hospitals were downgraded and another 10 were being monitored for downgrade at the end of 2008 while only 27 hospitals were upgraded. Factors that led to the downgrades—increasing bad debt, decreasing volumes of elective care and mounting investment losses—are expected to continue and intensify. A persistent economic recession will further undermine financial performance and credit quality will likely deteriorate.

As a result, healthcare issuers are facing higher costs and less access to capital. Credit spreads have increased dramatically across the spectrum. The healthcare municipal credit curve has risen more than 1.4% for AAA bonds, 2% for AA bonds, 2.8% for A bonds, and 3.5% for BBB-rated bonds over the last two years. Pricing for credit support has jumped three to more than four times over the same time period. The estimated average pricing for a liquidity facility was 12.5 basis points in 2006/2007 for AA-rated healthcare organizations. It is now approximately 80 basis points. For BBB-rated organizations, there is a 140 basis point difference in pricing from 2006/2007 to 2008.

The Banking/Healthcare Partnership

In an environment where credit is costly and scarce, hospitals and healthcare systems will benefit by forging long-term relationships with banks that can provide a range of financing options. Long-standing relationships between Providence Health & Services and Shands Teaching Hospital and Clinics and their bankers allowed the healthcare systems to move quickly when they had to refinance failing auction-rate securities. Merrill Lynch helped Providence Health & Services dampen the short-term effects of the collapse of the auction-rate securities market and still develop a plan for long-term deliberate action. A Bank of America letter of credit helped Shands Teaching Hospital and Clinics replace $125 million in auction-rate securities with a VRDB.

The quality and size of a bank partner makes a difference because some banking institutions will not be able to provide credit in the face of a deteriorating balance sheet. In 2008, three of the top eight investment banks — JP Morgan Chase &Co, Bank of America and CITI — provided 70% of the credit capacity in the market. Bank of America lead all banks as a provider of letter of credit and liquidity in all sectors as well as in healthcare. Bank of America leads all banks as a provider of letters of credit and liquidity in all sectors including healthcare.

A relationship with a large, well-rated bank will be essential for hospitals and healthcare organizations to provide flexibility to respond to today's uncertainties and plan for tomorrow's capital needs.

For more information about Bank of America's healthcare financial solutions, go to bankofamerica.com/healthcare.

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Meeting the Capital Markets Challenge in Healthcare

February 2009

As recently as February 2008, when the subprime mortgage crisis was beginning to stranglehold the credit markets, financial analysts felt that hospitals and healthcare systems would not be squeezed. Sure, lower-rated hospital credits would find it more costly to raise cash, but a full-blown credit crisis? Not for healthcare.

Then the bottom fell out. Investors lost confidence in bond insurers and the market for auction-rate securities failed. For a time, healthcare organizations were able to refinance auction-rate securities debt with variable-rate demand bonds (VRDBs) or standard fixed-rate bonds. In fact, healthcare borrowers issued more debt in the quarter between April and June than in any other quarter since 1990. VRDB issues between January and August 2008 were 312% higher than in 2007 and unenhanced fixed-rate issues were 171% higher. But in mid-September, the market for tax-exempt bonds eroded. In some cases short-term daily reset rates on VRDBs jumped up as high as 10%, VRDBs that had been tendered were not being remarketed to other investors, and for the most part only small bond issues were being completed. In October, 95% of the bond deals in the works for healthcare had been 'pulled,' and neither VRDBs nor long-term bond markets were working because skittish investors preferred to hoard cash or stash it in U.S. Treasuries.

In November, rating agencies revised their outlook for the hospital sector from "stable" to "negative." On top of investment portfolio losses that have weakened balance sheets and restricted liquidity and an economic downturn that will diminish reimbursement, the higher cost of capital is expected to depress operations and profitability for hospitals and healthcare systems for the next 12 to 18 months or perhaps longer.

