February 4, 2013

TO: State Directors
Rural Development

ATTN: Community Programs Directors

FROM: Tammye Treviño *(Signed by Tammye Treviño)*
Administrator
Housing and Community Facilities Programs

SUBJECT: Guidance for Feasibility Analysis of Health Care Facilities

The purpose of this unnumbered letter and attachments is to provide guidance and information to Rural Development Field Offices to assist them in the financial and technical evaluations of proposals submitted by Health Care Facilities for Community Programs Direct and Guaranteed loan financing.

While this unnumbered letter is geared to Critical Access Hospitals (CAHs) the principles apply to all Health Care Facilities.

The information below will be helpful in several areas of financial and technical evaluations:

1. Financial Indicators (also referred to as ratios)

Based on a number of dockets reviewed by the National Office for concurrence, it was concluded that the overall quality of the financial feasibility reports submitted was less than desirable and would not suffice as the financial feasibility analysis required by CF regulations.

Understanding a loan applicant's strengths, weaknesses and competition is vital when making key financial decisions. Financial analysis is part of the financial decision making process. As a decision maker, you must be able to use the analytical techniques of financial analysis. Most hospitals, health systems, and other healthcare organizations routinely evaluate their financial condition by calculating various ratios and comparing the values to those for previous periods, looking for differences that could indicate a meaningful change in financial condition. Many healthcare organizations also compare their own ratio values to those of similar organizations, looking for differences that could indicate weaknesses or opportunities for improvement.

EXPIRATION DATE: [redacted]

FILING INSTRUCTIONS:
Community/Business Programs

Critical Access Hospitals

Comparisons with other organizations are only as useful as the degree to which the organizations are similar. Contrasting the financial positions for a Critical Access Hospital (CAH) with that of a major teaching hospital is not informative because the two hospitals have vastly different missions. CAH's face a set of challenges disparate from non-CAH hospitals, so the development of financial indicators specific to their environment is critical in performance assessment. Because CAH's tend to have a higher risk of financial insolvency, assessing their financial performance is critical for ensuring their long term financial survival. Therefore, one key element in financial statement analysis is the collection of financial data for similar CAHs.

The Flex Monitoring Team, comprised of staff from The Rural Health Research Centers at the Universities of Minnesota, North Carolina at Chapel Hill and Southern Maine, conducted a 2005 study that developed and disseminated comparative financial indicators specifically for CAH's using Medicare Cost Report data (Healthcare Report Information System). The study attempted to provide CAH administrators with a set of comparative financial indicators designed specifically for small, Medicare cost-based reimbursed hospitals. The study was a collaboration between a university-based research team and practitioners with expertise in the financial management of CAH's. Together both parties worked to produce financial indicators that CAH boards and management can use to improve the financial management of their organizations. The full 2005 report may be viewed or downloaded from the Flex Monitoring Team website at http://flexmonitoring.org/documents/BriefingPaper7_FinancialIndicators.pdf.

Among the identified 114 financial ratios that have proven useful for assessing financial conditions, only 21 indicators are currently deemed appropriate for assessment of a CAH's financial condition. These 21 indicators were selected based on the following financial performance dimensions:

Profitability
Liquidity
Capital
Revenue
Cost
Utilization

The most-recently available U.S., State, and Peer Group Quartile financial indicator ratios may be viewed or downloaded from the Flex Monitoring Team website: http://www.flexmonitoring.org/prodresults.php?field=1 . These financial indicator categories can also be applied to other Health Care Facilities. While some CAH-specific ratios may not be applicable to all Health Care Facilities, the same principles apply.

2. Formats

Generally, an independent financial feasibility study is required for Health Care Facilities' replacement, expansion, improvement or renovation which will result in a substantial change in scope. Based on a number of dockets reviewed by the National Office for loan approval concurrence, many of the financial feasibility reports submitted do not meet the requirements of the regulations and do not suffice as the analysis. Exhibit A of RD Instruction 3575-A is an outline that may be used as a guide for the preparation of financial feasibility reports. The guide is a basic format that contains minimal guidelines and the report's writer is expected to fully disclose and analyze all significant factors that may have a favorable or adverse effect on the

