

Critical Access Hospital Replacement Process “The Manual”



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Acronyms

Acronym	Definition
A/E	Architect/Engineer
BP	Basis Points
CAH	Critical Access Hospital
CEO	Chief Executive Officer
CFR	Code of Federal Regulations
CM	Construction Manager
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
CPA	Certified Public Accountant
EBIDA	Earnings before Interest, Depreciation and Amortization
ESA	Environmental Site Assessment/Phase I Environmental Study
FHA	Federal Housing Administration
FPC Resources	Full Project Coordination
GMP	Guaranteed Maximum Price
GNMA	Government National Mortgage Association
Hill-Burton Act	Hospital Survey and Construction Act of 1946
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
ICAHN	Illinois CAH Network
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
NP	Necessary Provider
ORHP	Office of Rural Health Policy
PM	Project Manager
REC	Recognized Environmental Conditions
SME	Subject Matter Expert
SORH/Flex Office	State Office of Rural Health
USDA	U.S. Department of Agriculture

Introduction

Background

Legislation enacted as part of the Balanced Budget Act of 1997 created the Critical Access Hospital (CAH), a specially designated, small rural hospital that qualifies for cost-based payments for Medicare services. As of January 2009 there are more than 1,300 CAHs, which constitute a majority of all rural hospitals. Many of these community hospitals were built in the 1940s and 1950s and used funding from the Hill-Burton Grant Program of 1946. Over the past 60 years, numerous CAHs have made renovations, expansions, and/or major rehabilitations while about 100 facilities have replaced their entire hospital. Facility replacement may not be appropriate for all CAH-designated hospitals but it is an option that should be considered for hospitals with obsolete and/or worn infrastructure. According to the *2008 Rural Hospital Replacement Facility Study*¹, hospital leadership continues to report improvement in tangible measures of hospital performance and operational efficiency after replacement. Respondents also reported greater success in physician and staff recruitment and improved customer and employee satisfaction. Additionally, the majority of replaced CAHs have documented that expenses are lower (on a unit cost basis) than pre-replacement. Other intangible benefits include improved work culture, better quality of care and a significant boost to the local economy. In an effort to facilitate the renovation processes for Critical Access Hospital's who are very much in need of this support, the Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), and the [Office of Rural Health Policy](#) (ORHP), is pleased to make this detailed ***Critical Access Hospital Replacement Process: The Manual*** available.

ORHP works to sustain and improve access to health care services in rural America. Established in 1987, ORHP works both within government at the Federal, State and local levels, and with the private sector (associations, foundations, providers and community leaders) to seek solutions to rural health care issues. ORHP administers a range of programs designed to promote these efforts including grants to States under the Medicare Rural Hospital Flexibility Grant Program (FLEX Program) which facilitate CAHs address community needs.

At the Federal level, there are 2 major programs that can help CAHs meet their capital needs:

- HUD FHA Section 242 Hospital Mortgage Insurance Program (http://portal.hud.gov/portal/page/portal/HUD/federal_housing_administration/healthcare_facilities)
- USDA Community Facilities Program Guaranteed and/or Direct Loans (<http://www.rurdev.usda.gov/rhs/cf/cp.htm>)

See [Appendix B: Federal Government Programs](#).

Manual Purpose and Development

ORHP developed the ***Critical Access Hospital (CAH) Replacement Process: The Roadmap*** and ***The Manual*** to provide step-by-step guidance to help hospital administrators, board members, and community leaders perform a successful facility replacement. The Roadmap is meant to provide an overview of the facility replacement process while this companion document, *The Manual*, provides detailed guidance for hospitals that are planning facility renovation, expansion, or replacement.

The project team that developed *The Manual* relied primarily on (1) 2 large advisory groups (comprised of attorneys, public sector representatives, financial analysts, hospital consultants, lenders, and architects), (2) site visits to replacement CAHs, and (3) interviews with subject matter experts (SMEs). The *Manual* is based on insights from CAH leadership who have successfully completed facility replacement projects as well as the professionals that worked with them. This includes hospital administrators and board members, community leaders, financial advisors, lenders, feasibility consultants, architects, construction contractors, project managers, and community engagement and economic impact consultants.

1. Work Group (WG) and Consultation Group (CG): The 2 advisory groups of experts are comprised of a total of 40 members. The WG and CG reviewed a first draft of both the *Roadmap* and *Manual* and then again in final draft. They provided comments and much of their input was incorporated into the final documents.
2. Site Visits: In 2007, the team conducted site visits to four hospitals that have replaced and/or were in the process of facility replacement.
3. Interviews with Subject Matter Experts: The team conducted interviews with experts to get guidance and feedback on the facility replacement process.

The team sought to uncover which decisions, actions and events were most important in getting the projects successfully completed. The Manual documents the lessons learned from the pioneers who helped implement the first generation of CAH replacement facilities, from which the next generation of CAHs considering replacement will surely benefit.

How To Use This Manual

The *Manual* provides a comprehensive picture of the facility replacement process. It is a detailed document that discusses the phases, events, actions, and involved parties that are needed for a successful replacement project. The manual provides practical guidance on the facility replacement process, including: (1) assessing the CAH's physical and financial situation, (2) gaining community support, (3) identifying and obtaining financing, (4) working with lenders and Federal enhancement programs, and (5) completing the design and construction process.

The replacement process can take as little as 2 years or as long as 5. This *Manual* is built around the following four phases and estimated timeframes for the process:

- Phase 1: Planning and Preparation (6-12 months)
- Phase 2: Facility Design and Financing (3-12 months)
- Phase 3: Endorsement (0-1 month)
- Phase 4: Construction (12-30 months)

Getting Started

In addition to the phases, the manual includes [Estimated Project Costs and Fees](#), [Partners in the CAH Replacement Project](#), and [CAH Replacement Process Resources](#).

Some considerations to keep in mind:

- This manual is directed toward the hospital leadership team, which should include the project sponsors, hospital board, hospital management team (e.g., CEO, CFO, COO), and community leaders.
- This manual is arranged chronologically by phase and some events (e.g., project articulation, community engagement) span more than one phase.
- For each action step, background is provided, along with rationale, and strategy to complete the action step. Additionally, helpful tips and examples are identified.
- Every action step may not be required for every project.

While the phases, events, and action steps are listed sequentially (e.g., 1, 2, 3), it makes sense to work on a number of events and actions simultaneously. That is the only way you'll keep the project moving! Your hospital leadership team can use the *Manual* to understand the process and develop a project plan to reach your goal – a modern facility that meets your community's health care needs.

One CAH Board Member said, “The community would understand it if we put another \$10-12 million in this old building, but they'll think we're crazy if we spend \$20 million to build new and abandon this facility. The easiest thing for us to do is to pass this problem along to the board that sits here 10 years from now, but it would be the wrong thing.”

Getting Started

Developing Your Project Schedule and Work Plan

Facility replacement is a major capital project. It must be aligned with the hospital's strategic and facilities plan and also be informed by outside, objective data. Success is dependent upon the ability of the hospital leadership to: 1) be strategic and act based on realistic financial, operations, facilities, and market data; 2) get the best expertise to the table right from the beginning of the process; and 3) get and keep the physicians, staff and community fully engaged throughout the process.



You **must** develop a project plan and schedule. To get started, check out *CAH Replacement Process: “The Roadmap,”* which provides a sample project schedule and brief overview of the process. The project schedule provides a general timeline that shows the steps for completing the project. Your project schedule and plan should be based on realistic timeframes that are updated as you move forward.

Selecting Your Full Project Coordination Resources

One of your first steps should be to identify and hire a Full Project Coordination (FPC) resource team. FPC resources, individual or work teams, coordinate the CAH facility renovation/replacement project. These professionals help guide you through the entire process. Work with your project team right from the beginning so that you understand all of your options. You are not in this alone – there are experienced folks that can guide you through this process as they have guided other CAHs through a successful facility renovation or replacement!

You can do this! Be prepared for the inevitable bumps in the road and plan to dedicate 2-3 years to the overall process.

Facility renovation/replacement is a significant investment and you need to have the proper expertise from the beginning of the process in order to minimize business risks and maximize results. Specifically, your FPC Resource Professionals:

- √ Serve as the hospital's advocate throughout the process;
- √ Facilitate decision-making by clearly laying out the options as well as their options' efficiency and cost-effectiveness, which allows the hospital to make timely decisions and keep the project moving; and
- √ Have the proper experience and expertise to advise and facilitate as well as manage costs using their knowledge of the replacement process, including: financing, space programming, hospital design and construction, and CAH operations.

Now that over 90 CAH-designated hospitals have completed or are in the process of completing facility replacement, CAH-experienced professionals are readily available. CAH-designated hospitals should demand good representation to coordinate their facility replacement project.

A financial advisor shared a story about a financing proposal where the underwriter charges were quoted at more than double the going rate and the contract included a “breakage fee” if the hospital decided not to pursue financing with the firm. Neither of these costs is in line with industry standards. **Lesson Learned, “Long and short of it is that the hospitals don’t know what they don’t know and they need an advocate.”**

Why Is Full Project Coordination (FPC) Needed?

To have a successful replacement project, hospital management, board members and replacement experts have stressed the importance of having CAH-experienced consultants providing guidance and support. They recognize the inherent complexity in the process and have realized the benefits of FPC, both tangible (money and time savings) and intangible (the confidence of making decisions based on advice from experienced resources).

Any CAH considering a renovation/replacement should plan to commit a significant amount of time to the project; however, it would be difficult for you to be responsible for actual project coordination. During the entire renovation/replacement process, hospital leadership has to keep hospital operations running efficiently and effectively and the added burden of coordinating the financing and building a new facility is often too much to ask the leadership of the facility to manage.

Getting Started

Hospital leadership has expertise in hospital management, not facility replacement. Without the right guidance, there is the potential to make decisions that are not in the hospital's or the community's best long term interest. Project coordination and other consultant resources remove some of the stress, which helps you stay sane during the facility replacement process!

One hospital CEO that has been involved in numerous replacement projects stated, "Even though the board was initially resistant, the board chair stated throughout the project that hiring a Project Manager was the best thing they did." This CEO strongly recommends the use of a Project Manager and getting him/her onboard early. "The Project Manager brought the project in on time and under budget with only \$26, 000 in change orders." **Lesson Learned:** Get knowledgeable, experienced resources from the beginning.

Full Project Coordination Functions

You need FPC Resources for the following three functions (areas of expertise) including:

- 1) Financing Guidance; 2) Space Planning; and 3) Management of Design and Construction.

Table 1. Full Project Coordination (FPC) Functions	
1) Financing Guidance:	An Independent Financial Advisor helps the hospital navigate the financing process, including providing board education, exploring financing options, performing debt capacity analysis and/or financial feasibility, and facilitating interaction with lenders, underwriters and Federal enhancement programs. The hospital should be represented by a qualified financial advisor who will act on its behalf to seek the most cost-effective financing vehicle. Please note that an independent financial advisor is not the same as a lender or banker.
	<ul style="list-style-type: none"> √ Develop and Manage Overall Project Schedule √ Direct Market Demand Analysis √ Perform Debt Capacity Analysis and Set Financial Parameters √ Facilitate Replacement Decision and Reimbursement Resolution √ Identify CAH Credit Profile and Explore Financing Options √ Perform or Commission Financial Feasibility Study √ Facilitate Financing, including Select a Lender and Develop the Finance Structure √ Help Select Vendors and Negotiate Favorable Contracts (e.g., financial feasibility, lender, legal)
2) Space Planning:	Space planning translates expectations of patient visits, programs and services, and staffing into an estimate of the numbers and types of rooms and preliminary square footage needed in the new facility. Space planning supports strategic use of space to meet community needs and maximize hospital revenue. This role may be performed by an Architect, Facilities Planner, Owner Advocate, Owner's Representative or Project Manager .
	<ul style="list-style-type: none"> √ Perform Facilities Assessment √ Document Program and Staff Planning √ Draft Space Planning to Accelerate Design Process √ Facilitate Equipment Assessment
3) Management of Design and Construction:	Design and construction help drive project cost. An Owner Advocate, Owner's Representative or Project Manager provides independent guidance to the hospital and represents the owner's interests in the design and construction process. This role is so important that the HUD 242 Program requires a Project Manager or Owner's Representative, <u>not</u> associated with the construction contractor, for HUD-insured projects. The project management role performs construction monitoring for the owner and is responsible for coordinating all entities during the design and construction process. This role may also be performed by a Construction Management Firm, Construction Consultant or Architect .

Getting Started

- √ Represent Owner's Interests, Manage Project Schedule and Team
- √ Preliminary site selection and analysis
- √ Facilitate and Support Design Process
- √ Facilitate Pre-Construction (e.g., land acquisition and development, Phase I environmental and soil studies, local permits and approvals, utilities)
- √ Provide Expertise on Construction Methods and Contracting and Construction Estimates
- √ Perform Value Engineering
- √ Help Facilitate Bidding/Competitive Process for Design and Construction
- √ Perform Construction Management and Monitoring to keep project on schedule and ensure it meets hospital's requirements

The role of FPC Resources is to obtain the best finished product at the best price and in a timely manner. See [Partners in the CAH Replacement Project](#) for guidance on project team selection and members.

Phase 1: Planning and Preparation

Phase 1: Planning and Preparation (6-12 months) is when you identify the information, expertise, and human resources that will be needed throughout the replacement process. It is the ideal time to review and analyze the financial, operations, facility and market data needed to make the critical decisions for major capital improvements. Throughout the entire process, you have to plan and work on multiple events and action steps simultaneously.

Planning and Preparation covers the following four events and their corresponding actions:

- √ [Project Articulation \(9 Action Steps\)](#),
- √ [Facility Assessment and Design \(6 Action Steps\)](#),
- √ [Research Financing and Assess Feasibility \(4 Action Steps\)](#), and
- √ [Community Engagement and Capital Campaign \(2 Action Steps\)](#).

