply with regulatory mandates • Maintain community safety net services for health emergencies 	<ul style="list-style-type: none"> • Equipment purchases or upgrades • Process redesign around new equipment and treatment modalities • Renovations and expansion of ambulatory capacity • Joint ventures around ambulatory capacity • Implementation of digital capabilities
Consumers	<ul style="list-style-type: none"> • Rise of consumerism in selection of healthcare providers • External reporting of quality and safety data • Extension of life expectancy • Aging population that uses more services • Shifting regional demographics 	<ul style="list-style-type: none"> • Invest in programs and services for the changing needs of an aging population • Communicate quality externally • Report external information accurately 	<ul style="list-style-type: none"> • Facilities renovation or construction • Equipment purchases or upgrades • IT/IS enhancements to reporting

operate at a break-even point as long as it is covering its day-to-day cash needs. But the reality is that, to access capital when a hospital needs it, the hospital must have the same sort of fiscal health as any other industry. A KaufmanHall white paper notes:

Gone are the years of pursuing strategic missions centered around the improvement of health in local communities without financially sound business plans that generate profitable bottom lines. The hospital industry has crossed over from a “public,” mission-driven operating model to an operating model that closely resembles that of corporate America.¹⁹

So how do hospitals go about determining whether and how to spend capital? Has the capital decision-making process changed over time? How do hospitals know how much they have to spend? How do hospitals improve their access to capital? How do they calculate the potential return on a project? How do they know if they achieve that return? The following sections answer these questions.

Strategy and Capital Spending

Progressive organizations demonstrate a clear link between strategic and capital planning. In such organizations, a CFO does not merely receive a series of wish lists for capital projects. Rather, a strategic plan for the organization’s future success drives capital planning and spending. Such a plan addresses community needs, competitive strategy, physician resources, workforce changes, and opportunities for improved profitability, and sets a clear financial path to achieving those goals, a path that involves creating the balance sheet necessary to access the capital needed for growth.

Robert Richards, CFO of Good Samaritan Hospital, Lebanon, Pa., concurs. “Tight operational results are challenging the capital budgeting process,” Richards says. “We have had to become more collaborative internally between finance, operations, and planning.”

Liz Alhand, CFO of Presbyterian Healthcare Services in Albuquerque, N. Mex., points out that linchpins of the capital budgeting process from 20 years ago are disappearing and being replaced by more informed prioritization processes. “Bartering is the worst mistake we used to make—‘I’ll approve this if you’ll support that’—followed closely by disguising a bad financial decision by putting the label ‘mission’ on it.”

Hospital senior management teams are trying new strategies and tactics to foster growth. “New program investing is now a separate process from basic capital budgeting,” says Barry Rabner, CEO of Princeton Healthcare System in New Jersey. “We evaluate new programs mostly by contribution margin as well as fit with mission and strategy. We try not to make new projects compete against one another. Although we have a limited pool of capital, like everyone else, we are committed to finding the capital for projects that make sense to our financial results and overall strategy.”

Several executives pointed out the difficulty in knowing what is the next generation of technology and what is merely hype. They expressed concern about being too far ahead of the curve in implementing new technologies.

“Sometimes we see it in a trade magazine,” says Alhand, “and we have to have it. That’s not an effective way to figure out what you want to invest in next.”

The Capital Allocation Process

So how do CFOs and their senior management counterparts go about putting together a list of potential capital projects? Jason Sussman of KaufmanHall recommends the batch process. “It’s most effective to be able to prioritize your expenditures if you have them consolidated as one comprehensive portfolio,” he says. “With a complete inventory, a consistent method for determining return, and direct linkages between each project and a related strategy, you can more easily make decisions that complement one another.”

¹⁹ Kaufman, Kenneth, “Corporate Finance: A New Management Paradigm for Hospitals,” KaufmanHall & Associates, Northfield, Ill.

Marty Manning, vice president, operations, finance, Advocate Health Care, Oak Brook, Ill., concurs. “Once you have the full list together, you can arrange a multi-year plan. You can prioritize what needs to be done now and what happens later. You can plan for the items you know are approaching. It is important to develop a long-range projection of the demands on cash that projects approved today create to ensure you don’t create a cash crunch in future years. This is particularly true for projects such as construction projects that have a long lead-time. It is important that you do not eclipse capital capacity for future years by over committing in projects today.”