The high cost and lack of access to capital is making it more difficult for hospitals and healthcare systems to find the cash they will need to upgrade facilities and technology. Interest payments on borrowed money have been as much as 15% higher, on average, during some periods of 2008 than they were in the same period in 2007, according to the American Hospital Association (AHA). As a result, hospitals are reconsidering or postponing investments in facilities and equipment. An AHA survey reported in November found that 56% of hospitals were delaying renovations or expansions, 45% were rethinking the purchase of clinical technology or equipment, and 39% were taking a second look at investments in information technology.

Financial stress, which is mounting because of lower rates of admissions and elective procedures and increasing uncompensated care as well as a tight credit market, is forcing a sizable percentage of hospitals and healthcare systems to begin planning reductions in staff or services. While some hospitals and healthcare systems are holding their own (see the profiles on Shands Healthcare and Providence Health & Services), 53% of hospitals will be cutting staff and 27% will be decreasing services to weather the economic storm, according to the AHA.

The Tipping Point: Auction-Rate Securities

Auction-rate securities, which were created in 1984 to merge favorable aspects of both long- and short-term bonds, had operated so smoothly and profitably, they grew to a $333 billion a year market for municipalities and organizations, such as hospitals, colleges and utility districts. The securities were considered safe for both issuers and investors; only 13 auctions failed between 1984 and 2006, because the investment banks that packaged and ran the auctions that determined bonds' interest rates typically stepped in and bought up securities if they could not attract enough buyers.

Continued

Bank of America

But the crisis in the mortgage market undermined the solvency of investment banks as well as the companies that insured bonds against default. When insurers could no longer assure investors they were going to back bonds, and investment banks stopped shoring up failing issues, the auction-rate securities market crumbled.

In the immediate aftermath, the collapse of the auction-rate securities market sent hospitals scrambling. Organizations with bonds that had failed auctions had to act quickly to avoid having to absorb high interest rates, and enter into often difficult and complicated debt restructurings.

Over the long-term, the loss of auction-rate bonds means debt financing will be harder to come by and cost more for healthcare organizations. The loss of bond insurance means the credit enhancement will have to come from banks through letters of credit.

SNAPSHOT OF NEW ISSUANCE VOLUME
(Par Amount in $ Millions)

	JANUARY - OCTOBER 2008		JANUARY - OCTOBER 2007	
	Par	% of Total	Par	% of Total
Fixed	$ 228,905.0	67.3%	$ 281,624.9	76.1%
Auction rate	–	0.0%	33,640.5	9.1%
Variable-rate (VRDB)	101,455.2	29.8%	36,146.7	9.8%
Variable-rate long/no put	6,056.3	1.8%	12,219.7	3.3%
Zero-coupon	3,529.8	1.0%	6,253.9	1.7%
Convertible	5.1	0.0%	416.0	0.1%
Total issuance	**$ 339,951.4**	**100.0%**	**$ 370,301.7**	**100.0%**
Fixed-rate credit-enhanced	59,881.5	26.2%	152,062.9	54.0%
Fixed-rate credit-unenhanced	169,023.5	73.8%	129,562.0	46.0%
Total fixed-rate	**$ 228,905.0**	**100.0%**	**$ 281,624.9**	**100.0%**
FSA	32,433.1	54.2%	33,959.7	22.3%
Assured	19,808.7	33.1%	1,411.2	0.9%
MBIA	1,539.3	2.6%	35,414.2	23.3%
Berkshire	2,595.5	4.3%	–	0.0%
Ambac	744.8	1.2%	35,325.5	23.2%
Radian	330.4	0.6%	1,758.0	1.2%
FGIC	250.2	0.4%	23,483.0	15.4%
ACA	–	0.0%	557.0	0.4%
CIFG	38.1	0.1%	3,503.6	2.3%
XLCA	35.6	0.1%	9,139.3	6.0%
Other credit enhancement	2,105.8	3.5%	7,511.4	4.9%
Total fixed-rate enhanced	**$ 59,881.5**	**100.0%**	**$ 152,062.9**	**100.0%**

Source: Thomson Financial.