Event 1: Project Articulation

Project articulation helps the hospital leadership team develop and document its vision and requires a formal decision on facility replacement.

ACTIONS STEPS	DURATION	COSTS/FEES	INVOLVED PARTIES
1. Research and Hire FPC Resources 2. Commission Facilities Assessment 3. Obtain Debt Capacity Analysis 4. Obtain Market Demand Analysis 5. Make Replacement Decision 6. Approve Reimbursement Resolution 7. Discuss Relocation with CMS 8. Initiate CON Application 9. Draft Programming/Space Plan	1 – 6 months	FPC Resources Fee* Facilities Assessment Fee Debt Capacity Analysis Fee Market Demand Analysis Fee	✓ Project Sponsor ✓ FPC Resources ✓ Facilities Consultant ✓ CON Consultant ✓ CMS ✓ State CON Office ✓ CON Consultant ✓ SORH/Flex Office ✓ State Health Facilities Finance Authority (HFFA)

* If you utilize FPC Resources, their fees will be payable throughout the project based on services provided.

[Action Step 1: Research and Hire FPC Resources \(Event 1\)](#)

Background: Full Project Coordination (FPC) Resources is an individual or team that facilitates the replacement project and coordinates all critical aspects of the project, including board education, community engagement, financing, space planning, design and construction, and project resources.

Rationale: Full project coordination helps develop and implement a thoughtful facility replacement project that is aligned with the hospital's strategic plan and the needs of the community.

Strategy: Find and hire the best facility replacement consultants based on your project coordination requirements. Your resources should include professionals with

Phase 1: Planning and Preparation

expertise in financing guidance, programming and space planning, and management of design and construction. Set your resources in place early; Delaying the use of professionals in your planning process will only hinder your ability to sell the concept to the community!



- √ **Visit CAHs that have completed the replacement process.**
- √ Request recommendations for facility replacement resources from other CAHs, your [State Office of Rural Health \(SORH\)/Flex Office](#), your [State Health Facilities Finance Authority \(HFFA\)](#), and [Technical Assistance and Services Center \(TASC\)](#) (see page 50).
- √ Get references from other rural hospitals. Ask them what specific services were provided and how the FPC Resources added value.

Lesson Learned: Without experienced professional assistance, hospitals lose time in planning and design and there's a lot of opportunity to make costly mistakes.

Action Step 2: Commission Facilities Assessment (Event 1)

Background: It is highly recommended that you begin this process by commissioning a facilities assessment, which is a written assessment and evaluation of the hospital's current physical plant and associated facilities.

Rationale: A facilities assessment clearly identifies the capital needs that present the primary motivation for the assessment and lays out the costs and benefits of rehabilitation and replacement.

Strategy: The Facilities Assessment should always be performed by an external consultant who has experience with CAHs. You need to make the argument why the old site's renovation won't work as well as show the feasibility of replacement, including the reimbursement benefit. Even if it is obvious that replacement is needed, a documented rationale that shows the impact of replacement and rehabilitation is required to share with the community and potential funders.

Use your Master Facilities Planning Committee, which is composed of the hospital management team and board and community members, to perform the facilities homework and communicate the options and results to the board. The committee works with the FPC Resources and Master Facilities Planner throughout the design and construction process.

Profile: **Shoshone Medical Center** in Kellogg, ID was a 25-bed hospital built in 1958. Wheelchairs, unless folded up, did not fit into the patient bathroom. Boilers, elevator, plumbing, and electrical infrastructures were antiquated, making it difficult to find parts for them. Low ceilings didn't meet current air exchange ratios. The walls were thick and unsuitable for drilling, which made improvements difficult. Additionally, it was estimated to cost \$10 million to stay in the existing facility for 10 years with no new equipment or \$15 million to build a new facility and purchase new equipment. All of the identified problems were only going to get worse with each year, so the Board decided to replace the whole facility with a new one, which opened in January 2005.

Action Step 3: Obtain Debt Capacity Analysis (Event 1)

Background: The debt capacity analysis provides an estimate of the amount of debt that the hospital would be able to service or sustain.

Rationale: The debt capacity analysis establishes your preliminary financial parameters.

Strategy: The debt capacity analysis helps determine what you can afford. Use the debt capacity analysis to help determine capital financing needs, including capital campaign goals, if applicable. The debt-capacity analysis should be done in conjunction with the market-demand analysis in order to incorporate market potential (e.g., out-migration, population growth, aging) instead of straight lining based on past performance only. Debt capacity should guide your facility design (i.e., project budget). You must know the hospital's debt capacity before approaching facilities planners, architects and lenders.

A CEO recommends a debt capacity analysis early in the process to understand what hospital can afford. His hospital leadership team worked with three architects. The first 2 architects drafted big plans based on needs but the projects were not financially feasible. The third architect's design was based on the hospital's debt capacity. The facility expansion was completed in 2007. **Lesson Learned: Don't engage an architect without providing explicit financial parameters! Build only what you can afford!**

Action Step 4: Obtain Market Demand Analysis (Event 1)

Background: The analysis describes the market in geographic and demographic terms, identifies opportunities for growth, evaluates any competition in the marketplace and estimates projected market share or potential demand.

Rationale: The market demand analysis helps evaluate current and future markets to determine current community needs and the potential for expansion.

Strategy: The impact of a new facility varies by community and this is largely driven by market potential. Use the market demand analysis to help map out the hospital's scope of services (programming). The market demand analysis helps identify population demographics as well as out-migration and its reasons; thus helping you design a facility with services to capture that out-migration and increase market share. A market demand analysis may be performed by a feasibility consultant and is an important input into the hospital's strategic planning process. Some CAHs have successfully used the strategies and tools available from the Center for Rural Health Works (RHWks). The RHWks is the national focal point for analysis of the economic impact of health policies on rural America.

The market demand analysis provides a roadmap for where and how to grow your hospital by providing the services your community needs.

Action Step 5: Make Formal Replacement Decision (Event 1)

Background: Based on the facilities, financial, operational and market data collected, it is time for you to decide: go or no go!!!

Rationale: The board has to make a formal facility replacement decision. If the board chooses to proceed, the debt capacity analysis and market demand analysis will be a major component of the financial feasibility. If the board chooses not to proceed based on the financial risks of the project, it will have made this decision without incurring major costs.

Strategy: It is important to look strategically at the hospital's options to maintain and enhance the community's health care services. It is often more cost-effective to replace than renovate. Financial, operational and strategic constraints may be driving factors in the decision. If you decide on full facility replacement, you need to let the community know that facility replacement is a necessary business decision based on what the hospital and/or community can afford. If you decide on substantial renovation, many of the action steps will still be applicable. Your FPC Resources will help facilitate this critical decision.



- √ It's time to decide whether to replace or renovate.
- √ A replacement facility may provide an opportunity to grow, expand or change local health care services, improve operational efficiencies, and improve the quality of patient care and comfort.
- √ Hospitals unable to keep pace with depreciation, advances in medical technology, HIT and changing population needs may be at risk for compromising their performance, increasing their risk of closure, and jeopardizing the availability of needed services for rural populations.

One CEO stated, "Once market, financial and facility analyses were presented to the board, even the most apprehensive board members bought into the project with full support." **Lesson Learned:** It is critical to have a thorough and well documented decision making process.

Action Step 6: Approve Reimbursement Resolution (Event 1)

Background: Project development costs incurred prior to the financing closing are generally covered by the hospital's cash reserves or operating funds. A reimbursement resolution allows the hospital to be reimbursed for project development costs with finance proceeds. Reimbursement resolutions are only applicable to tax-exempt financings.

Rationale: A reimbursement resolution is required if the hospital wants to have the option of being reimbursed for project-related expenses; otherwise, the hospital will be limited in how far back in time (e.g., 6 months) and what types of expenses can be reimbursed from bond proceeds.

Strategy: A reimbursement resolution should be completed before you incur large expenditures. Public hospitals that can issue bonds should approve a reimbursement resolution directly. Others should work with the municipal board (e.g., town, city, county, State) with jurisdiction for the project to request the approval of a reimbursement resolution allowing preliminary costs to be included in the financing request.

Action Step 7: Discuss Relocation with CMS (Event 1)

Background: If any Necessary Provider (NP) CAH relocates its facility and begins providing services in a new location, the CAH must continue to meet Centers for Medicare and Medicaid Services (CMS) requirements known as the “75 percent rule.” The facility must continue to: 1) serve at least 75 percent of the same service area; 2) provide at least 75 percent of the same services; and 3) employ 75 percent of the same staff. [Relocation of CAHs with a Grandfathered Necessary Provider (NP) Designation (42 CFR 485.610)]

Rationale: State-designated Necessary Provider CAHs that are relocating must meet CMS requirements in order to continue to qualify for the CAH designation.

Strategy: Work closely with the CMS Regional Office and SORH/FLEX Office regarding continued CAH designation. State-designated NP CAHs must communicate with CMS prior to, during, and post-relocation Other CAHs must notify and work closely with CMS, as well.



- ✓ CEOs interviewed for the *2008 Rural Hospital Replacement Facility Study* were not subject to the CMS rule but felt “they would have met the 75 percent rule and that it would not have been an obstacle to their projects.”
- ✓ In September 2007, CMS issued revised national interpretive guidance in new Survey and Certification Letter #07-35, which is accessible at: <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-35.pdf>.

Action Step 8: Initiate Certificate of Need (CON) Application (Event 1)

Background: Many Certificate of Need (CON) laws were put into effect as part of the Federal Health Planning and Resources Development Act of 1974. About 36 states retain some type of CON program, law or agency as of 2008.

Rationale: Some States require that a CON be obtained before any significant health care project is allowed to proceed.

Strategy: Each State with a CON process has its own specific process or thresholds and it is incumbent upon you to be aware of the requirements and follow the steps prescribed. You should contact State CON officials to investigate the process at <http://www.ncsl.org/programs/health/cert-need.htm>. Clarify the CON impact based on the preliminary details in the design and financial feasibility, which will become part of the CON application.

CON programs remain a major hurdle for providers seeking to expand, modernize, or reshape their services. A CON consultant may be helpful in clarifying the CON impact and assisting with this important application.



- Specific Certificate of Need Requirements may include the following information:
- ✓ Summary of the proposed project
 - ✓ A brief description of each proposed service and equipment requirements
 - ✓ The number of square feet of construction/renovation
 - ✓ The number and type of beds/surgery suites/specialty rooms
 - ✓ Services to be expanded, added, replaced, or reduced
 - ✓ The total project cost and how the project will be financed
 - ✓ Estimated completion date

Phase 1: Planning and Preparation

Action Step 9: Define Programming/Draft Space Plan (Event 1)

Background: Programming determines hospital and community need, and provide the basis on which to plan for the necessary physical space. Space Planning translates expectations regarding patient visits, programs, services, and staffing into an estimate of the numbers and types of rooms needed in the new facility.

Rationale: The programming and space plan are the foundation of the architectural design and provide preliminary budget estimates.

Strategy: During the programming and space planning stage, use the debt capacity, market demand, facilities, and operations data to be strategic in determining the hospital's scope of services. Perform a thorough, up-front exploration of the program so that significant needs and constraints are discovered early in the project. If these issues are overlooked, it will be much more expensive and time consuming to address them later. Use the space plan to develop consensus around amounts and types of spaces needed for an efficient and effective facility, including the preliminary estimate of total square footage.



Tip

- ✓ Strong leadership is required during programming in order to keep the project scope and cost from expanding unnecessarily.
- ✓ Use design to maximize revenue, efficiency, and ability to expand.
- ✓ Based on the hospital's budget, begin at ground zero for services (e.g., ER, inpatient, and outpatient) and expand strategically (i.e., include services that are both needed and self-sustaining).
- ✓ You will have to make difficult choices about which services to continue, discontinue and/or add.

Lesson Learned: Getting guidance early in the process helps avert costly redesign fees after the design process has reached a more advanced stage.

Event 2: Facility Assessment and Design

Facility Assessment and Design (3-6 months) is a key task when beginning a facility replacement. Design drives construction and construction drives pricing, schedule, and ultimately, the project's cost. The project team includes the hospital's designated staff, project coordination resources as well as required design, construction, equipment and other professionals.

ACTIONS/ GOALS	DURATION	COSTS/FEES	INVOLVED PARTIES	
1. Complete Land Acquisition	3 – 6 months	Architect Fee	✓ Project Sponsor	
2. Perform Phase I Environmental (ESA) and Soils Studies		Phase I ESA and Soils Studies Fee	✓ FPC Resources	
3. Draft Schematic Design		Land Acquisition and Development Costs	Equipment Assessment Fee	✓ Architect
4. Perform Equipment Assessment				✓ Equipment Consultant
5. Select Construction Method				✓ Environmental Consultant
6. Finalize Project Budget				

Action Step 1: Complete Land Acquisition (Event 2)

Background: A well-located facility is critical to the hospital’s ability to provide access to the community it serves. This is particularly true when the hospital is re-orienting its strategy for more outpatient services.

Rationale: Land acquisition is an important decision and can be a big factor in the total project cost as well as the success of the replacement facility.

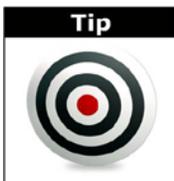
Strategy: Select appropriate site(s), evaluate the site(s) based on your needs (e.g., location, size, environmental study), and complete the lease or purchase of land. Land cost varies widely and land donations are encouraged. However, donated land can become very expensive due to development costs. For example, if the site is poorly located and all services (e.g., electrical, water, sewer, gas) have to be run to the site, it could be more expensive than a purchased site that already has services available. The search for appropriate sites is generally performed with a commercial real estate broker and Project Team (to assist in site evaluation).

Numerous local, State and Federal regulatory issues will need to be addressed during site development and construction. This could include surveys, legal work, zoning, local ordinance approvals and utilities. FPC Resources should identify and document these issues early as part of the project schedule. Local buy-in is critical to managing project resistance and potential delays.