An informal survey of CFOs in the industry indicated there are wide differences in the amount of effort that goes into the assembly of the list of capital projects and the range of parties that are involved in its assembly. The variation tended to be linked to size and complexity of the institution. Variances occur in:

- **Timing:** batch or periodic?
- **Team:** who provides input or requests capital? Physicians, department heads, strategic planners, business development executives, finance, the CEO, the board?
- **Categorization:** how are projects defined? How much capital is allocated to various categorizations of capital spending?
- **Assessment:** how are projects assessed, and how are they compared against one another and prioritized?

The CFO’s role seems to be threefold. First, as part of the senior management team, the CFO contributes fully in overall strategic planning for the organization, always with an eye on the financial ramifications. The second role is to drive the capital planning process, maintain the rigor around assessment, keep everyone honest, and serve as “quarterback” of the capital planning team. The third role is the quantitative role: understand debt capacity, provide a consistent methodology for assessing return on individual projects, and generally support the decision-making process.

Depending on the size of the organization, this role can be played by the CFO or by as much as a whole department dedicated to capital and financial planning.

Organizing the List

Now the list has been prepared—and it’s long. How does the capital planning team go about organizing the list for effective decision-making?

The internal goals that result from the external drivers tend to form a pattern around strategy, quality, profitability, competition, and regulation. And the capital responses fall into a limited set of categories: facilities renovations and construction, equipment purchases and upgrades, and IT and systems enhancements.

Each of these different investments can have a very different “return.” Ideally, the return is financial-revenue generation or operational efficiency. But in some cases, the return is the avoidance of a financial loss; in other cases, the return is compliance with a mandate. Management’s challenge is to balance the different types of return.

Financial executives interviewed for this report provided insight regarding the categorization of proposed capital expenditures. While the terminology used by each hospital differs, the categories of proposed projects could be identified as:

- **Strategic:** expenditures that further an organization’s long-term goal for success, such as the enhancement of quality or expansion into a new line of service; best practices would suggest that these initiatives generated a financial return by default, since otherwise they would not have become strategic goals of the organization.
- **Revenue-generating:** investment in expansion or creation of new revenue-generating activities; many hospitals had a centralized process for assessing the financial impact, so that competitive projects could be assessed on a level playing field.

- **Mandated:** capital expenditures that meet a regulatory requirement; examples are the seismic safety retrofit laws in California, Health Insurance Portability and Accountability Act (HIPAA) technology upgrades; this category can also include initiatives that are not required yet necessary to meet various patient-safety and quality initiatives.
- **Infrastructure:** structural items that need to be replaced, such as roofs and chillers; the replacement is typically budgeted outside of a competitive capital review process.
- **Minor routine:** typically, the purchase of equipment or upgrades that fall under a certain dollar level that varies among providers; some hospitals indicated they required a return on these minor expenditures, while others indicated the expenditures were at the discretion of department heads or vice presidents.
- **Major routine:** purchase or upgrade of equipment and systems that fall above the certain dollar level that has been established for discretionary spending; there may be significant overlap with this category and revenue-generating investments, as hospitals look to cover the cost of the investment with enhanced efficiency or increased throughput.

Narrowing the List

So what happens when a hospital has identified more infrastructure or routine replacements needs than revenue-generating or strategic needs? Or when there is not even enough capital capacity to meet the most urgent of needs?

KaufmanHall's Jason Sussman states the issue another way: "It is important to create a total portfolio that generates a positive return. If the entire portfolio of projects is focused on replacement and infrastructure, you'll never create the new cash flow necessary to reach your strategic goals as an organization. Essentially, you'll forever be in a mode of consuming rather than creating capital, not allocating the capital to initiatives that allow you to increase capital over time." The *now* versus the *future* dilemma is ever present, as hospitals try to narrow their lists of capital needs and create a capital plan to fulfill them.

"We never get to the bottom of the list," said Marty Manning of Advocate Health Care. "No matter how we prioritize and how much we spend, there is a bottomless pit of capital requests."