The Next Wave: VRDBs

Anxious to get out of auction-rate securities, healthcare organizations turned to commercial banks for liquidity, and converted or refinanced auction-rate securities with variable-rate products that were backed by banks. Though market rates of VRDB debt instruments are lower now, they rose more than expected in 2008, and bank support has been restricted and costly, according to Moody's U.S. Public Finance. Variable-rate debt structure also has added risk. In addition to the put-risk associated with a failed remarketing when the bonds are put back to the bank or to the hospital for payment, Moody's in November 2008 identified other risks that had previously been thought to be low priority:

- Variable-rate bonds as well as commercial paper failed remarketing, and remarketing agents were not willing to take the bonds into inventory, obligating hospitals to pay off the bonds on accelerated terms under bank liquidity agreements.
- For the first time since self-liquidity programs were initiated, draws were made on VRDB or commercial paper backed by a hospital's own liquidity.
- Short-term interest rates spiked, particularly for weekly floaters in October.
- Long-term rates were higher and demand for fixed-rate hospital bonds was lower than anticipated.
- Bank liquidity became less available and carried tighter covenants and more restrictive terms for hospitals.

Moody's concluded that hospitals with significant cash reserves or completed capital plans should be able to handle the credit crisis by absorbing interest rate expense as a portion of their total expenses. But lower-rated hospitals that need to secure financing will have few opportunities to obtain capital at favorable rates.

Downstream Effects on Healthcare Organizations

Not surprisingly, the credit crunch is raising the cost hospitals and healthcare organizations have to pay when they borrow money to finance building projects, facility improvements or technology acquisitions. In a report prepared by the AHA, more than a third of hospitals (33%) noted that interest expenses for variable-rate bonds were rising. Interest expense in third quarter 2008 ($262 million) was 15% higher than it was in 2007 ($218 million). Just about equal numbers of hospitals faced increased collateral requirements (12%) or they suddenly were not able to issue bonds (11%), refinance auction-rate debt (11%), or roll over or renew credit (10%).

More than half of the hospitals (56%) have decided, therefore, to reconsider or postpone planned renovations or facility expansions. Forty-five percent of hospitals are deferring the purchase of more advanced clinical technology or new clinical equipment, and 39% are reducing their investment in information technology. The report, The Economic Crisis: Impact on Hospitals, included data from a survey of 736 hospital CEOs conducted between October and November 2008, as well as preliminary third quarter 2008 data from 557 hospitals and other sources.

Hospitals and healthcare systems have a constant need for capital to keep up with advancements, provide quality care and expand or improve treatment options for patients and remain competitive in their marketplaces. However, the ongoing credit crisis is making it extremely difficult for healthcare organizations to access debt markets. AHA has mapped out a series of strategies to ease the credit crunch. In the Road to Economic Recovery: a Proposal to Support Health Care in America, which was published early in January 2009, AHA makes four principal recommendations:

1. Strengthen the Federal Housing Administration's Section 242 Program. The Section 242 Hospital Mortgage Insurance construction program insures mortgage loans for the construction, rehabilitation, replacement and equipping of hospital facilities, as well as the refinancing of related existing debt. It has supported more than 360 financings totaling more than $13.5 billion in 40 states since 1968. AHA believes the program can help ease the credit crunch for many hospitals by covering more types of facilities and services; reduce the cost of financing for new technology by using Ginnie Mae real estate mortgage investment conduits to insure

Continued

Shands Teaching Hospital and Clinics: Capital Planning for Today and Tomorrow

Shands Healthcare is a Florida-based healthcare system that includes two academic medical centers, two specialty hospitals and four community hospitals in a triangle encompassing Orlando, Jacksonville and Gainesville. Like many healthcare organizations, Shands Healthcare is spending wisely and paying careful attention to commitments.