Decision

- √ Finalize location and land acquisition ASAP.
- √ Land Cost + Site Development Cost = Total Land Cost.
- √ Conduct Phase I ESA prior to land acquisition, even for donated land.
- √ Address conventional land issues: title search, environmental and soils tests, and flood plain.
- √ Focus on visibility, exposure, and expansion for location.
- √ Plan with a 25-30 year horizon.
- √ Bring in as much of the current service area as possible (CMS 75 percent Rule).
- √ Provide convenient access to the doctors and patients you seek to serve.



Tip

During the planning phase, you should also consider whether it is appropriate to include a Medical Office Building (MOB) with the plans, particularly if you plan to have provider based clinics. Recent CAH guidelines no longer allow NP CAHs to have new “off campus” provider based units. This has made CAHs re-think MOB and consider doing the MOB simultaneously or plan to have enough land for future MOB needs. “On campus” is a new issue that CAHs now need to include in the evaluation process.

Lesson Learned: Hospitals sometimes don’t resolve land cost issues until later in the process especially when the funding comes from hospital cash reserves or operations. The hospital should identify its land budget and source(s) of funds early in process.

Action Step 2: Perform Phase I Environmental Study (Event 2)

Background: A Phase I Environmental Site Assessment (ESA) is generally required in commercial real estate transactions to identify potential or existing environmental contamination liabilities. The site examination may include the identification and/or assessment of chemical residues, asbestos containing materials, hazardous substances, mold and mildew, and indoor air quality parameters.

Phase 1: Planning and Preparation

Rationale: A Phase I ESA may identify Recognized Environmental Conditions (RECs), which can drastically affect the price and value of property as well as increase the buyer's liability if the property is contaminated. The new owner may be required to "clean up" and/or remediate the land at their own cost.

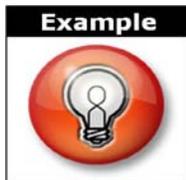
Strategy: Conduct Phase I ESA prior to completing land acquisition and get guidance from your project team about other land or site development issues.



- √ Always expect the unexpected during land acquisition and site development.
- √ Potential environmental issues and remediation may create delays and additional costs, which are an impediment to financing.
- √ You may want to have at least 2 potential sites in case either has issues that will negatively impact your cost and timeline.
- √ Your architect should be aware that during the past 2 years, some projects have encountered significant project delays and costs for reviews, approvals and permits due to site development issues related to the Clean Water Act of 1972. The severity of the issue varies by state agency in its application of this law.

Action Step 3: Draft Schematic Design (Event 2)

An architect provides various levels of documentation, guidance and support throughout the project, including: 1) Schematic Design; 2) Design Development; 3) Construction Documents; 4) Bid Support; and 5) Construction Supervision. Each stage of the architectural design process adds a level of detail to the project plans and specifications. The Master Facilities Planning Committee should review progress as the design takes shape.



CAH Prototype

- √ In 2004, HHS and HUD commissioned BBH Design to develop 25- and 15-bed versions of a one- and 2-story prototype hospital for rural America.
- √ The CAH Prototype, approved in February 2005, is available at: http://portal.hud.gov/portal/pls/portal/docs/PAGE/FHA_HOME/LENDERS/LENDER_S_HEALTH_CARE_FACILITIES/DOCUMENTS/PROTOTYPE.PDF.
- √ The CAH prototype design is a decision-making tool for rural hospital leaders to estimate program space requirements and costs associated with a replacement facility project.

Background: The schematic design focuses on the "scheme," or overall high-level design. The schematics are line drawings indicating the basic size and appearance of the facility and only preliminary costs may be estimated from the schematics.

Rationale: The schematic design is the first phase in the architectural design process.

Strategy: The Architect works with the Master Facilities Planning Committee over 2-3 months to transform the space plan into the actual conceptual space arrangement of a finished building. Use the schematic design to refine the project budget. Update the project budget through each design phase.

Health Information Technology (HIT)



Overall Design Considerations

- √ **The debt capacity analysis and programming and space plan should drive the architectural design. Don't design something you can't afford!**
- √ Work with a CAH-experienced architect licensed to practice in your state and knowledgeable of local requirements.
- √ Design affects staffing, which could have a significant impact on operations.
- √ Physicians and staff should be involved but cannot dictate design as it jeopardizes project cost and strategic goals. You have to be willing to say "NO" to requests the hospital cannot afford.
- √ Design should incorporate new technologies, e.g., telemedicine, high speed wiring, health record connectivity, and energy efficiencies.
- √ Design more direct patient care space for enhanced Medicare reimbursement.
- √ Local politics can be an enormous factor in design decisions. Having outside consultants will help limit the impact of local politics on the project.

Design To Dos

- √ Assess impact on hospital's strategic presence and image.
- √ Consider Medicare implications, revenue potential, and financing implications.
- √ Consider long-term operating and maintenance costs.
- √ Listen to your architect.
- √ Keep your expectations realistic.

Profile: Drumright Regional Hospital (Drumright, OK) selected a CAH- experienced architect with CAH design knowledge and a contractor who understood that small, rural hospitals have unique needs. A visit to the facility clearly reflects the efficiency and effectiveness of the hospital design. Drumright is a 15-bed hospital, which opened in March 2005 with a total replacement cost of \$7.8 million. While architect, contractor, and owner's representative kept the facility simple to save money, the facility is pleasant and welcoming, bringing confidence to the Drumright community, which is evidenced by high inpatient volumes and busy outpatient and surgical activity. **Lesson Learned:** A well-designed facility enhances your ability to operate efficiently while providing high-quality services to your patients and a positive work environment for your staff.

Action Step 4: Perform Equipment Assessment (Event 2)

Background: Perform a current inventory of existing furnishings and equipment to determine 1) what items should move to the new facility, 2) what items should be sold, and 3) what items are needed for the new facility.

Rationale: Furniture, Fixtures and Equipment (FFandE) is a big factor in total project cost and should be addressed early and refined throughout the project.

Strategy: Hire an equipment consultant early as equipment requirements should align with the programming and space plan. The equipment planner works with the architect to coordinate placement of furniture and equipment with design drawings and coordinate mechanical, electrical and plumbing (MEP) needs.



- √ Too often, CAHs cut required equipment needs to stay within the budget when construction costs rise. However, the proper equipment is needed to provide services and is a key factor in generating revenue.
- √ The equipment budget needs to allow for equipment upgrades in one to 2 years once the project is completed.
- √ Some CAHs have been successful in purchasing used or refurbished equipment.
- √ Invest in the best technology (e.g., digital mammography, MRI, 16 or 64 Slice CT) you can afford based on your budget and strategic plan.

Phase 1: Planning and Preparation

Action Step 5: Select Construction Method (Event 2)

Background: Select one of the three general methods of construction: 1) Traditional Bid Process, 2) Construction Management, or 3) Design-Build.

Rationale: Construction and equipment generally represent 70 percent or more of the total project budget. The construction method will impact project team composition, contractor selection, bid process, and project cost.

Strategy: FPC Resources will provide guidance regarding the pros and cons of construction methods. State/local requirements may impact your choice of construction method. It is critical to find a reputable contractor with good references regardless of the construction method. CAH experience is valuable. See Table 2 for a detailed description of construction methods along with some pros and cons.

Table 2. Construction Method Descriptions	
<p>1) Traditional Bid Process. The hospital (Owner) commissions an architect to develop drawings and specifications, then manages a competitive bidding process to obtain construction costs, leading to an Owner/Contractor Agreement to construct the building. The Owner, Architect, and Contractor work together (as separate entities) to construct the building. The hospital has the security of knowing the cost of the project.</p>	
<u>Pros</u>	<u>Cons</u>
<ul style="list-style-type: none"> • May yield lowest price construction, but attracts contractors with little or no hospital construction experience, which can jeopardize a good outcome of a properly built structure. Contractor experience with hospital construction is vital to good outcomes. 	<ul style="list-style-type: none"> • Cost surprises often occur at bid openings. Bid overrun leads to owner disappointment. • Architects are not always (some are) strong support with driving the construction schedule which leads to owner disappointment in occupancy dates.
<p>2) Construction Management. The hospital commissions an architect and construction manager (CM) at nearly the same time to work together as a team developing designs, construction drawings, specifications, and cost estimates/bids leading to the construction of the building. The process must be conceived as a “daily working process as a team” to constantly monitor and evaluate program, design, and costs as the design progresses. The team members must have hospital experience and it is beneficial in controlling costs and schedule if the architect and CM have had experience working together.</p> <p>CMs can contract where the CM is At Risk or Advisor. Best advantage for the hospital is CM At Risk, whereby the CM holds all the subcontractors and is responsible for the overall cost and usually bonds the entire construction amount. CM can contract as Advisor providing the same pre-construction services, but thereafter in bidding and construction, acting only as an advisor and manager of construction with all construction contracts held directly with the hospital.</p>	
<u>Pros</u>	<u>Cons</u>
<ul style="list-style-type: none"> • The owner can usually select the CM on the basis of qualifications and experience with competitive fees instead of absolute lowest bid. • The CM can have valuable insight as to construction market conditions, assisting with cost-effective decisions, including design material selections. • The project can be on a faster timeline than traditional bid projects. 	<ul style="list-style-type: none"> • State law in several States limits the contracting options with a CM.

Phase 1: Planning and Preparation

3) **Design-Build.** The architect and contractor are part of the same firm, resulting in a concentration of decision-making with a single entity. The hospital may be able to save time overall and contract costs have traditionally been less than under other methodologies. The hospital contracts with a design-builder as a single source responsibility to develop designs, construction drawings, and subcontracts to achieve the hospital's defined scope, design performance, and materials/finishes performance at the agreed project cost. The design-builder may be a team of companies or one company with all or some design professionals and all or some of the needed construction labor or staff.

Pros	Cons
<ul style="list-style-type: none"> • Single source responsibility for the hospital. The hospital is removed from disagreements between the architect and contractor. • There are many ways to configure a contract, which emulate desired aspects of other processes, e.g., open bidding, open book accounting. 	<ul style="list-style-type: none"> • Owner does not have complete control over all aspects of the design or contracting process. • Owner may be disappointed with material and/or equipment selections the design-builder makes to stay within his budget and function to the minimum performance of the specifications.

Action Step 6: Finalize Project Budget (Event 2)

Background: The preliminary project budget provides a working document until you can finalize the budget in a later stage after construction documents have been completed. The project budget includes all of the costs related to the project, including site acquisition and development costs, hard costs, equipment costs, costs related to financing and/or fundraising and other "soft" costs. The contractor's cost estimates will be based on the architect's drawings and the description. The cost estimates will change as the drawings progress from schematic design to design development to construction documents.

Rationale: A firm construction estimate or guaranteed maximum price (GMP) is required in order to proceed with pricing. Get input from your project team to ensure that design and pricing are appropriate and realistic.

Strategy: Beginning with rough estimates, the project budget becomes increasingly refined and detailed as the design proceeds. The hospital, FPC Resources, and project team will play roles in developing and continuing to refine the project budget. FPC Resources will have the responsibility for making sure all parties understand the design and construction budget parameters and how changes to design parameters will impact project cost.

Event 3: Research Financing and Assess Feasibility

ACTIONS/ GOALS	DURATION	COSTS/FEEES	INVOLVED PARTIES
1. Implement Financing Strategy 2. Research Financing Options 3. Commission Feasibility Study 4. Prepare Financing Information	3 – 6 months	Feasibility Study Fee	✓ Project Sponsor ✓ FPC Resources ✓ State HEFA ✓ Lenders/Underwriters ✓ Federal Program Staff

Action Step 1: Implement Financing Strategy (Event 3)

Background: Rural hospitals have long struggled for capital financing, but the market has learned that replacement hospitals can be financed responsibly. Every hospital,

Phase 1: Planning and Preparation

its environment and financial condition, and the markets play a role in the financing.

Rationale: While the hospital leadership team (e.g., CEO, CFO, Board Chair, Board members) will be intimately involved in the financing process, the Financial Advisor guides the financing process and coordinates it with other aspects of the project to minimize the hospital's business risks.

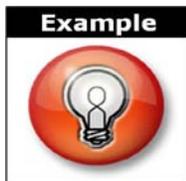
Strategy: FPC Resources help you establish the preliminary finance plan, which identifies and quantifies the project budget and funding sources. Hospitals typically fund projects with a combination of organizational equity, capital campaign, government grants and debt financing. You need to understand the amount of debt you can afford and the amount of funds you can raise.



Tip

The use of a Financial Advisor with experience working with CAHs is recommended to:

- √ Align the financing strategy with the hospital's strategic plan
- √ Help educate the hospital leadership team on the potential financial impact of replacement vs. rehabilitation
- √ Identify operating improvements (e.g., Medicare reimbursement, aging accounts receivable) that could positively impact the bottom line
- √ Help identify options for paying upfront costs prior to closing
- √ Set financial parameters through debt capacity and market demand analyses
- √ Identify financing options and provide cost/benefit analyses
- √ Facilitate or implement financial feasibility analysis
- √ Identify whether commercial or Federal enhancements are appropriate
- √ Facilitate selection/coordination of capital campaign consultant, financial feasibility consultant, underwriter/lender and other consultants



Example

According to the *2008 Rural Hospital Replacement Facility Study*, funded by Stroudwater Associates, participating hospitals, the study sought out a variety of funding sources, including:

- √ Guarantee from System: nine hospitals accessed capital through their affiliated system relationship, most often as part of a larger bond package
- √ Guarantee from County/City: five hospitals used County/City backing to issue and guarantee the debt;
- √ Private Placement: three hospitals used Private Placement; and
- √ Bonds: 10 hospitals used a variety of programs to access capital independently.

Nearly all CAHs held major fundraising/capital campaigns to supplement financing. Some foundations have remained active after the replacement project was completed.