Exhibit 15

ABC Health System Capital Project Scoring Criteria and Weights		
Benefit Area	Criteria	Sample Weights/Scoring
Strategic/ Market	Fit with key strategic goals	0.5 point for each strategic goal met
	Support of clinical priorities	1 point if yes, 0 if no
	Effect on market position	1 if market share gain, -1 if market share loss, 0 if no change
MAXIMUM SCORE: 5 WITH SIX GOALS		
Financial/ Operational	Revenue potential	2 points for positive revenue impact
	Achievability of operating savings	2 points if yes, 0 if no
	Capacity to increase productivity	2 points if yes, 0 if no
	Return on investment	2 if >10%, 0 if 0-10%, -2 if <0%
	Level of investment	0.5 for every \$x million in costs
MAXIMUM SCORE: 8 IF NO CAPITAL COST		
Stakeholder/ Community Impact	Effect on quality of care	1 for improvement, 0 for no change
	Effect on patient satisfaction	-1, 0, or 1 depending on level of improvement (negative to positive)
	Level of medical staff support	-1, 0, or 1 depending on level of support (negative to positive)
	Increases employee satisfaction	-1, 0, or 1 depending on amount of change (negative to positive)
MAXIMUM SCORE: 4		

Source: Johnson, Tracy K., "The Capital Challenge: Needs versus Resources," *hfm*, May 2003, pp. 62-68.

CFOs and others involved in the capital budgeting process used terms such as “balance,” “rigor,” and “discipline” to describe the way they categorize and assess capital projects.

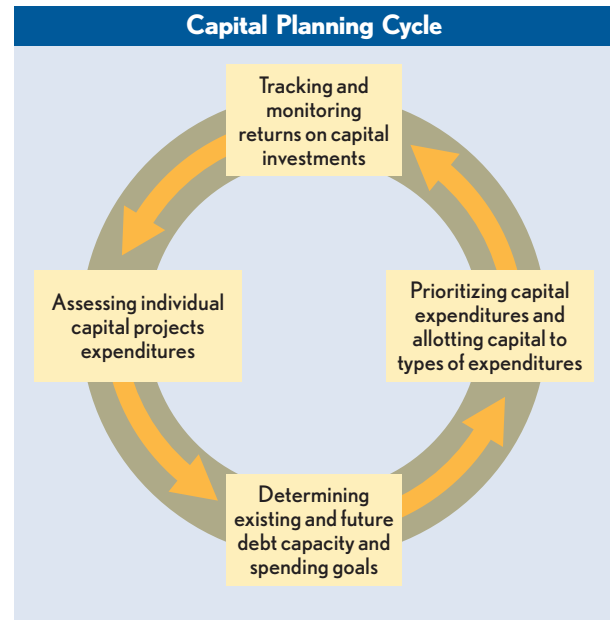
“We weigh our requested capital projects against a variety of criteria,” said Mike Vaci, director of finance at Northwestern Memorial Hospital in Chicago. “One of the primary factors is scoring the project against our main goal of providing the best patient experience. Sometimes projects like facility renovations score highly on this criterion, but don’t generate a financial return. They must be balanced with other projects that generate enough financial return to meet our overall hurdle rate. Achieving the hurdle rate is critical for the long-term financial viability of the organization and our ability to best serve our patients. We rely on the capital committee and this process to select the projects that will benefit the hospital and its patients the most.”

The process for assessing potential capital projects varies widely in complexity and duration. The chief consideration, according to many CFOs interviewed, is the financial impact of the project, regardless of whether it generates a prospective return or not. The return can be, as noted earlier, the avoidance of a loss in patient revenues, or the retention of physicians, or some level of operating efficiency from a plant or equipment upgrade, even if it’s “merely” replacement.

Beyond purely financial considerations, CFOs cited the following issues that could be “scored” in assessing a capital project (see an example in Exhibit 15):

- **Urgency:** is it broken? Is it vital to patient safety or regulatory compliance? Is someone else going to build it if we don’t? Is there a certificate-of-need deadline or moratorium approaching?
- **Human resources:** does the hospital have access to people who can implement the project? Are they in the marketplace at all? Does the project replace scarce resources?
- **Organizational readiness:** can the hospital implement the project? Is the timing right? Are there too many other competing initiatives going on?

Exhibit 16



Several steps are common to most organizations and provide an overview of the key decision points in the process (see Exhibit 16).

The variation in individual hospitals’ capital spending decision-making processes has to do with the parties that are involved in each step, the tools they use, the extent and complexity of the process itself, and special considerations for different types of organizations (see Exhibit 17).

The Final Decision

“The reality is that no matter how much analysis you put around the capital process,” says Peter Markell, CFO of Partners Healthcare System in Boston, “the final decision is always a ‘dog fight.’ There are always judgment calls and negotiations that take place, because project assessment is an art, not a science.”