Unlike many other healthcare organizations that are retrenching as a consequence of the capital crunch, Shands Healthcare is able to proceed with construction of a 192-bed cancer and emergency medicine center, which is scheduled to open in late 2009. But that is because financing for the project was secured in 2007. The healthcare system borrowed $225 million early in 2007 and another $125 million in November of that year. The second financing was bond-insured auction-rate securities. As an A-rated organization, Shands Healthcare found liquidity when it needed to refinance the auction-rate securities in February 2008 with a bank letter-of-credit-enhanced demand obligation. The letter-of-credit-backed variable-rate demand loan, which has been remarketed in different amounts with different maturities, has bridged the gap between dailies and long-term bonds. The objective, said William J. Robinson, vice president and CFO, is to continue removing volatility risk from the capital structure. "I had a couple of opportunities to take a variable-rate product and put it back in the market as fixed. I did that simply to reduce some of the volatility. Every time I have an opportunity, I have been moving in a more conservative direction," he said.

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Trending forward five or 10 years, Robinson expects other major projects will be in the works. But for now, Shands Healthcare is concentrating on securing financing for routine capital needs, which fall between $60 million to $75 million a year, through operating cash flow. Robinson would prefer to stay out of the debt market for the time being. "The only real options right now are unenhanced fixed-rate debt, and the market is not settled enough to do that in a predictable way," he said. "If you have to borrow money, you can do it at unattractive rates for the borrower. You also have to give up an extended no-call period, so you are locked into those rates for a while. So if you can avoid it, I would stay out of the market for the next year," Robinson said.

Providence Health & Services: Weathering the Auction-Rate Securities Market Collapse

Providence Health & Services, Renton, Wash., is a multistate, not-for-profit healthcare system that operates in five states: Alaska, California, Montana, Oregon and Washington. It has 26 hospitals, 10 long-term care facilities and a variety of other facilities that earn in excess of $6.5 billion in revenues a year.

At the beginning of 2008, Providence Health & Services had approximately $1.6 billion in outstanding long-term debt that was divided in half, with 50% in variable-rate securities with periodic reset dates and 50% in fixed-rate bond issues. When the auction-rate securities market toppled, Providence Health & Services had about $700 million in 14 series in multiple states that had to be addressed.

"My immediate goal was to preserve cash and as much flexibility as possible. Some of the solutions were never meant to be long term."

Just the day before the market actually collapsed, Sue Painter, system director, chief investment officer/treasurer, along with healthcare system attorneys and bankers, reviewed the indentures on all the outstanding bond issues, prioritized those that would cause the most problems and moved as quickly as possible to avoid the effect of adverse rates, but still developed a plan for deliberate action over the long term. "My immediate goal was to preserve cash and as much flexibility as possible. Some of the solutions were never meant to be long term," Painter said.

To "stem the bleeding," Providence Health & Services closed 10 transactions within six weeks. The remaining four issues were not immediately refinanced because they still had attractive interest rates based on formulas rather than failure rates.

The refinancings took a variety of forms. Three series of bonds in California were converted into long-term fixed-rate debt. Four series in Oregon were converted into different types of variable-rate modes under existing documents to take advantage of the most attractive pricing mechanism at the time. In one case, the auction period on existing debt was extended for nine months, the bonds were wrapped into a trust and the trust certificates were sold with a hard tender. Three series of taxable auction-rate securities were redeemed with taxable commercial paper. "We have $200 million in commercial paper outstanding, so a quarter of our debt is in the variable mode, but we are managing it differently," Painter said.

With three series of fixed-rate bonds that closed the first week of November, Providence Health & Services was the first healthcare organization to return to the debt market after a four- to six-week period when no healthcare bonds were issued, according to Painter. The issues were well-received because the healthcare system is highly rated, financially strong and familiar to investors. "We trade frequently; we issue at least once a year so we are known better than infrequent issuers. We also are a strong credit. When you have a crisis, investors are looking for names they know, organizations they trust and credits that are strong," Painter said.

borrowings; dampen mortgage reserve requirements by providing federal matching funds; free hospitals from an existing capital freeze by allowing them to refinance existing obligations that are not related to a construction or renovation project; and improve overall federal mortgage insurance operations by increasing funding for the FHA Office of Insured Health Care Facilities.

2. Create a new program for construction grants and credit subsidies for hospitals that cannot meet eligibility requirements for the Section 242 program, including community hospitals as well as hospitals that provide state-of-the-art tertiary care or research and training.