One hospital had approximately \$4 million in outstanding accounts receivable (A/R). The hospital hired a company that specializes in collections. The company charged less than \$100,000 to perform collections and train hospital staff to properly perform collections. The hospital collected \$2.4 million of the outstanding \$4 million. **Lesson Learned:** Hospitals considering facility replacement have to get their finances in order, which may include improving Medicare billing and reducing outstanding A/R.

Action Step 2: Research Financing Options (Event 3)

Background: The financing options for CAHs can be complex and confusing. Each financing structure has unique characteristics that will likely have both desirable and

Phase 1: Planning and Preparation

undesirable qualities. When a hospital chooses to build a replacement facility its strategic plans and credit strength will determine its access to capital.

Rationale: The ultimate goal is to develop a financial strategy that maximizes access to the capital markets and minimizes the cost of capital.

Strategy: Financing options are based on the hospital's credit profile. The use of a qualified and experienced Financial Advisor with CAH experience will provide the widest range of potential funding options which must be explored for the best financing terms. Borrowers with stronger credit profiles have more financing options, while weaker ones have fewer. The latter will often choose to access the capital markets using some form of credit enhancement.



A hospital's credit strength or financial health is the single most important factor in determining its cost of capital. The following ratios are used most frequently when assessing creditworthiness:

- √ Debt Service Coverage
- √ Days Cash On Hand
- √ Operating Margin
- √ Debt to Capitalization

The amount a bank will lend a hospital is usually limited to a direct multiple of a hospital borrower's cash flow (e.g., 3-4 times).

Lesson Learned: Many CAHs do not feel they will qualify for financing and/or are concerned about the hospital's ability to repay an investment in its facilities. FPC Resources will help the hospital understand its options and can greatly impact the hospital's ability to gain financing.

Below is a brief introduction to financing options as well as additional financial resources.

Table 3: Financing Options and Additional Federal Government Enhancements
1) Unenhanced (Non-Rated) Conventional Revenue Bonds
<p>Hospitals with excellent credit strength may choose to issue bonds without credit enhancement.</p> <ul style="list-style-type: none"> • Small investor market compared to other options and limited market liquidity • Interest rates may be higher than other tax-exempt options • Estimated Timing: 4 to 6 months • Investor control upon default
2) Enhanced Revenue Bonds (Commercial Enhancements)
<p>Hospitals have the option to obtain commercial enhancements to obtain better interest rates on their bonds, including letters of credit and bond insurance. Bond insurance often is not available to community hospitals with more modest financial means and generally smaller transactions. A letter of credit issued by a commercial bank is an irrevocable obligation to make bond payments if a borrower cannot.</p> <ul style="list-style-type: none"> • Bank Letters of Credit and for-profit Bond Insurance are enhancement options • Generally requires borrower underlying credit profile of "BB" or higher • Enhancement cost varies based on hospital's credit profile and transaction size • Tax-Exempt Fixed Rate and Floating Rate options are available • Interest rates vary by rating and term • Estimated Timing: 4 to 6 months • Enhancer establishes covenants and loan restrictions • Enhancer control upon Default
3) Federal Government Programs
<p>The Federal government has enhancement programs for CAHs that offer direct loans or loan enhancements; however, the hospital still has to engage lenders. Each of these entities has standards that must be met, and insurance/guarantee has a cost attached to it. As the</p>

Table 3: Financing Options and Additional Federal Government Enhancements

insurer/guarantor, these entities would bear the brunt of any default; accordingly, they put applicants under the same scrutiny as lenders during the application review.

- HUD FHA Section 242 Hospital Mortgage Insurance Program
- USDA Community Facilities Program Guaranteed and/or Direct Loans

See [Appendix B: Federal Government Programs](#).

4) Additional Financial Resources

The FPC Resources will help you evaluate additional financing sources. In addition to accessing capital through loans, most creditors will expect some type of hospital or community contribution. Additional local financial sources may include: capital campaign, tax revenues, and state/local grants. Local resources are an important resource for financing capital projects. Community fund-raising campaigns can be an effective way of fundraising with the proper strategy. Capital campaign funds raised **prior to loan closing** can favorably impact the loan amount.

An additional financial resource may be your State health facilities finance authority. Most States have agencies that act as the vehicle for providing financing to public and non-profit hospitals through loans funded by the issuance of tax-exempt bonds. The National Association of Health and Educational Facilities Finance Authorities (NAHEFFA) provides a state-by-state listing on its website at <http://naheffa.com/members.html>.



- ✓ Your financial advisor will be in the best position to explain the options for getting the most cost-effective financing.
- ✓ The cost of financing is not determined solely by the financing rate.
- ✓ Timing and financing requirements will impact the final project cost. For example, Federally enhanced financing may require that Federal Davis Bacon Act provisions apply to construction, which may increase construction costs.
- ✓ Develop elements of your work plan simultaneously because the financing timeline impacts costs due to opportunity costs, lost revenues, and construction inflation associated with a longer timeframe.
- ✓ Interest rates and access to capital may not be as favorable.

Action Step 3: Commission Financial Feasibility Study (Event 3)

Background: The financial feasibility study provides in-depth financial, operations, and demographic data that is the basis for financing. The fundamental purpose of a financial feasibility study is to determine and evaluate your ability to repay borrowed funds.

The financial feasibility study:

- ✓ Describes your project, its rationale, and financial implications for your hospital.
- ✓ Consists of historical and prospective financial statements and other pertinent information that present the facility's expected financial position, results of operations, and changes in financial position.
- ✓ Provides financial projections for 3-5 years, including revenues and expenses based on estimated patient visits, projected payor mix, assumed staffing levels and estimated project costs.

Rationale: The financial feasibility study demonstrates that loan proceeds, together with cash flow of the facility, are sufficient to complete the project and cover annual debt service requirements.

Strategy: The feasibility study may be prepared by FPC Resources or a feasibility consultant with expertise in health facility financial consulting especially CAHs. The feasibility study should follow the guidelines provided by the financing source, e.g., lender and/or Federal program. A compilation level study is generally required for unenhanced financings. An exam level feasibility study, which requires attestation by a CPA, may be required depending on lender/enhancement requirements and hospital credit profile.



- √ The financial feasibility study is the basis for financing decisions.
- √ Your underlying assumptions should be appropriate and make sense based on your financial and market demand data.
- √ Factors impacting financial parameters include: historical financial performance; community demographics; Medicare issues – past vs. projected; operating issues – past vs. projected; facility design; and potential impact on community and physician recruitment by replaced facilities.

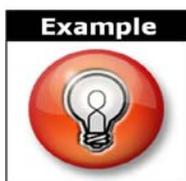
Action Step 4: Prepare Financing Information (Event 3)

Background: Up to this point, you may have participated in preliminary discussions with prospective financing sources. Now your focus turns to preparation of the financial information packets based on the financial feasibility study. Now is the time to learn more about Federal loan enhancements, if applicable, and commence with the development of a financing packet and/or Federal enhancement application. Go ahead and contact staff at HUD and USDA. Their job is to help you.

For Federal Government programs, the application requirements are unique to the 2 programs (HUD and USDA) and require additional information. However, the feasibility study is still the basis for the application. The hospital has to select a lender prior to submitting its application.

Rationale: If you do not plan to use an enhancement, you should have the required financial, design, and construction information to move forward with the financing process. Hospitals with weaker credit profiles may consider Federal government enhancements in order to get the most cost-effective financing.

Strategy: Your financial advisor and/or lender can help you decide if an enhancement is required and which would work best given your credit profile and other unique characteristics. [Appendix B: Federal Government Programs](#) provides program overviews that may help to determine if either program might be suitable. Remember, your lender is your partner in this process.



HUD's preliminary review focuses on eligibility, market need, and financial strength. HUD performs a review of the hospital and proposed project with the information provided by the hospital and mortgage lender.

HUD FHA Hospital Mortgage Insurance Program Application Process:

1. Self Assessment to determine if FHA mortgage insurance is right for you.
2. Choose a Lender who is active in the program.
3. Preliminary Review: FHA performs based on minimum eligibility requirements at

<http://www.hud.gov/offices/hsg/hosp/eligibility.cfm>.

4. Pre-Application Meeting at FHA headquarters to discuss the proposed project, application process and issues that may affect loan eligibility.
5. Application Submission: The hospital and mortgage lender will complete and submit application at: <http://www.hud.gov/offices/hsg/hosp/winter06.pdf>.
6. Underwriting: FHA conducts an underwriting analysis of the proposed project, including a site visit.
7. Commitment: If the hospital and project are approved, a commitment is issued.
8. Closing: Following the commitment, HUD counsel assists the mortgage lender, hospital, and legal representatives to close the loan.
9. During construction of the project, HUD staff members monitor the project, approve loan draws, and conduct site visits.
10. Final Endorsement: Once construction is completed and the final draw has been made, the final mortgage amount is established and amortization begins.



USDA's process begins at the Field Office level as there is an emphasis on involvement and knowledge of local communities. However, all guarantees over \$3 million must be reviewed and approved by headquarters. Guarantees and loans are made based on financial feasibility, cash flow, and reasonable project costs. Projects must be modest in size, design and scope.

USDA Guaranteed Loan Application Process:

1. Lender and borrower submit pre-application.
2. Field Office visit to project site.
3. Lender and hospital complete and submit application.
4. USDA performs credit analysis, evaluations and environmental assessment.
5. USDA obligates guaranteed authority and issues Conditional Commitment.
6. Hospital completes construction with interim construction financing.
7. Development work is completed and facility is operational.
8. Lender closes permanent loan and requests the guarantee.
9. USDA issues Loan Note Guarantee after verifying conditions met.

USDA encourages local financial institutions to participate as the guarantee does not count towards the lender's loan limit. USDA also offers small Direct Loans that have eligibility criteria similar to that of the Guarantee Program, but availability is limited. Interest rates for the Direct Loan Program are established by USDA. Interest rates, terms and covenants for guaranteed loans are determined by the lender. Borrowers may pursue a Direct Loan to supplement other funding.



- √ The FHA Hospital Mortgage Insurance and USDA Guaranteed Loan Programs do not provide loans. Thus, the lender is a co-applicant in the process and provides the actual project funding.
- √ USDA Guaranteed Loan Program does not provide construction funding.

Event 4: Community Engagement and Capital Campaign

ACTIONS/ GOALS	DURATION	COSTS/FEES	INVOLVED PARTIES
1. Develop and Implement Community Engagement Plan 2. Develop and Implement Capital Campaign Plan	Ongoing	Campaign Consultant Fee Marketing and Development Costs	<ul style="list-style-type: none"> ✓ Project Sponsor ✓ Board ✓ FPC Resources ✓ Consultant ✓ Development Office ✓ SORH/Flex Office ✓ Rural Health Works ✓ Community

Action Step 1: Develop and Implement Community Engagement Plan (Event 4)

- Background:** As soon as you start considering facility replacement, begin planning to involve your community, which has to be a priority throughout this process.
- Rationale:** Replacing an existing hospital facility can be an emotional issue for members of the community. Resistance from even a few members can derail a project or make it more costly. You must address the 2 biggest concerns that community members generally have: “Why do we need a new hospital?” and “How are we going to pay for it?”
- Strategy:** Start the conversation with the community early by sharing the importance of local health care and the hospital’s role and contribution to the community. Establish and implement a communications strategy to initiate and build community support for the hospital project. Keep community engagement as an ongoing initiative. Community engagement requires 1) board education and leadership, 2) physician and staff involvement, 3) telling your story, and 4) engaging the local media, elected officials, and health department analysts.



Tip

Board Education and Leadership

The board needs to be efficient and effective during this process. The CEO and FPC Resources will work with the board to facilitate timely decisions based on the hospital’s operational, financial, and facilities data, which form the basis for the hospital’s story.

- ✓ Strong board leadership is needed for community to buy-in.
- ✓ While board members have diverse opinions and disagree, boards need to “be quick and quiet” so they do not share negative information with the community.
- ✓ Know your message before you begin community engagement.
- ✓ Speak with one voice and share a consistent message.
- ✓ Sell your overall vision at the local and State level for buy-in from community leaders, the community, and elected representatives.

Once the Board had the facility assessment, which showed that replacement was more cost- effective than renovation, the Board had a strong message and stayed on target. “It was clear that if we spent one more dollar on the existing facility, the dollar was wasted.” Hospital leadership took the message and supporting data to the community.

Tip



Physician and Staff Involvement

Physicians and frontline staff can be the best ambassadors for the hospital. Keep them informed from the beginning of the process and give them tools to effectively engage the community.

- √ Physician input and involvement is critical in getting the message out to and raising funds in the community.
- √ Work with the physicians to gain their support throughout the process.
- √ Facility replacement greatly impacts the quality of care and breadth of services physicians can provide to their patients.
- √ Frontline staff have strong ties within the community and need to be informed, so that they can help get your message out into the community.
- √ Frontline staff may provide insight to community reaction and engagement.

Tip



Telling Your Story

When telling your story, the message from hospital leadership, physicians and staff should be consistent. The story is based on the strategic process the hospital used to 1) identify its facilities options and 2) decision to pursue facility replacement. Refer to replacement as the “proposed project”; do not imply that the replacement hospital is a “done deal.” The story should identify your key objectives, including:

Hospital's Financial Impact on Community

- √ Hospital's current economic impact on the community.
- √ The financial impact of the replacement on the community, The Center for Rural Health Works (RHWs) has tools that can be useful (p.51).
- √ Describe the hospital's current financial condition and how a new project would affect the hospital's bottom line.
- √ Communicate the hospital's benefit to the community as a large employer. Convey the number of employees and the financial impact to the community with and without the hospital.
- √ Share the results of other hospitals that have replaced and that replacement is an investment in the hospital and community's future.

Hospital's Health care/Service Impact on the Community

- √ Share why the facility is needed and how it will benefit the community.
- √ Share service area demographics, including who you are serving and out-migration.
- √ Inform the community of free services that the hospital provides to the community (e.g., providing an ambulance at local games).