financial success of the proposed facility. Attachment 1 is a detailed format that contains guidelines for preparing feasibility studies for Health Care Facilities. The format offers sufficient documentation to determine economic feasibility as well as financial viability. In most cases, the financial evaluation and forecast must be supported by an **examination report** prepared by a Certified Public Accountant (CPA). The examination of historical and prospective financial information provided by the applicant must be prepared in accordance with the standards of attestation of the American Institute of Certified Public Accountants (AICPA), and culminate in an examination report on the reliability of the applicant's financial statements and management's underlying assumptions. A CPA's written report is held with confidence and supported by the reputation of the CPA and/or firm and further backed by professional liability insurance. The AICPA examination standards can be viewed or downloaded from the AICPA website at http://www.aicpa.org/Research/Standards/AuditAttest/DownloadableDocuments/AT-00301.pdf.

Per AICPA AT §301.29, the examination of prospective financial statements is a professional service that involves --

(a) Evaluating the preparation of the prospective financial statements.
(b) Evaluating the support underlying the assumptions.
(c) Evaluating the presentation of the prospective financial statements for conformity with AICPA presentation guidelines.
(d) Issuing an examination report.

The examination report should clearly document whether the examining CPA has a basis for reporting on whether, in his or her opinion:

(a) the prospective financial statements are presented in conformity with AICPA guidelines, and
(b) the assumptions provide a reasonable basis for the responsible party's forecast.

3. Technical Feasibility

Guide 6 to RD Instruction 1942-A contains an outline used as a guide when preparing preliminary architectural reports. A CAH prototype is available and technical staff is encouraged to utilize the CAH prototype as a guide to provide appropriate designs and help control project costs when reviewing proposals for CAH's and other Health Care Facilities. The prototype is available on the Health Resources and Services Administration (HRSA) website: http://www.hrsa.gov/ruralhealth/resources/criticalaccess/criticalaccessreplacement.html. Program staff should work closely with technical support staff when assisting applicants in the preparation of a sound architectural study.

4. Predevelopment Cost

Based on discussions with lenders, other agencies, and state offices a major issue is assessing the ability of Health Care Facilities to provide funds for predevelopment costs such as:

Preliminary architectural feasibility study
Financial feasibility study
Environmental analysis
Land and rights costs
Legal costs

In some cases the applicant has sufficient reserves. In other cases short-term financing or grants from other sources are obtained. It is important in early discussions with perspective applicants to discuss the requirement and sources of payment of predevelopment costs.

The overriding consideration should be that Rural Development funding of Health Care Facilities will result in financially and technically feasible projects which have substantial community support and are within the means of a community or non-profit entity to successfully own and operate.

If you have any questions, please contact Karen Safer in Community Programs at (202) 720-0974.

Attachments

CAH FINANCIAL INDICATORS

Attachment 1

Performance Dimension and Indicator	Significance and Definition	Median
Profitability Indicators	Measure the organization's ability to make a profit	
Total margin	Net income/Total revenues	2.33
Cash flow margin	((Net income - (contributions, investments and appropriations)) + depreciation + interest) / (Net patient revenue + other income - (contributions, investments and appropriations))	3.12
Return on equity	Net income / Fund balance	5.72
Liquidity Indicators	Measure the organization's capacity to pay its debts in a timely manner	
Current ratio	Current assets / Current liabilities	1.9
Days cash on hand	(Cash + marketable securities + unrestricted investments) / [(Total expenses-depreciation)/Days in period]	41.74
Net days revenue in accounts receivable	(Net patient accounts receivable) / (Net Patient service revenue / Days in period)	59.31
Capital Structure Indicators	Measure the extent to which an organization uses debt and equity financing	
Equity financing	Fund balance / Total assets	62.99
Debt service coverage	(Net Income + depreciation + interest) / (Current portion of long-term debt + interest expense)	2.77
Long-term debt to capitalization	Long-term debt / (Long-term debt + fund balance)	20.65
Revenue Indicators	Measure the amount and mix of different sources of revenue	
Outpatient revenues to total revenues	Total outpatient revenue / Total patient revenue	0.57
Patient deductions	(Contractual allowances + discounts) / Gross total patient revenue	23.40
Medicare inpatient payer mix	Medicare inpatient days / (Total inpatient days - Nursery bed days - Skilled Nursing Facility (SNF) swing bed days)	78.86
Medicare outpatient payer mix	Outpatient Medicare charges / Total outpatient charges	37.38
Medicare outpatient cost to charge	Outpatient Medicare costs / Outpatient Medicare charges	60.35
Medicare revenue per day	Medicare revenue / (Medicare days - Nursing Facility (NF) swing bed days)	1283.98
Cost Indicators	Measure the amount and mix of different types of costs	
Salaries to total expenses	Salary expense / Total expenses	45.65
Average age of plant	Accumulated depreciation / Annual depreciation expense	12.32
Full Time Employees (FTEs) per adjusted occupied bed	(Number of FTEs / [((Inpatient days - NF swing days - nursery days) (total patient revenues / (Total inpatient revenue - NF revenue - other Long Term Care (LTC) revenue))) / Days in period]	6.17
Utilization Indicators	Measure the extent to which fixed assets (beds) are fully occupied	
Average daily census swing-SNF beds	Inpatient swing bed SNF days / Days in period	1.51
Average daily census acute beds	Inpatient acute care bed days / Days in period	2.87