Other CFOs agreed, and many felt the success of the decision-making rested on the integrity of the process. They cited two issues that seemed consistently

Type of Organization	Special Considerations and Challenges
Academic	<ul style="list-style-type: none"> Healthcare needs for service expansion and replacement may compete with academic needs (e.g., dorms). Perception by capital markets of being an "academic" credit vs. a "healthcare" credit may result in limitations on debt capacity, although in some instances, the large endowments on the academic side may also increase the debt capacity of the organization as a whole.
System-affiliated	<ul style="list-style-type: none"> Competition for overall funding against other system hospitals or other sectors of an integrated delivery system (e.g., physicians, post-acute care) Debt capacity may be enhanced as a hospital within a system with overall debt capacity even if you have none based on your own financial results.
Stand-alone	<ul style="list-style-type: none"> Debt capacity may be limited because of the perception that there is no "deep pocket" to bail you out in times of financial distress.
For-profit	<ul style="list-style-type: none"> Hospitals may need to balance need for profit against community need driving programmatic decision-making.
Rural and critical access	<ul style="list-style-type: none"> The ability to invest in traditionally profitable services may be limited by low need for those services in the community. FHA has recently begun to emphasize mortgage insurance for critical access hospitals, which may result in more capital in that sector than its stand-alone financial results would justify.
Urban	<ul style="list-style-type: none"> Excessive competition for services in a community may force decision-making as a defensive rather than strategic measure.
Teaching	<ul style="list-style-type: none"> Teaching need for various services and venues may drive decision-making on programs instead of financial and strategic return. The organization may be focused on maintaining "state-of-the-art" status on most equipment, which can skew the capital allocation process.
Financially distressed	<ul style="list-style-type: none"> Debt capacity is most likely limited because of financial condition. Medicare capital reimbursement may be used to fund operations rather than capital acquisitions, replacement, or upgrades because of pure cash management challenges. "Capital" may be used to pay down major liabilities before spending on fixed assets.
Public	<ul style="list-style-type: none"> Capital constraints can be imposed by regulatory or municipal agencies that sponsor the hospital. Capital may also be provided, without required payback, for certain projects, thereby increasing capital spending without increasing the debt burden. Government affiliation may result in higher capital spending per project because of constraints around contracting and purchasing, or the mandated use of governmental agencies to manage construction.
Religiously affiliated	<ul style="list-style-type: none"> Religious and ethical imperatives may preclude hospitals from investing in some profit-making ventures, largely around fertility. Capital may be supplemented through philanthropy as a result of mission.

to determine the credibility of the capital allocation process: stakeholder involvement and leadership. If there are major stakeholders in the hospital, frequently physicians, that have not been included at some stage of the capital planning process, then some will always claim their requests were not heard. And if the leadership—generally the CEO, sometimes the board—allows negotiation to happen outside of the process, then those who took part in the planning wonder why they bothered.

Of course, these ideas do not suggest that the CEO has no “slush” fund or that everyone needs to sit on the capital planning committee. There will always be times when unanticipated opportunities or needs arise that require capital, and most organizations allow for this situation in their overall spending. As far as stakeholder involvement, what is important is not that everyone directly participates, but that everyone has the opportunity to submit requests and feel represented during the capital planning process.

Typically, the medical staff can feel under-represented during the capital planning process, which is clearly not in the hospital’s best interest. CFOs we interviewed offered the following practical suggestions for including them:

- Reinforce the message that medical staff can and should submit requests along with everyone else in the organization.
- Meet with the medical executive committee or other chiefs to make them aware of the process.
- Communicate the broader message of the goals the hospital is set on achieving and how this drives the capital allocation process.
- Involve physicians in evaluating and prioritizing capital projects.

The ultimate decision on capital spending rests with the board. But how involved the board members have been during the process, and how much they understand the implications of their decisions, can vary from hospital to hospital.

“The most frequent mistake made by boards in capital decision-making is to miss the relationship between profitability and capital access,” says Mike Williams, president and CEO of Community Healthcare Corp., a Texas-based organization that operates not-for-profit hospitals that have been targeted by for-profit systems. “Access to capital is a reflection of one thing—operating efficiency. And if your capital projects can’t show increasing operating efficiency through cost reduction or revenue enhancement, you’re not meeting your hospital’s strategic business goal of generating ongoing capital.”