3. Back remarketing of existing debt. The lack of bond insurance and loss of the auction-rate securities market has restricted or made it extremely expensive for hospitals and healthcare systems to issue new financing to meet bond covenants or make payments on existing debt. Funding from the Term Asset-Backed Securities Loan Facility (TALF), which was announced by the Federal Reserve in late November 2008 and is partially funded under the federal Emergency Economic Stabilization Act of 2008, could be used to back hospital debt so it can be restructured.

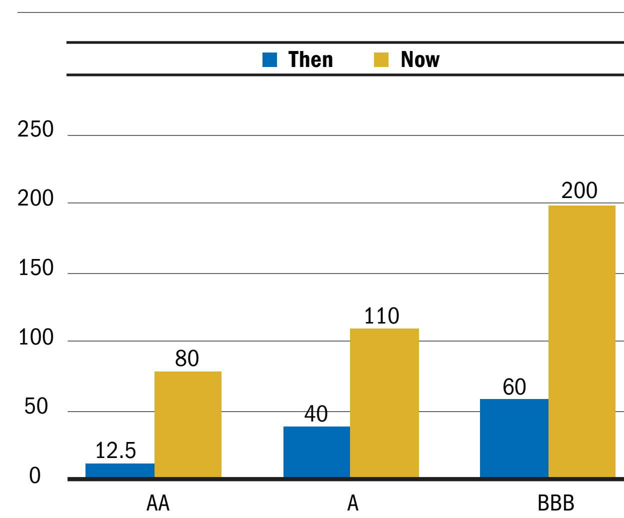
4. Create incentives to purchase tax-exempt bonds. Provisions in the Tax Reform Act of 1986 that removed incentives for banks to buy tax-exempt bonds should be lifted to help channel capital to infrastructure projects.

AHA believes these steps will increase the demand for municipal bonds and add liquidity to the market so hospitals across the country will be able to finance healthcare projects that promote the health not only of U.S. citizens and healthcare organizations, but of local, regional and national economies.

The Bank Perspective

Banks typically provide credit and liquidity in support of short-term debt for hospitals and healthcare systems in the form of letters of credit that back VRDBs. The market for healthcare letters of credit has been extremely tight, however, for reasons that mirror what has been going on in

Estimated Average LOC Pricing for Healthcare
2006 / 2007 versus 2008



Source: BAS Municipal Credit Syndications.

the overall banking industry.

Virtually every bank in the world has been damaged one way or another in the last 18 months because of the mortgage-related credit crisis. Individual banks have reported massive losses and significant declines in estimated value. On the lower end of the spectrum, losses ranged from $2.6 billion for Bear Stearns and $5.28 billion for Bank of America. On the higher end, loss amounts were $10.3 billion for Morgan Stanley, $22.5 billion for Merrill Lynch, and $24.1 billion for Citigroup. Writedowns as a percentage of shareholder equity were lowest for Bank of America at 9.5% and highest for UBS at 82.9%, among the top eight investment banks worldwide.

The overall banking sector and its involvement in public finance contracted significantly in 2008 and more mergers are expected. Among 14 major U.S. and European banks, five, including Merrill Lynch, were acquired by other financial organizations and five closed public finance in 2008. The crisis in the sub-prime mortgage market as well as the failure of the auction-rate securities market and downgrades of bond insurers, which raised liquidity risk, as a result has eroded bank balance sheets.

Meanwhile, the need for bank liquidity for short-term municipal issues of all types has grown significantly not only to meet ongoing capital needs, but also to support failing auction rate security debt. The need to refinance failed auction-rate

securities and overcome the loss of AAA bond insurance capacity caused a massive wave of supply to hit both the fixed- and variable-rate bond markets early in 2008. But the volume of fixed-rate bond issues decreased dramatically throughout 2008, and the market was sporadic as deals were getting done “by appointment only” or not at all.