Tools to Engage the Community

- √ Develop a written story that provides an overview of the hospital leadership's vision and includes frequently asked questions (FAQs).
- √ Use targeted focus groups to achieve greater participation.
- √ Identify the best avenues for getting the information out.
- √ Use multiple means of conveying your message (e.g., newspapers, newsletters, local television, cable and radio stations, talks to service clubs and special interest groups).
- √ Become active in established community groups where the hospital will be in a strategic position to gain influential friends. Pay the dues to have a hospital representative participate in the local community service clubs (e.g., Kiwanis, Rotary, Lions).



Early Engagement of the Local Media, Elected Officials and Health Department Analysts

The local media, elected officials, and health department analysts can help make or break your project. Engage them early, so that they are in the know and can serve as a project champion when you run into the inevitable obstacles.

- √ Identify any individual, position, or organization that can oppose your project and plan how to gain their buy-in or at least minimize any negative impact.
- √ Engage the local media, including newspaper editorial boards, radio and television stations.
- √ Consider hiring a company to perform a market analysis. For example, most hospitals automatically use the local newspaper to communicate with the community. For one hospital, its market analysis recommended targeting radio and television ads during NASCAR and WWF. The campaign was successful because its target audience listened to and watched these programs.
- √ Inform your local, State and national legislative representatives of the community's intent and seek their support.
- √ If elected officials are brought into the project from the outset, they may champion the project and it will also be something that can be a win for them as well.
- √ Get in touch with the financial analysts who work for the local health departments because they crunch the numbers for local government regarding health care needs in the community
- √ Make sure the hospital's data justifies the replacement and synchronizes with local health department financial analyst's data.



Marketing

- √ A new hospital is a massive undertaking and marketing is a key component for a successful hospital. A marketing consultant may be needed to effectively manage this process.
- √ You will need to increase and maintain new business during facility planning, including a plan to turn the out-migration around early.
- √ You will need to plan to educate the community of the new changes to the hospital and promote the new facility, including physician recruitment.
- √ Don't forget to plan and budget for new physician recruitment.

Economic Impact and Community Health Engagement Process

In the *2008 Rural Hospital Facility Replacement Study*, "Hospital executives noted that the new facility bolstered economic development activity. The hospital was often cited as a key factor in attracting businesses to relocate or expand in the local community." The [National Center for Rural Health Works](#) has utilized the following options to assist communities with CAH replacement.

Option 1: provide an **economic impact** of the construction of a CAH replacement facility and provide an economic impact of the CAH itself.

- The economic impact of the CAH replacement facility construction shows how much value the construction brings to the rural economy (jobs, income and retail sales) as well as the additional local government income from taxes on increased sales.
- The economic impact of the CAH facility illustrates the value of the CAH facility to the community each and every year shown in terms of the number of jobs and income (wages and salaries and benefits) generated by the hospital workers annually as well as the local government income from sales taxes.
- These 2 economic impact studies can be summarized in a one-page handout to utilize at Hospital Board meetings and other community meetings.

Phase 1: Planning and Preparation

Economic Impact and Community Health Engagement Process

Option 2: Provide a **community health engagement process** including the economic impact studies and the following: 1) Community health resources directory; 2) Community health needs assessment survey, which may identify out-migration; 3) A series of five to six community meetings.

- This option requires a resource team to prepare products and provide a series of meetings to distribute the products. This process involves a large community health steering committee and a series of newspaper articles to distribute the information to the community at large.
- Through a series of five to six meetings, the products are shared with the committee members. After the series of meetings is complete, the community must take the lead in implementing the community action plan and doing any additional health promotion activities.
- This process is more resource-driven and can be valuable in gaining the community health steering committee and overall community's support for local health services, including the CAH facility. The process can be designed to emphasize the CAH facility replacement.

The Center for Rural Health Works also prepares physician feasibility studies for communities, which essentially calculates the number of primary care physicians a community can support and provides salary estimates for those physicians. This information can be used to help develop the hospital's physician recruitment plan.

For further information, go to <http://www.ruralhealthworks.org/download.html> or contact: Dr. Gerald A. Doeksen, Director (gad@okstate.edu) or Cheryl F. St. Clair, Associate Director (cheryl@okstate.edu).

Action Step 2: Develop and Implement Capital Campaign Plan (Event 4)

Background: If your hospital has not nurtured a "culture of giving" campaign in the past, this surely is the time to begin. Communities have watched hospitals struggle for survival and they want to make sure that if they contribute, the hospital will continue to be there. Your capital campaign is your opportunity to partner with the community to keep the hospital moving forward and growing so that it will continue to provide quality health care services long into the future. In order to have a successful campaign, your hospital must align its capital campaign with the facility replacement.

Rationale: A capital campaign helps the community collect funds prior to financing and can have an enormous impact on the hospital's debt capacity.

Strategy: A capital campaign includes several stages and each stage requires extensive planning. Capital campaign donations come from foundations, corporations and individual donors. You should begin capital campaign planning by engaging a capital campaign consultant to perform the following tasks:

- √ Assess the community's fundraising capacity,
- √ Help you align the capital campaign with facility replacement,
- √ Help identify capital campaign team members and methods for identifying potential donors, and
- √ Help you understand how to make the "ask" (the consultant does not make the "ask" for you).

And be sure to engage at least 2-3 community leaders to lead your capital campaign!

Example



Your Capital Campaign Plan:

- √ Outlines the steps you will take to raise funds including the timeline, team members, and specific fundraising goals.
- √ Identifies the campaign organization and staffing.
- √ Incorporates information from the capital campaign feasibility study, which identifies volunteer leadership, potential donors, and fundraising estimates.
- √ Should include your specific capital campaign goals and purchases in mind, possibly focusing on equipment, which may be 20 percent or more of construction.
- √ Funds collected prior to financing closing will have the biggest impact on your debt capacity.

Phase 2: Facility Design and Financing

Phase 2: Facility Design and Financing (3 – 12 Months) focuses on the completion of the facility design (construction documents) and obtaining a guaranteed maximum price (GMP) or bidding for the project. During this phase, you will have most of the detailed costs associated with the project and can proceed with the final steps to obtain financing proposals from prospective lenders and/or complete the financing application for a government enhancement program. The feasibility study, completed in Phase 1, is the basis for financing and requires financial, programmatic, and facility design information.

Facility Design and Financing covers the following four events and their corresponding actions:

- √ [Project Articulation \(2 Action Steps\)](#),
- √ [Design and Construction Development \(4 Action Steps\)](#),
- √ [Obtain Financing \(2 Action Steps\)](#), and
- √ [Community Engagement and Capital Campaign \(2 Action Steps\)](#).

Event 1: Project Articulation

ACTIONS/ GOALS	DURATION	COSTS/ FEES	INVOLVED PARTIES
1. Submit CON Application and Obtain Approval 2. Continue Discussion with CMS	1 – 6 months	CON Application Fee CON Consultant Fee	<ul style="list-style-type: none"> ✓ Project Sponsor ✓ FPC Resources ✓ CON Consultant ✓ State CON Office ✓ CMS ✓ SORH/Flex Office

[Action Step 1: Submit CON Application and Obtain Approval \(Event 1\)](#)

Background: As part of the community engagement process, make sure that other local health care providers are aware of the proposed project and work to get their buy-in. Resistance from other local health care facilities can delay CON approval and create conflict within the community.

Rationale: If your state requires a CON, the CON must be approved prior to construction.

Strategy: Hospitals need a well-prepared, defensible CON as it may be challenged by other local health care providers. With resources scarce and with health care costs reaching frightening levels, you should be able to present the project as one that is more complementary to the health care needs of the community rather than competitive to existing providers, a scenario few can contest.

[Action Step 2: Continue Discussion with CMS \(Event 1\)](#)

Background: Necessary Provider CAHs must communicate with CMS prior to relocation, during relocation implementation, and post-relocation.

Rationale: Relocation may pose a risk to CAH designation.

Strategy: During its relocation, construction, and implementation phase, the Necessary Provider CAH must: 1) notify the CMS Regional Office of any changes to the

Phase 2: Facility Design and Financing

information submitted with its initial relocation attestation letter; and 2) work appropriately and closely with the State Survey/Licensure Agency (SA) and, as necessary, local authorities. Your State Office of Rural Health can be very helpful here. <http://www.hrsa.gov/ruralhealth/about/directory/index.html>.

Event 2: Design and Construction Development

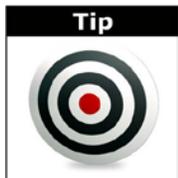
ACTIONS/ GOALS	DURATION	COSTS/ FEES	INVOLVED PARTIES
1. Draft Design Development Drawings 2. Refine Equipment Budget 3. Draft Construction Documents/Support Bid Process 4. Obtain Guaranteed Maximum Price (GMP)/Signed Construction Agreement	1 – 6 months	Architect Fee Equipment Consultant Fee	✓ Project Sponsor ✓ FPC Resources ✓ Architect ✓ Construction Contractor ✓ Equipment Consultant

Action Step 1: Draft Design Development Drawings (Event 2)

Background: In the schematic design phase, the focus was on the project as a whole. During design development, the second design phase becomes important to give individual attention to each space and each detail of the project.

Rationale: Design development drawings are required to further develop the project and refine the project budget.

Strategy: The project team is focused on integrating all program requirements into the design and providing the contractor with the information necessary to complete a comprehensive project design development estimate. At the conclusion of design development, the building layout is finalized and the location of program spaces is fixed. Any change to the project’s scope or program during this phase will likely incur budget and schedule impacts. The Master Facilities Planning Committee will continue to provide the design team with a hospital perspective of the design specifications. The project proceeds to the next phase when the hospital approves the design development documents.



In this phase, the project is developed to a level of detail necessary to work out a clear, coordinated description of all aspects of the project, including:

- ✓ Floor plans show all the rooms in correct size and shape.
- ✓ Specifications are prepared listing the major materials and room finishes.
- ✓ Major elements including equipment, fire protection, mechanical, electrical, structural, telecommunications and plumbing systems are designed and coordinated through enlarged scale drawings, detailed elevations and plans, and design mock-ups as required.
- ✓ The Architect verifies that the design complies with building codes and works with engineers to design the structure, mechanical and electrical systems.

Action Step 2: Refine Equipment Budget (Event 2)

- Background:** As the design development and Construction Documents are completed, the project team has more information to refine the equipment requirements and budget (FFandE).
- Rationale:** Equipment is a substantial portion of the construction budget and equipment requirements and costs must be monitored throughout the project.
- Strategy:** The equipment consultant, architect and contractor work with the hospital's equipment manager to refine the equipment needs and budget as the design is finalized. The equipment consultant may perform acquisition of new and refurbished equipment. The hospital's equipment planner may serve as liaison between individual departments and the project team. The equipment must also meet the Center for Medicare and Medicaid Services (CMS) meaningful use guidelines (proposed at the time of this publication).

Action Step 3: Draft Construction Documents/Support Bid Process (Event 2)

- Background:** Once you have approved the design development documents, the focus shifts from design to communicating the design and providing all information necessary for construction. Construction documents (or bid documents) constitute the last stage of the architectural design process.

Health Information Technology Note: The equipment needs must meet the Center for Medicare and Medicaid Services meaningful use guidelines when purchasing Health Information Management (HIM) systems.

- Rationale:** The construction documents provide a set of final and complete drawings together with final specifications suitable to use in bidding out the job to contractors.
- Strategy:** The Architect works with the project team to develop fully-specified construction documents that will allow contractors and/or subcontractors to bid on the work with a full understanding of what is required, allowing the hospital to obtain fair and accurate bids. These drawings and specifications become part of the construction contract. The Architect also assists the hospital in the preparation of bidding documents and review of contractor submissions. The hospital leadership should have a clear understanding of what is in the final contract documents.

Action Step 4: Obtain GMP/Signed Construction Agreement (Event 2)

- Background:** Based on the construction documents, the contractor develops an agreement with a construction cost figure that becomes an integral part of the financing process.
- Rationale:** A firm estimate of construction costs is sufficient for initial financing application; a signed construction contract is required for financing closing.
- Strategy:** It is sound business practice, and the required procedure of some lending sources, to obtain bids from qualified contractors to build the facility. Eventually, the hospital will want to have a contract with a firm price executed

Phase 2: Facility Design and Financing

with the selected general contractor, design-build firm or Construction Manager (CM). Choosing a qualified and reputable contractor or CM is critical to the success of your project. You want to choose someone who has the right level of experience to build your project on time and within budget. The contractor/CM generally coordinates with the Architect and FPC Resources during the bid process and assists with subcontractor selection.



- ✓ You need a contractor with expertise in rural hospitals, especially CAHs
- ✓ Local contractors need to be involved but usually do not have the capacity or expertise to understand the overall project scope and cost.
- ✓ The price of materials and labor are constantly changing. Usually upwards.
- ✓ CM at Risk may provide GMP once design is at least 75 percent complete.
- ✓ A lump sum bidder may hold its bid for 45-60 days and a CM will usually hold its GMP for up to 120 days before renegotiation.
- ✓ Interview contractors and check references. Before signing the contract, contractor should be able to name its project superintendent and manager.

Event 3: Obtain Financing

Once you have a signed construction contract, you can move forward with the financing process. There is a general process for capital market financing; however, if a government enhancement program is used, there are additional requirements that must be met that may increase the financing timeframe.

ACTIONS/ GOALS	DURATION	COSTS/ FEES	INVOLVED PARTIES
<p><u>1. Capital Market Financing</u></p> <p>Obtain Financing Proposals from Prospective Lenders</p> <p>Select Lender/Underwriter</p> <p>Engage Bond Counsel</p> <p>Select Issuing Authority</p> <p><u>2. Government Enhancements and Loans</u></p> <p>Submit Application</p> <p>Obtain Approval</p>	1 – 9 months	<p style="text-align: center;"><u>Government Programs</u></p> <p>Government Enhancement Application Fee (if applicable)</p>	<p>✓ Project Sponsor</p> <p>✓ FPC Resources</p> <p>✓ State HFFA</p> <p><u>Capital Market</u></p> <p>✓ Issuing Authority</p> <p>✓ Bond Counsel</p> <p>✓ Lender/Underwriter</p> <p><u>Government Programs</u></p> <p>✓ Lender</p> <p>✓ Federal Program Staff</p>

Action Step 1: Capital Market Financing (Event 3)

Background: By the time you get to this point, you've done the hard work. With the help of FPC Resources, you developed a financing strategy, understand your hospital's credit profile, completed the project design and executed an agreement with a construction contractor, explored your financing options, and completed the financial feasibility study. This is where your hard work pays off – obtaining the funds you need to complete your project.