Boards and senior management teams, as well as their internal capital planning teams, frequently rely on external advisors. “We don’t do bond deals or other financings every day,” says Robert Richards of Good Samaritan. “The external advisors give us perspectives we might not think of on our own, from their experiences with other deals in other markets. We hire them for an honest opinion, not just to get a deal done. And they know the details—the bond covenants, what to say to the rating agencies, the hot issues.” External advisors can include investment bankers, financial advisors, feasibility or planning consultants, and sometimes the lenders themselves. When a credit enhancer is involved in the potential financing of a purchase, they may also offer advice, although it sometimes comes in the form of a critique of the submitted business plan. Advisors can be used to answer a number of questions, but the following questions should be kept in mind when selecting financial advisors and determining their scope of work:

- How will they be paid and will the payment arrangement affect the objectivity of their advice?
- Are they licensed or do they follow industry guidelines for the information they are preparing?
- Have they performed similar analyses in the past that resulted in successful purchases or financings?

Despite the use of both internal and external advisors, the ultimate decision typically rests with the board upon the recommendation of the CEO. Many not-for-profit boards are composed of well-intentioned lay people who may or may not have the skill sets to understand the financial and operational implications of their capital spending decisions.

The CFO can play a critical role in board education—about the specifics of the projects, the operating implications, the financing structure, potential risks and probabilities of not achieving the projected rates of return, and critical success factors.

“Sometimes the best help we can give our board members is to teach them to ask the right questions,” says Domenic Segalla, CFO of the North General Hospital in Harlem, N.Y. “Of course, once they learn, you may have to answer more difficult questions. But ultimately, the process benefits the organization as a whole, and that’s to everyone’s individual benefit.”

Living with Your Capital Spending Decisions

So now you’ve spent the money and implemented the project. How do you know if this was the right choice? The analysis involved in your decision-making process provides the first step in monitoring results:

- Compare actual results to projected.
- If the actual results vary, drill down on details in such areas as projected volumes, cost savings, operating indicators, and revenue per volume.
- Work with operations management to make sure that the comparison has been portrayed accurately.

When monitoring shows significant variances in any of these areas, the variance may be the result of incomplete implementation, poor estimation, or unforeseen circumstances.

Incomplete implementation. Identify areas of greatest financial impact for specific restructuring attention. An example would be the automation of a billing process that was supposed to result in FTE savings. The billing department manager may not have completed the reduction in FTEs. Or once the implementation was complete, the department head may have decided

to retain the FTEs for other areas of focus, like cash acceleration. In the second instance, the comparison of actual to projected savings would have been misleading because the FTEs had been “reduced” in their original function and applied to another function, thereby achieving the goal of the initiative, but potentially increasing costs in another area.

Poor estimation. Ensure that the monitoring data is consistently reported against the projected information. As with the example of the FTEs that had not been reduced in the billing department, the data may not accurately reflect the actions that occurred as a result of the initiative. Communication between finance and operations is vital to resolving these consistency issues.

Unforeseen circumstances. Work with operations to find alternatives to combat the unforeseen circumstances. In most cases, the original analysis should have foreseen a number of potential risks associated with the project, so there may already be alternatives to consider.

One of the critical features of a successful capital project is that it has a viable exit strategy. A hospital may want to establish an amount of time to meet specific returns and calculate the ongoing return. Contracts that are established with clinicians and vendors should consider specific “out” clauses for the hospital as well as the contractor. The hospital also should consider what to do if the investment does not work out from a political and community perspective, because it is always hard to close a service and take something away from the community, even if the community has not really used the service.

“There’s no shame in making the wrong decision based on the information available at the time,” says Liz Sweeney of Standard & Poor’s, who rates hospital credits, in part, on the financial performance generated by their past initiatives. “What’s important is the exit strategy. Hospitals have the tendency to stay in every line of service they enter, without regard to continued financial performance. A demonstrated track record of admitting a mistake, cleaning it up, and moving on is valuable context for the rating process.”

6. Steps toward the Future

Hospitals all over the country are acquiring fixed assets. There are clear state-by-state distinctions in spending trends, which suggests some linkage to regulatory or competitive environment. Nonetheless, even hospitals in states with the most limited access to capital are in fact replacing aging plant and equipment, although they may be doing so at a higher cost of capital.