Attachment 2

Guidelines for Preparation of Financial Feasibility Studies Healthcare Type Facilities

Section I – Signed and Dated Opinion Letter

Section II – 5 years Historic and 5 years Forecasted Financial Statements and Schedule of Ratios

- Historical and Forecasted Statements of Activities and Changes in Net Assets
- Historical and Forecasted Statements of Financial Position
- Historical and Forecasted Statements of Cash Flows
- Schedule of Historic and Forecasted Ratios
  - See the Flex Monitoring report at: http://www.flexmonitoring.org/documents/DataSummaryReportNo9_StateMedians2011.pdf for a list of the 21 financial indicator ratios which must be included and how to calculate the ratios. The ratio analysis should be included as a Table to the examination report.
  - Include the financial indicator ratios for each of the most-recent 5 historical years as reported in the Hospital's "CAH Financial Indicators Report" (Flex Monitoring Team), and calculate the financial ratios for each year of the 5 forecasted years. Include in the Appendix of the examination report the Hospital's Flex Monitoring Team "CAH Financial Indicators Report" for the most-recently reported year.
  - Determine the correct Peer Group for the applicant CAH. For each ratio show how the applicant CAH ratio value compare to the corresponding 2010 and 2011 quartile ratio values for that Peer Group (e.g. "the CAH ratio value is between the Peer Group 25 and 50th quartile values"). The Flex Monitoring Peer Group quartile ratios reports are at http://www.flexmonitoring.org/index.php

    NOTE: Hospital management should be aware that all ratios indicating subpar performance by the hospital will require a satisfactory explanation during the application review process. Therefore, hospital management should include explanations and supporting documentation (as-applicable) for all ratios that are subpar in comparison to the Peer Group 50 percent quartile value.

Section III – Summary of Significant Financial Forecast Assumptions and Accounting Policies

Basis for Assumptions

- Provide an overview of what is included in the financial forecast, and a description of the methodology used by the examiner to in his/her review of the reasonableness of the assumptions.

General Description of the Hospital and the Surrounding Health Care Market

- Provide a description of organization structure (e.g., non-profit/501(c)(3)). List the services offered in the hospital (including inpatient, outpatient and long-term care services).
- List and describe all affiliated organizations (including all subsidiaries, parent organizations/holding companies, and joint ventures) and describe basis for affiliation. Include an organization chart clearly showing the linkages with all subsidiary/parent/related organizations. Attach copies of all Agreements with network hospitals.
- Describe the governance structure, and list key governance members and their qualifications.
- List of key management personnel and their qualifications (including at a minimum: Chief Executive Officer (CEO), Chief Operating Officer (COO) (if applicable), Chief Financial Officer (CFO), Medical Director, Nursing Director).

Project Description

- Provide objectives to be accomplished as a result of the project.
- Provide a breakdown of construction expenses.
- Summarize changes to structural components of service areas as a result of the project.
- Provide timeframes for completing the project, including forecasted start and completion dates.
- Provide Certificate of Need (CON) information, where applicable (indicate the date the CON was approved by the State, or the status of CON application if approval has not yet been obtained).