Rationale: If you've decided on using capital market financing without commercial/Federal enhancements, you should be able to move forward with the financing process.

Phase 2: Facility Design and Financing

- Strategy: There are various steps required for a capital market financing and your FPC Resources will continue to guide you through the steps listed below:
- √ Obtain financing proposals from lenders/underwriters
 - √ Select issuing authority
 - √ Engage borrower's counsel and local counsel related to financing
 - √ Evaluate loan documents
 - √ **Select lender/underwriter**
 - √ Adhere to lender due diligence
 - √ Conduct meetings with bond issuers and insurance companies
 - √ Print preliminary official statement
 - √ Price bonds and loan closing



Recommendations for making the financing decision:

- √ Be sure to have an experienced financial advisor and/or lender with CAH experience to guide you through the financing process and listen to them.
- √ Review and understand contract requirements and/or make sure that your financial advisor and attorneys understand the requirements and explain them to you.
- √ You need to understand the lender's requirements and your responsibilities during construction and throughout the life of the loan.

Action Step 2: Government Enhancements and Loans (Event 3)

Background: If you decided to use a government program, you initiated the pre-application process earlier. Now, you have to submit your application, which will be based on 1) the program's requirements; 2) your financial feasibility study; and 3) a construction estimate. A signed construction contract must be submitted prior to the actual commitment.

Rationale: A financing application is required in order to pursue the HUD FHA Hospital Mortgage Insurance Program or the USDA Guaranteed Loan program.

Strategy: The programs above must select a lender as the programs offer a guarantee or insurance, not the actual loan. For both programs, your lender is a co-applicant with you. Federal Program Staff are there to help you – so use them.

Your FPC Resources and Lender will guide you during the application review and decision process. Once the application is submitted, clarifications or additional information may be required by the lender or Federal Program Program Staff. The Federal staff is responsible for assisting the hospital's lender and leadership in 1) navigating through their respective agency and 2) meeting documentation requirements and deadlines. The Federal program staff is the hospital's primary contact and acts as advocate for both the applicant and the agency, i.e., they make certain that the application is fairly presented for review but also is cognizant of the government's need to limit any undue exposure that may result from approving a poor credit risk. Site visits may be made to the applicant's site to discuss findings, observe the management team in action, and speak with members of the community, hospital staff, and others, as deemed appropriate.

Phase 2: Facility Design and Financing



- ✓ Under both programs, bonds may be used (tax-exempts are allowed by FHA).
- ✓ All applications require programmatic, financial, and architectural information.
- ✓ For USDA, both Direct and Guaranteed Loans may be used.
- ✓ Stay in touch – keep the funder apprised of interim events or progress.
- ✓ State grants, capital campaign funds, and other funding are welcomed benefits to the financing package.
- ✓ FHA program is standardized. For USDA, the process can become more complex if you have multiple lenders with differing requirements.

Event 4: Community Engagement and Capital Campaign

ACTIONS/ GOALS	DURATION	COSTS/ FEES	INVOLVED PARTIES
1. Continue Community Engagement 2. Continue Capital Campaign	Ongoing	Marketing and Development Costs	<ul style="list-style-type: none"> ✓ Project Sponsor ✓ Board ✓ FPC Resources ✓ Campaign Consultant/ Development Office ✓ SORH/Flex Office ✓ Community

Action Step 1: Continue Community Engagement (Event 4)

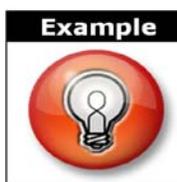
Background: You should continue to engage physicians, staff and the community through regular meetings, written updates, the Website, newspaper, and capital campaign, if applicable.

Rationale: You've made progress so update the story and keep telling it. Community members will continue to question you about the "proposed project."

Strategy: Continue to balance sharing information with identifying information that has to stay among hospital leadership (e.g., decisions not yet made). As the facility and financing process has developed, share the updated information with the community.



- Provide regular progress updates to the community:
- ✓ Keep physicians and staff informed through regular (e.g., quarterly) meetings. Staff especially may have anxiety regarding the job security.
 - ✓ Draft a community newsletter to discuss the process and progress.
 - ✓ Develop a schedule for attending and presenting at community meetings and be sure to distribute the hospital's newsletter, if available.
 - ✓ If you implement the community health engagement process, you already have a communications plan.



- Share a proposed facility replacement building project rationale including:
- ✓ Your vision, mission, and values to remind the community that the hospital is here to serve the community.
 - ✓ The process you used to look at hospital building and grounds to determine whether or not the facility meets current needs as they relate to safety, efficiency, and access to services (e.g., ceiling height, handicapped accessible).
 - ✓ The strategies you considered to address these issues (e.g., maintain status quo, renovation). Make the case for replacement, esp the economic benefits.
 - ✓ Provide QandAs to share how the hospital plans to pay for the replacement facility and how CAH designation affects the hospital's ability to pay.
 - ✓ If you don't get the financing, note that you will continue to evaluate all options.

Action Step 2: Continue Capital Campaign (Event 4)

- Background:** This is a good time to review your capital campaign progress vs. goals to see where additional focus is needed. Continue to identify stakeholders and keep them informed. During the fundraising stage, you will update the capital campaign plan to reflect issues identified in your business plan as well as changes in your budget.
- Rationale:** A successful capital campaign demonstrates community support for your project, raises the hospital's visibility and serves as a symbol of the community's ability to come together for a common purpose.
- Strategy:** The campaign usually kicks off quietly in a leadership phase when you will ask those closest to your organization to give you early support. The public phase (when you raise funds from the community at large) usually doesn't occur until you've reached at least half of your goal. The entire campaign can take 3 years or longer and it is critical for each phase of the campaign to be integrated with design, construction and financing activities.



- √ A capital campaign helps build the hospital's capacity to raise friends and funds.
- √ The board, board development committee, capital campaign committee (generally comprised of community leaders), and senior management will all play a key role in the campaign, both as donors and fundraisers.
- √ The more money you raise, the less money you have to borrow!

Phase 3: Endorsement

Phase 3: Endorsement (0 – 1 Month) represents official acceptance of loan terms. The responsibilities and duties of all parties are defined. Once the loan documents are signed and funding is assured, construction can begin.

Endorsement covers the following events and their corresponding actions:

- √ [Endorsement \(2 Action Steps\)](#),
- √ [Begin Construction \(2 Action Steps\)](#), and
- √ [Community Engagement and Capital Campaign \(2 Action Steps\)](#).

Event 1: Endorsement

ACTIONS/GOALS	DURATION	COSTS/FEES	INVOLVED PARTIES
<p><u>Capital Market Financing</u></p> <p>1. Loan Closing</p> <p><u>Government Programs</u></p> <p>2. Receive Initial Funding and Approval to Construct</p>	0 – 1 month	<p>Financing Fees (Attorney/Bond Counsel Fees and other processing fees)</p> <p>Initial Funds Disbursement</p> <p>Government Enhancement Fee</p>	<p>✓ Project Sponsor</p> <p>✓ FPC Resources</p> <p>✓ Attorneys</p> <p><u>Capital Market</u></p> <p>✓ Issuing Authority</p> <p>✓ Bond Counsel</p> <p>✓ Lender/Underwriter</p> <p><u>Government Programs</u></p> <p>✓ Lender</p> <p>✓ Federal Program Staff</p>

[Action Step 1: Loan Closing \(Event 1\)](#)

Background: The hospital and lender executes the loan documents. The loan closing represents the official acceptance of loan terms.

Rationale: The loan closing provides the initial funds disbursement and the ability to move forward with construction.

Strategy: The FPC Resources and Lender provide guidance to the hospital to close financing. The loan closing or endorsement is focused on agreement to the legal covenants and attorneys are involved on all sides. It is important for the hospital to be clear on all requirements for the financing. The hospital is generally reimbursed for allowable project costs incurred prior to closing (e.g., architectural fees, land costs, CON fees). Payments are generally made to the lender/underwriter, architect, construction contractor, consultants, and attorneys.

[Action Step 2: Receive Initial Funding and Approval to Construct \(Event 1\)](#)

Background: For the government programs, you are issued a Commitment, which is followed by the official loan closing, or Endorsement. Now construction can commence. The Commitment is conditioned on the hospital agreeing to the covenants and allows financing to be finalized.

Phase 3: Endorsement

Rationale: The loan closing provides the initial funds disbursement and the ability to move forward with construction.

Strategy: The strategy is the same as action step 1. You'll also need to be aware of the Federal program's requirements as well as your lenders.



Please note the following for the Federal programs:

- √ For USDA, you have to have a separate construction loan and the guarantee becomes effective for permanent financing after construction completion.
- √ HUD FHA provides insurance with each draw of funds to cover costs during construction and then throughout the permanent loan amortization period.

Event 2: Begin Construction

ACTIONS/GOALS	DURATION	COSTS/FEEES	INVOLVED PARTIES
1. Complete Pre-Construction 2. Begin Timely Groundbreaking	0 – 1 month	Allowable Project Costs	<ul style="list-style-type: none"> ✓ Project Sponsor ✓ FPC Resources ✓ Lender/Federal Staff ✓ Construction Contractor ✓ Architect

[Action Step 1: Complete Pre-Construction \(Event 2\)](#)

Background: Pre-construction includes making sure that the site is prepared and ready to accept contractor's entry.

Rationale: It is important to get construction started on-time.

Strategy: As you get closer to financing, you should make sure that the site is prepared and construction can begin immediately after loan closing. Some programs may even allow for early start of construction. Managing the project schedule is key, including getting the site prepared to begin construction on time and the availability of labor and pricing of materials. And there's always the weather and other surprises! Try to manage the time your financing will be completed as to when it would be advantageous to begin construction upon the award (e.g., spring, summer).

[Action Step 2: Begin Timely Groundbreaking \(Event 2\)](#)

Background: The groundbreaking is a symbolic and practical event that allows you to announce your progress in a big way. A timely groundbreaking also means that pre-construction is on schedule.

Rationale: The groundbreaking ceremony should generate excitement within the community and hopefully show that the project is on schedule.

Phase 3: Endorsement

Strategy: Project goal to have a timely groundbreaking, which means that all required building permits, local requirements and inspections are factored into the project schedule and attended to as required. This is the chance for you to show off what has been accomplished. Invite everyone who has participated in the capital campaign, including politicians, notables and the press.

Event 3: Community Engagement and Capital Campaign

ACTIONS/GOALS	DURATION	COSTS/FEES	INVOLVED PARTIES
1. Continue Community Engagement 2. Continue Capital Campaign	Ongoing	Marketing and Development Costs	<ul style="list-style-type: none"> ✓ Project Sponsor/Board ✓ Campaign Consultant/Development Office ✓ SORH/Flex Office ✓ Community

[Action Step 1: Continue Community Engagement \(Event 3\)](#)

Background: Once funding has been awarded and construction begins, the community will be interested in watching your progress. This is no longer a proposed project – this is an active project and you should continue to keep all interested parties informed.

Rationale: Continued community support is needed for a successful project.

Strategy: Continue to implement your community engagement plan. This should take the form of frequent progress reports through your identified “ambassadors,” covering such topics as the attainment of major milestones in construction, success in staff recruitment, and feedback on fundraising. A newsletter from the existing hospital Website is an excellent way to communicate the new hospital’s progress.

[Action Step 2: Continue Capital Campaign \(Event 3\)](#)

Background: The groundbreaking is also a great time to begin the public part of the capital campaign.

Rationale: Continued community support is needed for a successful capital campaign.

Strategy: Hopefully, you’ve raised more than half of your goal. Now that the community knows the project is happening, use the momentum to get the community involved in your capital campaign. As your hospital is built, your project has switched from being theoretical to real; existing and potential donors have something tangible to see for their efforts, and your capital campaign team should be able to use this transition as motivation for a change in approach.

Phase 4: Construction

In **Phase 4: Construction (12 – 30 Months)**, emphasis is placed on construction management and monitoring to ensure that the project is within budget and on schedule. At project close, an attestation of project costs may be required and loan amortization begins.

Construction covers the following events and their corresponding actions:

- √ [Monthly Requisitions \(2 Action Steps\)](#),
- √ [Pre-Closing and Construction Completion \(1 Action Step\)](#),
- √ [Final Closing/Endorsement \(1 Action Step\)](#), and
- √ [Community Engagement and Capital Campaign \(2 Action Steps\)](#).

Event 1: Monthly Requisitions

ACTIONS/ GOALS	DURATION	COSTS/FEES	INVOLVED PARTIES
1. Manage Timely Construction Progress 2. Achieve Substantial Completion	12 – 30 months (depending on contract terms)	Allowable Project Costs	<ul style="list-style-type: none"> ✓ Project Sponsor ✓ FPC Resources ✓ Construction Contractor ✓ Architect ✓ Lender and/or Federal Program Staff

Action Step 1: Manage Timely Construction Progress (Event 1)

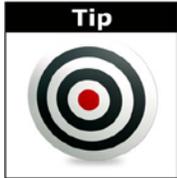
Background: A well-coordinated construction process will hopefully result in delivery of your new facility on time and within budget. It's wise for the hospital to hire a Project Manager (PM) to manage the project on its behalf. The contractor builds the project; the architect verifies the acceptability of the work; the construction lender verifies the progress and adequacy of the work; local and state officials review construction for adherence to their requirements; and the owner manages the players and the process.