A spike in the Securities Industry and Financial Markets Association (SIFMA) index from 2% to 8% in September 2008 then provoked a mass exodus of investor money from short-term municipal bond funds. Although the municipal market has normalized since then, there has been a decline in demand for VRDB transactions because of a high volume of tenders, inability to find enough new buyers for tendered bonds, high volume of non-remarketed bonds, and the requirement that bank holders of letters of credit or standby bond purchase agreements must pay the purchase price for tendered bonds.

The uncertainty and volatility of the bond markets have made banks less willing to assume risk and provide liquidity for the demand or put feature of VRDBs. Banks consequently are crafting covenants and terms more tightly and raising the costs of issuing letters of credit and providing liquidity.

The changes in the banking sector and bond markets are having a negative effect on hospitals and healthcare systems because healthcare is considered to be one of the riskier sectors in public finance. Even in good times, healthcare is viewed as one of the less desirable forms of municipal debt. While issuers with strong underlying credits will have access to the debt markets, hospitals and healthcare systems are expected to face a challenging financial future. As a harbinger, Moody’s Investors Service reported that the number of nonprofit hospital credit downgrades in 2008 had not been seen since 2001. Fifty-three

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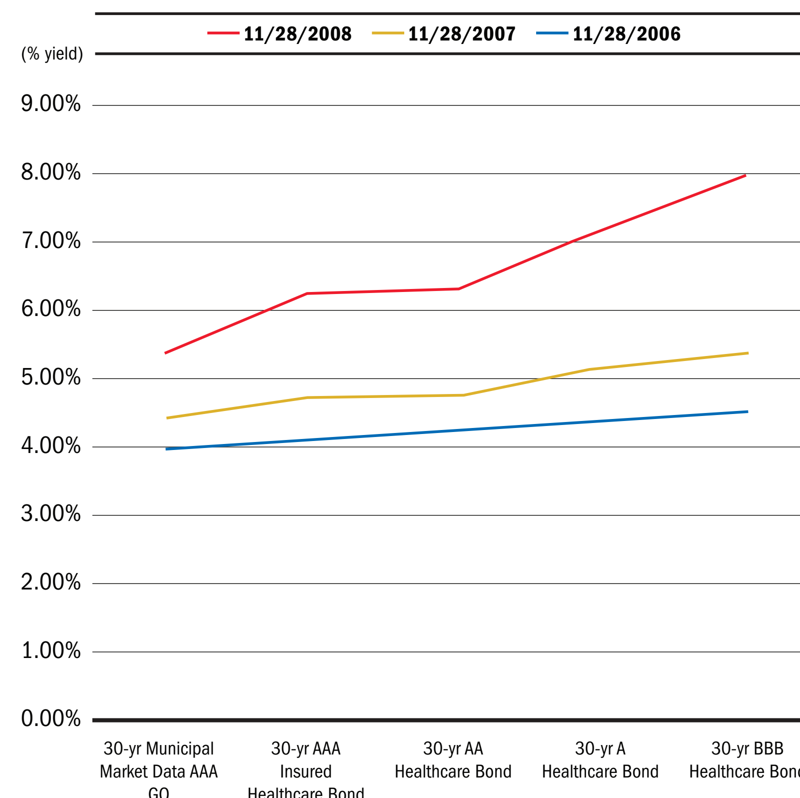
Impact of the Credit Crisis on Municipal Interest Rates
Credit spreads for healthcare borrowers at both ends of the credit spectrum have increased dramatically.

Healthcare Municipal Credit Curve



Spread Between AAA and AA Yields	
11/28/2006	0.27%
11/28/2007	0.36%
11/28/2008	**0.93%**

Spread Between AAA and A Yields	
11/28/2006	0.39%
11/28/2007	0.78%
11/28/2008	**1.81%**

Spread Between AAA and BBB Yields	
11/28/2006	0.55%
11/28/2007	1.01%
11/28/2008	**2.61%**

Rise in Absolute Yield Over Past 2 Years	
AAA Bond	1.42%
AAA Healthcare Bond	2.08%
A Healthcare Bond	2.84%
BBB Healthcare Bond	3.48%

Source: Thomson Financial. Data comes from both secondary and primary market sources.