Financing Plan

- State the Sources and Uses of Funds for the project. Sources should clearly show the Community Facility (CF) loan amount and other sources of funds.
- State the date of initial closing and date that permanent financing begins to amortize.
- Indicate the time period (start and stop date) during which capitalized interest will be required.
- State the interest rate for capitalized interest and interest rate on the CF loan.

Summary of Significant Accounting Policies

- Explain which organization(s) financial performance and accounts are included in the financial forecast.
- List those affiliates/subsidiaries/parent/holding company/related organizations whose financial performance and accounts do not appear in the financial forecast.
- Summarize significant accounting policies.

Net Patient Service Revenue

- Provide an overview of the various payor systems under which the hospital receives patient revenues. Address each payor system that provides more than 5% of hospital revenues.

Historical and Forecasted Payor Mix – Revenues from Inpatient Services

- State the net revenues by payor for last 5 historical years and all forecasted years.
- Separately identify all payers that provided more than 5% of the hospital's inpatient revenues.
- Provide revenue by payor mix for each new or expanded service.
- Explain reasons for changes in payor mix.

Historical and Forecasted Payor Mix – Revenues from Outpatient Services

- Provide net revenues by payor for last 5 historical years and all forecasted years.
- Separately identify all payers that provided more than 5% of the hospital's outpatient revenues.
- Provide revenue by payor mix for each new or expanded service.
- Explain reasons for changes in payor mix.

Historical and Forecasted Reimbursement Methodologies – Inpatient Services

- Include a description for each payor that provided more than 5% of the hospital's inpatient revenues. Background and information on the history and forecast for each payor should be detailed enough to understand changes in payor revenues after accounting for any changes in utilization. Information showing case mix intensity is required for all payers using case payment methodologies. Each managed care contract should be explained in sufficient detail to understand method by which payments are received and how revenues from each managed care contract were estimated and differences from historical contracts.
- List all revenues received from special payment pools (developed pursuant to a hospital "tax" for charity care, etc.; or funded via legislation through appropriations; or by any other method) must be isolated and clearly described.
- State all medical education payments by payor type; each must be isolated and clearly described.
- Provide the Historical and Forecasted Medicare update factor for each year.

Project Initiatives

- For each revenue-generating service area that is being materially realigned, expanded or reduced, and for all new services, identify and quantify increases or decreases to revenues and expenses and provide corresponding assumptions. State whether the applicant organization has explicitly identified all factors expected to materially affect the operations of the entity during the prospective period. State whether these forecast assumptions are suitably supported, and document the specific sources of information used to determine the reasonableness of the assumptions.
- Identify all expense-center activities (not identified above) that will be consolidated or made more efficient and quantify corresponding savings to be achieved and provide corresponding assumptions. State whether the applicant organization has explicitly identified all factors expected to materially affect the operations of the entity during the prospective period. State whether these forecast assumptions are suitably supported, and document the specific sources of information used to determine the reasonableness of the assumptions.

Other Operating Revenue

- Each source of operating revenue should be separately identified.
- Revenues received from affiliates should be separately identified.

Non-operating Revenue

- Each source of non-operating revenue should be separately identified.

Operating Expenses

- **Salaries and Wages**
  - Clearly identify the number of Full-Time Employees (FTE's) for each year (excluding contracted services). Show interns and residents and salaried physicians separate from the rest of the hospital staff. If the hospital operates nursing home beds or other long-term care services, these FTE's should also be shown separate from staff for acute care services.
  - Explain all major initiatives (and the corresponding impact for each initiative) for any staffing reductions.
  - Calculate FTE's per adjusted occupied bed and compare to CAH Peer Group medians.

- **Fringe Benefits**
  - Explain historical performance and forecast assumptions.
  - State whether the Fringe Benefit forecast assumptions are suitably supported, and document the specific sources of information used to determine the reasonableness of these assumptions.

- **Contractor Services**
  - List all services that are contracted and the annual amounts paid for each contracted service and the estimated FTE's used by the contractor in providing the service.

- **Supplies and Other Expenses**
  - All other expenses should be itemized.
  - Operating leases should be separately identified.

- **Insurance Expense**
  - Itemize all insurance expenses.
  - Assess the adequacy of the hospital's insurance coverage (and insurance reserves).