Rationale: Timely construction progress sounds simple, but in reality, it is a huge challenge.

Strategy: As a sound business practice, the owner should maintain detailed oversight of the construction progress. Being CEO of a CAH is a very challenging job. The hospital generally has someone that represents the hospital's interests when design or construction issues arise and provides an independent viewpoint to make sound decisions. The hospital may hire a Project Manager, Owner's Representative or Owner Advocate. Despite the best efforts of qualified and experienced professional architects and contractors, some errors or omissions are likely to occur in complex design solutions. With a knowledgeable representative, delays or disputes, which could otherwise progress to become problems, can be avoided or minimized.

Phase 4: Construction

The owner's representative helps drive construction progress and serves as liaison between the hospital and the project team (e.g., construction contractor, architect). There should be regular meetings, typically monthly, throughout the project to address issues, manage requisitions, and ensure timely construction progress.



Tip

Project Budget

- √ Owner's representative serves as the liaison between the hospital (owner) and the project team and drives the construction process.
- √ Early detection of funding and progress variances based on budgeted vs. actual budget line items (i.e., where we are, where we're going).
- √ Owner's representative should know and work within established payment process to avoid crises. This includes facilitating monthly requisition meeting at which subcontractor invoices are submitted by a cut-off date to ensure timely payment.
- √ Owner's representative monitors project balance to make sure the project be completed with the remaining funds.
- √ For government enhancement programs, the invoices have to go through the agency as well as the lender for approval.

Project Schedule

- √ Weather is a big factor as is availability of materials and subcontractors, particularly in remote rural areas.
- √ The architect helps maintain quality and provides monitoring and supervision.
- √ The owner's representative should report regularly to the Owner regarding the construction vs. original schedule and clearly identify issues and changes that need to be made.

Action Step 2: Achieve Substantial Completion (Event 1)

Background: Substantial completion is a date officially determined by the architect of record. Substantial completion triggers warranties for equipment, systems, and construction materials.

Rationale: Meeting the project deadlines is important from a budget and schedule perspective. Substantial completion is a project milestone.

Strategy: The project goal is timely construction progress. Project needs to meet deadlines for substantial completion. There may be state/local penalties if substantial completion deadlines are not made. Within one year after project end owner's representative conducts a warranty walk-through and verifies that any required repairs were completed.

Event 2: Pre-Closing and Construction Completion

ACTIONS/ GOALS	DURATION	COSTS/FEES	INVOLVED PARTIES
1. Perform Project Completion and Cost Certification	0 – 1 month	Capitalized Interest during Construction	<ul style="list-style-type: none"> ✓ Project Sponsor ✓ FPC Resources ✓ Construction Contractor ✓ Architect

Phase 4: Construction

Action Step 1: Prepare for Project Completion, Cost Certification and Closeout (Event 2)

- Background:** For cost certifications and use of any unutilized project funds, each lender/program has its own requirement.
- Rationale:** A project cost certification is worth doing internally, whether or not it is required as part of the project closeout.
- Strategy:** Owner’s representative should be advised to keep excellent records throughout the process as many financing entities require some type of cost certification. This is an opportunity to catch duplicate invoices, identify double payments, and missing or non-submitted invoices. There are the final draws for project expenses, cost certification, and final closing, which is where the permanent loan is placed. Debt service payments (amortization) usually commence within 30-90 days of the original estimated project completion date. The disposition or use of any unused project funds is subject to the provisions of the documents signed at loan closing.

Event 3: Final Loan Closing/Endorsement

ACTIONS/ GOALS	DURATION	COSTS/FEEES	INVOLVED PARTIES
1. Final Loan Closing/ Endorsement	1 – 3 months		<ul style="list-style-type: none"> ✓ Project Sponsor ✓ FPC Resources ✓ Construction Contractor ✓ Lender/Program Executives ✓ Attorneys

Action Step 1: Final Loan Closing/Endorsement (Event 3)

- Background:** Final endorsement includes conversion of the construction loan to a permanent loan and may include the final advance of funds. Final closing does not necessarily correspond to commencement of amortization.
- Rationale:** Each lender and enhancement program has its own requirements, many of which are similar, for the final closing/endorsement.
- Strategy:** A big part of the closing is document assembly and review. Numerous certifications are required for final closing. After construction is completed and costs certified, the final mortgage amount is determined. If your project came in at or under budget, congratulations!

Event 4: Community Engagement and Capital Campaign

ACTIONS/ GOALS	DURATION	COSTS/FEEES	INVOLVED PARTIES
1. Continue Community Engagement 2. Continue Capital Campaign	Ongoing	Marketing and Development Costs	<ul style="list-style-type: none"> ✓ Project Sponsor/Board ✓ Campaign Consultant/ Development Office ✓ SORH/Flex Office ✓ Community

Phase 4: Construction

Action Step 1: Continue Community Engagement (Event 4)

Background: The hospital is now in the construction phase and the end goal is in sight. During construction, the community will watch your progress. Throughout the construction process and during the grand opening, be sure to recognize major contributors.

Rationale: Continued community support is needed for a successful project.

Strategy: Continue to implement your community engagement plan, including progress reports through your “ambassadors.” Think about ways to keep the community engaged in the new facility once it opens. This is your opportunity to enhance the hospital’s relationship with your community – don’t miss it!

Action Step 2: Continue Capital Campaign (Event 4)

Background: During the construction process, review your progress for meeting your timeline and fundraising goals.

Rationale: Continued community support is needed for a successful capital campaign. Based on your plan, you may wish to continue fundraising after the construction has completed.

Strategy: As you end the capital campaign, focus your efforts on 1) meeting your fundraising goals, and 2) developing your fundraising plans to convert your capital campaign donors to general fund donors and ongoing supporters of the hospital. Keep your volunteer leadership motivated and work with them to continue your fundraising efforts. Despite the opening of the project, there is a need to remind the community that there will be an ongoing funding needs for equipment and possibly to implement community outreach programs.



- √ The project construction and completion phase is your opportunity to:
- √ Kick your campaign into overdrive. Many people want to see a shovel in the ground before they are willing to contribute.
- √ Invite the public, employees and the press to the Groundbreaking Ceremony. Have a small reception after to celebrate.
- √ Display project renderings and floor plans in the lobby.
- √ Keep the community apprised of the project’s progress. Offer conducted tours for key supporters during the construction phase.

Estimated Project Costs and Fees

A facility replacement project represents a large investment of capital. Please see below the estimated project costs and fees based on a \$25 million project, with \$22.5 million loan and \$18 million construction component. CAH may need to use cash reserves or hospital operating funds to pay upfront costs prior to bond or loan closing. Costs and fees are generally allowable costs and eligible for reimbursement at closing. FPC Resources helps the CAH negotiate favorable, competitive contracts for services.

Overall Project Cost Considerations

- Estimate **total project cost** at about 130-140 percent of the construction amount, which includes site costs.
- Additional costs other than construction include **facility and equipment assessments, land acquisition and site development, financing costs, consultants, attorneys, and furniture, fixtures, and equipment.**

Phase 1: Planning/Preparation

- It is critical to know the environmental history, soil condition, floodplain designation, zoning and deed restrictions on a new land parcel prior to acquisition. Free land can have a huge cost! Land acquisition and financing, if needed, may be challenging and costly and should be addressed as early as possible.
- A Financial Advisor may work on contingency for a \$10,000 - \$25,000 retainer.
- Accounting firms may perform a **debt capacity analysis** for \$5,000 - \$15,000.
- A CAH should be able to retain a CAH-experienced **architectural firm** for a total fee between 6.5 and 7.5 percent of construction costs. The standard AIA contract calls for the total fee to be incurred (and payable) as follows: 1) Schematic Design 15 percent; 2) Design Development 20 percent; 3) Construction Documents 40 percent; 4) Bidding 5 percent; and 5) Construction 20 percent, for a total of 100 percent.
- The **feasibility study** cost may generally be obtained for \$30,000 to \$60,000 for a compilation, and \$50,000 to \$90,000 for an examination.

Phase 2: Facility Design and Financing

- If a Certificate of Need (CON) is required, the **CON application fee** may vary by state and be commensurate with project size.
- FHA Hospital Mortgage Insurance Application Fees: 80 basis points (bp) total, including 15 bp with application, 15 bp at loan commitment, and 50 bp at initial closing. FHA program includes fixed rate funding for construction and permanent financing.
- USDA Guaranteed Loan Program has a 1 percent fee due at closing and no annual fee. USDA program does not include construction financing.

Phase 3: Endorsement

- **Financing fees** are estimated at 3-4 percent of the loan with allocations of about 1-2 percent to the lender/underwriter, 0.5 percent to the financial advisor, and 1 percent for attorneys (hospital attorney, bond counsel) and other fees. Fee estimates will fluctuate based on the financing vehicle (e.g., bond, mortgage) as well as whether the hospital is using a government enhancement.
- At loan closing and **initial fund disbursement**, the hospital is reimbursed for allowable project costs made prior to closing (e.g., accounting services, land costs, CON fees). Payments are generally made to FPC Resources, architect, construction management firm/contractor, and attorneys.

Estimated Project Costs and Fees

- HUD FHA Hospital Mortgage Insurance has an annual mortgage insurance premium of 0.5 percent of remaining mortgage balance.

Phase 4: Construction

- **Allowable project costs** are paid from loan proceeds as they are incurred.
- The **interest during construction** will vary based on financing method. For loans, construction interest may be estimated at about half year of interest on the total loan. Thus, if the loan is \$22.5 million and the interest rate is 7 percent, the interest during construction is estimated around \$780,000 annually. Bonds are issued at closing, however, so construction interest is accrued on the entire financed amount, or \$1.57 million of interest annually.

Full Project Coordination (FPC) Resources

Depending on the structure of your FPC Resources, costs will vary. Generally, consulting fees are reimbursable at finance closing. The fee for FPC Resources varies based on the type and level of services provided. FPC Resources may include project coordination, financing guidance, facilities assessment, debt capacity analysis, financial feasibility, and/or management of design and construction. Consultants should clearly identify the services that will be provided. Below are three options for FPC Resources; more options exist. The full fee is not generally required upfront; however, a retainer may be required.

- **Option 1 – Full Project Coordination:** Negotiate a flat fee for FPC Resources if the services are provided by one consultant or firm. The fee may range from \$50,000 – \$250,000 depending on the range of services provided. This fee may cover all three FPC areas of expertise.
- **Option 2 – Begin with Financial Advisory Services:** If you use various firms for your FPC Resources, you may want to begin with the Financial Advisor, as part of its role is to help negotiate favorable contracts for project services. There is a wide range of charges for financial advisory services. Financial Advisor services may cost approximately \$50,000 – 60,000 for the project coordination and financing. The cost could run up to \$150,000 if financial planning and/or feasibility study is included.
- **Option 3 – Project Management Firm:** If you use a project management firm for your FPC Resources, they generally charge a percentage (3 – 4 percent) of the construction cost, for example, \$540,000 for an \$18,000,000 construction project. Project management services should be provided from the beginning of the project and through the full construction period. Project management firms perform a full range of services, from site assessment and selection to value engineering and space planning to management of the construction project. Good project management firms with expertise in rural health care and CAHs have saved projects more than they charge.

Transition to New Facility

The transition to the new facility is critical to the hospital's continued successful operation. Work with your project team to identify what is required for the transition early in the process so you know what to expect regarding resources, cost, and challenges. We recommend hiring a Transition Planner to manage the move-out, move-in and start-up operations.

Estimated Project Costs and Fees

ESTIMATED PROJECT COSTS and FEES: Project Snapshot

This \$25 million project budget is an **estimate**. The financing is based on \$2.5 million equity and \$22.5 million financing. Please note that the budget is not all-inclusive, in that this focuses on the actual replacement project. This is a rough estimate as your project team will help build out your project budget. All projects may not require all costs and fees listed below; however, the budget does not include every potential expense for a replacement project. Although costs are noted in a specific phase, the entire cost may not be due and payable during that phase (e.g., FPC Resources). Transition costs, including the Transition Planner, moves to the new facility, and initial operating capital, are not addressed.

Service	Estimated Costs/Fees	Comments
Phase 1: Planning/Preparation		
Full Project Coordination (FPC) Resources	\$62,500	√ Estimate .5-1% of total project cost or \$125,000 - \$250,000; For this project budget, .5 % for the financial advisor is included in the estimated financing fees in phase 3 (\$187,500 – 125,000 = \$62,500)
Facilities Assessment	5,000*	√ Facilities assessment ranges from \$2,500 – \$10,000
Market Demand Analysis	5,000	√ Perform early in process to identify <u>market potential</u>
Debt Capacity Analysis	5,000*	√ Analysis ranges from \$5,000 – \$10,000
Architect Fee	189,000	Total architect fee estimated at 7% of construction cost. √ Phase 1: Schematic Design
Appraisal Fee	5,000	√ Applicable if hospital is using current property as an asset going into the loan; \$5,000 – 10,000 √ May be included in financing costs
Equipment Assessment	10,000	√ For current inventory listing movable vs. sell or dispose √ Selection of new replacement equipment with specifications could increase fee up to \$20,000
Financial Feasibility Study	50,000	√ Feasibility study type based on financing requirements √ Compiled Forecast estimated at \$30,000 - 60,000 √ Examined Forecast estimated at \$50,000 - 90,000
Phase I Environmental (ESA) and Soils Studies	5,000	√ Complete studies prior to land acquisition
Capital Campaign Consultant and/or Marketing/Development	100,000	√ Costs vary for marketing and development based on the level of community engagement or capital campaign √ Estimate is based on 10% of \$1 million campaign goal
Land Acquisition Costs	Varies	√ Costs vary widely and land donations are encouraged √ Land acquisition should be addressed early due to land and site development costs and financing, if needed
Phase 1 Total	\$421,500	Total does not include the estimated costs noted with * as the service may be included in the FPC Resources Fee
Phase 2: Facility Design and Financing		
Architect Fee	819,000	√ Phase 2: Design Development, Construction Documents, Bidding
CON Application Fee	Varies	√ Varies by state; commensurate with project size
Phase 2 Total	\$819,000	

Estimated Project Costs and Fees

Phase 3: Endorsement		
Initial Funds Disbursement	--	√ Hospital is reimbursed for allowable project costs made prior to closing (costs for phases 1 and 2)
Financing fees	700,000	√ Estimate 3-4% of amount financed
Owner's Contingency Fund	900,000	√ 5% of construction cost to fund unforeseen items
Phase 3 Total	\$1,400,000	
Phase 4: Construction		
Construction and Site Development (Allowable project costs)	18,000,000	√ 60,000 sq. ft. @ \$300/sq.ft. √ Subject to regional adjustment √ Includes contractor's fee and general conditions
Equipment and Furnishings	3,600,000	√ Estimate 20% of Construction amount
Architect Fee	252,000	√ For services provided during construction
Capitalized interest during construction	780,000	√ Estimate per each 12 months of construction; based on 7% on \$22.5 million loan
Phase 4 Total	\$22,627,000	
Estimated Project Cost	\$25,477,500	
Costs (Options)		
Project Management Fee	540,000	√ 3-4% of construction cost for project management firm
Federal Program Fee	200,000	√ Estimate 1% (USDA) or 80 basis points (FHA)
Options Total	\$740,000	Total does not include the estimated costs noted with * as the service may be included in the FPC Resources Fee
Total Project Cost	\$26,217,500	

* Service/fee may be included in FPC Resources Fee

Partners in the CAH Replacement Project

A replacement project requires the right expertise, guidance, and support. CEOs cannot do this alone! Even so, senior leadership (board and administration) should plan to commit a significant amount of time to the replacement project.