So what is the “right” investment in capital assets for a hospital? Is it annual depreciation or something higher or lower? How does the CFO decide?

Individuals we interviewed offered a number of practical suggestions to consider:

- *Know what you want to be when you grow up.* Each hospital should have a financial picture of its ideal future. The picture may be different for each hospital. Some may focus on break-even cash flow or operating margin as a first goal. Others may focus on strengthening their overall balance sheet or targeting specific goals for a credit rating. Nonetheless, it is necessary to have a goal in order to determine how an individual capital initiative fits with your future.
- *Know how each potential capital initiative helps meet your future goals.* There are many different ways of interpreting ROI. A project can generate a positive cash flow or margin. It can avoid a potential loss of volume and revenue. It can be a loss-leader that generates growth somewhere else. The point is, if it doesn't generate a return that gets you to your ultimate goal, you need to strongly reconsider the investment.
- *Know how to make mandatory investments part of the return.* Sometimes you need to invest in administrative or infrastructure initiatives. The way to look at the return is to ask, what if you don't make the investment? Will you be subject to government penalties?

Will you be unable to communicate with insurers? Will the roof cave in? Most mandatory investments have a silver lining if you look hard enough, such as potential streamlining of billing operations as a result of certain HIPAA requirements.

- *Know the story you want to tell.* Lenders and credit enhancers all spoke about the “story” as being the most compelling piece of information in accessing capital. If the business plan is sound and convincing—and you've convinced yourselves!—then you may have more access to capital than you think.

The senior financial executive can play a vital role in the education of all decision-makers in the organization. You can guide the process, set parameters for discussion, educate those who request capital in how to make their case, and educate the board and other senior management team members on the financial and future implications of their decisions.

The first two *Financing the Future* reports have shown diminishing capital access and inadequate capital spending in recent years. That's the present. But what about the future?

The next *Financing the Future* report, to be released March 2004, will begin examining the future of capital need. This report will forecast hospitals' capital needs for the next five years, identifying critical areas for investment, anticipated expenditures, and factors likely to affect capital access. The report will include tools to help hospitals identify, quantify, and plan for their own capital needs. The following report will cast a critical eye on future capital access, with tools to help hospitals secure and manage the capital they need to finance their futures.

Visit *Financing the Future* on the web at www.financingthefuture.org to keep abreast of the latest tools, cases, news, and analysis.

To learn more, contact the Healthcare Financial Management Association at (800) 252-HFMA (4362) or visit the Financing the Future website at www.financingthefuture.org.

financing the future

Financing the Future is a year-long project that will give healthcare professionals the perspective and tools necessary to meet the capital challenges of today and tomorrow. Led by the Healthcare Financial Management Association (HFMA) in partnership with GE Healthcare Financial Services and with research conducted by HFMA and PricewaterhouseCoopers, Financing the Future is bringing together key stakeholders in the industry to quantify capital need and access, identify best practices for capital planning, provide tools for determining capital need, recommend innovative techniques for capital access, and suggest areas for policy change. www.financingthefuture.org



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HFMA is the nation's leading membership organization for more than 33,000 healthcare financial management professionals employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant. HFMA offers educational and professional development opportunities, information on key issues, technical data, and networking opportunities with the ultimate goal being to create a more supportive environment in which members do their business. For more information, visit HFMA's web site at www.hfma.org.



GE Healthcare Financial Services

GE Healthcare Financial Services, a unit of the General Electric Company, is the premier provider of capital, financial solutions and related services for the global healthcare market. With \$10 billion in assets, GE Healthcare Financial Services offers a full range of financing capabilities from equipment leasing and real estate financing to working capital lending and vendor programs. With a dedicated focus and a deep knowledge of the healthcare industry, GE Healthcare Financial Services collaborates with customers to create tailored financial solutions that help them improve their productivity and profitability. GE Healthcare Financial Services' web site is www.GEHealthcare.com. "GE Healthcare Financial Services is committed to providing solutions for healthcare organizations around the world, tailoring financial products and services to each of our customer's needs and situations," said Rick Wolfert, President and CEO of GE Healthcare Financial Services. "By working with HFMA on 'Financing the Future,' we will learn more about healthcare organizations' current and future capital needs, as well as available sources of capital. The information will benefit everyone; we'll be a more knowledgeable lender, our customers will be better informed borrowers, and the healthcare industry can begin to improve its financial health."



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