- **Interest Expense**
  - Segregate interest expenses on the CF loan and other interest expenses related to other debts, leases, etc.

- **Depreciation and Amortization Expense**
  - Show depreciation guidelines used by the hospital.

- **Provision for Doubtful Accounts/Bad Debt and Charity Work Expense**
  - Explain historical performance and forecast assumptions.
  - State whether the Doubtful Accounts/Bad Debt and Charity Work Expense forecast assumptions are suitably supported, and document the specific sources of information used to determine the reasonableness of these assumptions.

Balance Sheet Assumptions

- Explain historical performance and forecast assumptions for each of the following:

  Accounts Receivable
  Other Receivables
  Inventories
  Prepaid Expenses
  Other Assets (break-out all assets greater than $100,000)
  Due from Third Party Payors (break down by payor)
  Pension Fund
  Malpractice Insurance Fund, if self-insured (also, assess the adequacy of the hospital's insurance reserves)
  Assets Limited as to Use

Accounts Payable and Accrued Liabilities
Accrued Payroll and Vacation Benefits
Due to Third Party Payors (break down by payor)
Estimated Malpractice Payable, if self-insured

- State whether each Balance Sheet forecast assumption is suitably supported, and document the specific sources of information used to determine the reasonableness of these assumptions.

Capital Expenditures

- Summarize capital expenditures in recent years (break out by capital equipment, renovation, maintenance, new construction, and capital leases).
- Explain how capital expenditure projections were derived (i.e., how does the hospital develop its capital needs program). Break out by capital equipment, renovation, maintenance and new construction.

Sensitivity Analyses

The following scenarios should be analyzed and reported:

- 10 percent reduction in inpatient discharges (from the forecasted volume).
- Medicare update factor reduced (by 1 percent increments) to 0 percent. A separate analysis for the entire forecast period should be shown for each 1 percent decrease.
- All proposed changes to the reimbursement system for any payor class. Any legislation that has been passed but not yet put in place should be analyzed.
- Other sensitivity analyses, as required based on analysis.

Section IV – Summary of Significant Demand Forecast Assumptions

General Methodology

Include a brief statement describing how patient utilization was forecasted; discuss factors such as historical utilization patterns, length of stay, patient origin, population trends, hospital use rates, market share, capital facilities plans for the Hospital and other area health care providers, and current trends and activities of health care providers and insurers which may affect the Hospital.

- State whether these forecast assumptions are suitably supported, and document the specific sources of information used to determine the reasonableness of these assumptions.

Historic & Forecast of Inpatient and Outpatient Utilization

Provide a general statement identifying the major factors that are affecting overall patient utilization. This statement will also include the major initiatives that the Hospital is taking that will affect the assumptions for the forecast.

Inpatient Utilization

Provide a list and discussion of the factors affecting inpatient activity including such factors as population growth, use rates, market share, and average length of stay.

Outpatient Utilization

Provide a list and discussion of the factors affecting outpatient activity including such areas as the Emergency Room, Ambulatory Surgery, Clinic Visits, Renal Dialysis, Laboratory, Radiology, etc.

Service Area Definition and Patient Origin

Provide a description of the primary and secondary service areas; how they are determined, their location, and identification according to zip codes and a map. Service areas should be separately identified for general acute care inpatient services and outpatient/ambulatory services. Additionally, if the hospital has any other specialty service (e.g., long-term care, rehabilitation care) then that service area should be separately identified if it is different than the service area for the overall inpatient general acute care services. This information may be obtained from the State Hospital Association.

Population of the Service Areas

Include an historical (most recent census data and current year estimate) summary as well as a forecast summary of the primary and secondary service area populations by zip code. Population data should also be broken out by age group (0-17, 18-44, 45-64, 65 and over) and for females 15-44. This information can be obtained from governmental entities such as the National Planning Data Corporation.

Socioeconomic Characteristics of the Service Areas

This section should provide a description of the economic health and stability of the Hospital's service area. The major service categories should be listed according to employers and employees in areas such as:

- Services
- Manufacturing/Mining
- Wholesale and Retail Trade
- Government
- Transportation, Public Utilities, Finance, Insurance and Real Estate
- Construction

Include a profile chart of the largest 10 to 20 employers. This information may be obtained from the State or Regional Industrial Management Council.

Include a narrative and chart displaying the historical and current unemployment information for the County, Major Statistical Area, State, and United States. This information is usually obtained from the U.S. Bureau of Labor Statistics.

Include a narrative and chart displaying Median Household Income for the primary and secondary service areas and, for comparison, by surrounding Counties, the State, and the United States. This may be obtained from the National Planning Data Corporation.

Include a description of the impact of the proposed project on the local economy (i.e., permanent and construction jobs created, economic and social spin-off, etc.).

Market Assessment of Other Health Care Providers within the Service Area

Include a list of other area hospitals, their proximity to the Hospital, and their percent of market share in the Hospital's primary and secondary service areas if greater than 1 percent. This information should be broken-out in the same manner as the service area section (i.e. separately identify outpatient/ambulatory and other specialty services if service areas are different than general acute inpatient). Data is obtainable from several sources including the State Hospital Association.

Include a list and description of the services provided by each of the competitor facilities located within the organization's primary and secondary service areas. Include a discussion of the impact on the organization's forecast assumptions due to major capital improvement and healthcare services initiatives by competitor hospitals (last 5 years), and from any planned future capital improvement and healthcare services of competitor facilities located within the organization's primary or secondary service areas.

Market Share by Service

Include a narrative and charts showing historical trends (last 5 years) for total hospital discharges and a breakdown for all major services showing the market share of the Hospital and its competitors in the primary and secondary service areas. Information is obtainable from several sources including the State Hospital Association.

Provide a narrative and charts of competitive hospital utilization statistics (for all competitor facilities within the primary and secondary service areas) with comparisons to the hospital in inpatient areas such as Discharges, Average Length of Stay, Percent Occupancy, Patient Days, Average Daily Census, and Available Beds. Similarly, provide outpatient activity data for visits and procedures in areas such as Emergency Room Visits, Ambulatory Surgery, Clinic Visits, Renal Dialysis, Laboratory Procedures, Radiology, etc. This information may be available from Blue Cross/Blue Shield and State Supplement to the Institutional Cost Report.

Provide the identity and location (city, county, state) of each competitor facility included in the narrative and charts, and of any other hospitals with comparison data which is included in the report.

Inpatient Use Rates

Include a narrative and charts depicting use rate for the primary and secondary service areas. Use rate measures total hospital discharges from the service area population and is expressed in discharges per 1,000 population. The historical and projected use rates should be provided for each major service (e.g., medical/surgical, obstetrics, etc.) broken down by primary and secondary service area and by fee-for-service patients, managed care patients and total patients. Historical (last 5 years) comparative use rates should be displayed through charts for the defined service areas, city or county if appropriate, the State, and the United States.

Provide the identity and location (city, county, state) of each competitor facility included in the narrative and charts, and of any other hospitals with comparison data which is included in the report.

Hospital's Historical Utilization

Include a series of charts depicting inpatient historical (last 5 years) and forecasted utilization statistics by total and major service areas as well as by outpatient visits and procedures.

Hospital's Medical Staff

Include a narrative and charts which analyze the medical staff including their admissions patterns, age and specialty characteristics, as well as support for the Hospital and the project. Provide a chart of the top admitters (ranked from highest to lowest total annual admissions in the most recent fiscal year and equaling at least 80 percent of total hospital admissions) showing physician specialty, age, and number of admissions. Provide a narrative and a summary chart of the most-recent 5 years historical recruitment and turnover of physicians.

Physician Questionnaire Results

Include a description and results of a survey of physicians' attitudes and perspectives regarding the Hospital and the proposed project.

Business Organization and Corporate Relationships

Describe how the Hospital is affiliated (e.g., a subsidiary, parent, affiliate, joint venture, etc.) with any other organization, indicating name, address, type of legal relationship, and nature of affiliation. Describe the Hospital's collaboration with network hospitals and other entities to integrate healthcare delivery as well as its relationship with existing and developing managed care organizations in its primary and secondary service areas.

Section V – Other Information which the Feasibility Consultant Deems Appropriate.

Section VI – Evaluation of Governing Body and Management Team (To be prepared by feasibility consultant although not required to be included in financial feasibility study).

Appendix