Please note that “**Involvement Parties**” specifically lists the Project Sponsor for each event. The designated Project Sponsor may be represented by board chair, board member, hospital administrators (e.g., CEO, CFO, COO), or community leaders. The Project Sponsor, Board Chair, CEO and CFO should be engaged throughout the process. The hospital may hire FPC Resources to represent the hospital’s interests and guide the project throughout the entire process; however, hospital leadership is still responsible for making decisions.



Warning

- √ The replacement process is completed during normal hospital operations. Hospital operations must continue at the same level or higher as this will impact hospital finances and financial feasibility.
- √ Hospitals are generally considered one of the most complex facilities to design and build, which is why it is important to have health care-experienced professionals who are experts in CAH design and construction.
- √ The hospital’s interests must be represented throughout the entire facility replacement process.
- √ This is a collaborative effort and it is critical to have key project team members that can work well together as partners. Be sure to get recommendations and plan to interview several FPC Resources, architects, and contractors and hiring the team that works best with you and your community.



Tip

Partners in the CAH Replacement Project

There are various compositions for the project team based on your project goals and decisions. The team members you select will greatly impact the project cost, timeframe and success. Choose your team members wisely by doing your research and talking to CAH resources, including CAHs that have completed this process.

Your CAH Replacement Project Team may include:

- √ *Project Sponsor/Hospital Leadership Team
- √ *Full Project Coordination Resources
- √ *Lender(s)
- √ *Architect
- √ *Construction Contractor/Construction Management Firm
- √ Equipment Consultant
- √ Environmental Consultant
- √ HUD and USDA Staff
- √ Financial Feasibility Consultant
- √ Capital Campaign Consultant
- √ Attorneys/Bond Counsel
- √ Issuing Authority
- √ Medicare Reimbursement (Billing) Consultant and/or A/R Collections Consultant
- √ CON Consultant

* These are key project team members who will be involved throughout the project. Early collaboration between the project team, particularly the FPC Resources, architect and construction contractor, is recommended.

Important Resources for the Hospital Leadership Team may include:

- √ State Office of Rural Health (SORH)/FLEX Office
- √ State Health Facilities Finance Authorities
- √ National Center for Rural Health Works

- √ State Certificate of Need (CON) Office
- √ Centers for Medicare and Medicaid Services (CMS)
- √ Rural Health Resource Center Technical Assistance and Services Center (TASC)

Project Team Members

- **Project Sponsor(s)/Hospital Leadership** are an involved party for each event. The Project Sponsor and/or Hospital Leadership may include board chair, board members, hospital administrators (e.g., CEO, CFO, COO), or other community leaders. The Project Sponsor, Board Chair, CEO and/or CFO generally represent the hospital's interests and guide the project. Hospital leadership is responsible for requesting the required information, making decisions, engaging the community in the process, and hiring the consultants and contractors who provide services to make the project possible.
- **Full Project Coordination (FPC) Resources** are highly recommended. FPC Resources, whether an individual or team, should be there at the beginning of the process to coordinate the project and provide unbiased expertise, guidance, and support to facilitate decision-making and action. FPC Resources serve as the hospital's advocate throughout the replacement process. FPC Resources facilitate decision-making to keep the project moving, including clearly laying out the hospital's options as well as the options' efficiency and cost-effectiveness.

FPC Resources is needed for three critical project functions and must have these areas of expertise:

1. Financing Guidance: The hospital should be represented by a qualified financial advisor who will act on its behalf. An **Independent Financial Advisor** helps the hospital navigate the financing process, which may include board education, exploring financing options, performing debt capacity analysis and financial feasibility, and facilitating interaction with lenders and/or Federal enhancement programs.
 2. Programming and Space Planning: Programming and space planning support strategic use of space to meet community needs and maximize hospital revenue. This role may be performed by a **Facilities Planner, Owner Advocate, Owner's Representative or Project Manager**.
 3. Management of Design and Construction: **Owner Advocate, Owner's Representative or Project Manager** provides independent guidance to the hospital and represents the owner's interests in the design and construction process. Please note that this role is **not** associated with the construction contractor.
- **Lender(s)** take many forms, (e.g., local or national bank that provides its own resources; a bond agency that sells taxable, tax-free, or industrial development bonds on behalf of the borrower; or mortgage insurers and guarantors). Ultimately, the lender will be responsible for the collection of the debt service payments made by the hospital. Lenders also step in if there are difficulties with loan payments, and to alert any insurer or guarantor of any recognized problems from operational or financial performance standpoints.
 - A licensed **Architect** is required to design an appropriately-sized facility with the requisite services that the community needs and can afford. Architect must be licensed in the state where the project is located. The architect is responsible for preparation of drawings and specifications, usually in three progressively detailed stages as well as all engineering consultations required by the Architect/ Engineer to complete drawings and specifications.

- **Construction Contractor/Construction Management Firm** is responsible for providing a fully functional construction project for the price agreed upon in the construction contract. Engage early in the process. The construction contractor is an important part of the team (construction cost is generally 70 percent or more of the project budget) and should be engaged early in the process.
- **Equipment Consultant** performs an inventory of existing equipment as well as identifies the equipment required for the new facility. They help align equipment requirements and budget with the programming and space plan. Equipment is a key component of project cost and should be addressed early in the process.
- **Federal Program Staff** include representatives of Federal credit enhancement programs that may facilitate access to capital, including HUD and USDA. Insurance and guarantees are referred to as “credit enhancements” since they effectively enhance the creditworthiness of the borrower. Private firms as well as the U.S. Department of Housing and Urban Development (HUD) provide insurance; the U.S. Department of Agriculture (USDA) provides guarantees as well as direct loans.
- **Financial Feasibility Consultant** presents both a historical and current picture of the hospital’s operations and financial condition, as well as economic and demographic trends and events; projects future hospital operations and financial performance and ability to service the debt associated with the proposed project.
- **Capital Campaign Consultant** assesses the community’s fundraising capacity and helps the hospital develop and implement its capital campaign plan, including training the hospital to “make the ask.”
- **Attorney/Bond Counsel** preside at the closing with attorneys who represent both the hospital and the lender and are very involved at the bond and loan closings; making certain all program and legal obligations are met. Attorneys should also review various financing and other contracts (e.g., construction) prior to the closing.
- **Medicare Reimbursement (Billing) Consultant and/or Collections Consultant** provide guidance on improving Medicare billing or collection of outstanding accounts receivable. Hospital leaders and other experts identify these consultants as beneficial in improving hospital cash flow and financing position.
- **CON Consultant** helps clarify Certificate of Need (CON) impact of replacement and develop a strong CON application that meets your State’s CON requirements, if any.

Important Resources for the Hospital Leadership Team

See the [Resources](#) section for additional information.

- **State Office of Rural Health (SORH)/Flex Office** has been instrumental in CAH replacements by providing information and support related to economic impact, community engagement, financial feasibility studies, CON application/waiver, financing resources, and working with the CMS Regional Office regarding continued CAH designation.
- **State Health Facilities Finance Authorities (HFFAs)** are capital financing resources for hospitals and health care facilities.
- Some **States** require approval of a Certificate of Need (CON) and may have review procedures for other aspects of major capital projects.
- **Technical Assistance and Services Center (TASC)** provides technical assistance to CAHs, including guidance on replacement resources. TASC maintains a consultant database.

CAH Replacement Process: Resources

There are numerous organizations and publications to support CAH-designated hospitals as they pursue facility replacement/renovation. Please see the below list, which includes the resource, a brief description, and Website address to access information.

Organizations

The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Office of Rural Health Policy (ORHP)

The [Office of Rural Health Policy](#) (ORHP) works to sustain and improve access to health care services in rural America. Established in 1987, ORHP works both within government at the Federal, State and local levels, and with the private sector (associations, foundations, providers and community leaders) to seek solutions to rural health care issues. ORHP administers a range of programs designed to promote these efforts including grants to States under the Medicare Rural Hospital Flexibility Grant Program (Flex Program). This program helps CAHs address the needs of their communities.

<http://ruralhealth.hrsa.gov/overview/>.

State Offices of Rural Health (SORH)/Flex Program

State Offices of Rural Health, funded by the ORHP, provide a focal point within each of the 50 States that links rural communities with State and Federal resources that can help them improve their local health care systems. These Offices also receive grant funds to help CAHs better address the needs of their communities. The list of State offices can be accessed at: <http://www.nosorh.org/regions/directory.php>.

Rural Health Resource Center/Technical Assistance and Services Center

The Rural Health Resource Center, funded by ORHP, provides information, tools and TA to help States and rural communities address their health care issues. The TASC provides similar resources that are focused on the needs of CAHs. TASC also manages a consultant database and may be a resource for CAHs looking for facility replacement consultants. Publications include: [The Availability and Use of Capital by Critical Access Hospitals](#) and [New Data Summary Report on CAH Financial Indicators](#). Tools include: [Construction Financing Proforma Financial Statements](#), and [Facility Design Planning Principles](#). TASC can be accessed at: <http://www.ruralcenter.org/tasc>.

Rural Assistance Center (RAC)

The Rural Assistance Center (RAC), funded by contract from ORHP, is a rural health and human services "information portal." RAC helps rural communities and other rural stakeholders locate the full range of available programs, funding, and research that can enable them to provide quality health and human services: <http://www.raconline.org/>. Critical Access Hospitals: http://www.raconline.org/info_guides/hospitals/cah.php

National Center for Rural Health Works (RHWks)

The National Center for RHWs, funded by grants from ORHP, provides data, tools and TA about the impact of health care on local economies. This information provides the basis for helping communities conduct a strategic planning process to improve their access to care. For further information, go to <http://www.ruralhealthworks.org/download.html> or contact: Dr. Gerald A. Doeksen, Director (gad@okstate.edu) or Cheryl F. St. Clair, Associate Director (cheryl@okstate.edu).

National Rural Recruitment and Retention Network (3RNet)

The National Rural Recruitment and Retention Network (3RNet), funded by contract from ORHP, is a not-for-profit organization with members in all 50 States. This recruitment firm helps rural communities, hospitals and clinics find and hire doctors and other health professionals. Go to: <http://www.3rnet.org/>.

State Health Facilities Finance Authorities: Most States have agencies that act as the vehicle for providing financing to public and non-profit health care providers through loans funded by the issuance of tax-exempt bonds. Website at: <http://naheffa.com/members.html>.

Publications

Critical Access Hospital Prototype, HHS, HRSA, Office of Engineering Services and ORHP
The CAH Prototype, approved in February 2005, provides architectural specs for a 25- and 15-bed versions of a typical CAH replacement facility. The CAH Prototype is at: <http://www.rurdev.usda.gov/rhs/cf/Design/PROTOTYPE.pdf> .

4th Annual 2009 Rural Hospital Replacement Facility Study: How Replacement Facilities Impact Operations and the Bottom Line: Findings From the Field by Stroudwater Associates
This annual report describes the impact that replacement has on the hospital and community.
<http://ruralhospitalreplacement.com/>

Financing Options for Nonprofit Rural and Community Hospitals by Lancaster Pollard
An introduction to capital financing options for small, rural hospitals considering facility replacement. The site also has *The Capital Issue*, a quarterly newsletter on capital financing at: <http://www.lancasterpollard.com/site.cfm/our-focus/health-care.cfm>.

Transforming Hospitals: Designing for Safety and Quality by the Agency for Health Care Research and Quality, HHS
This document describes the link between a hospital's physical design and its key quality and safety outcomes, including the impact on patients and staff.
<http://www.ahrq.gov/qual/transform.htm>

Capital Project Work Plan prepared by Capital Link
This document provides technical assistance to FQHCs that are developing capital projects:
www.caplink.org

Centers for Medicare and Medicaid Services (CMS) Guidance Related to CAH Relocation
Relocation of CAHs with a Grandfathered Necessary Provider Designation allows CAHs to continue their designation after relocation based on the 75 percent Rule. CMS relocation guidance can be found at:
<http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-35.pdf> and
<http://www.cms.hhs.gov/transmittals/downloads/R32SOMA.pdf>. CMS' CAH Center is at:
<http://www.cms.hhs.gov/center/cah.asp>.

U.S. Department of Agriculture's (USDA) Capital Assistance Funding: A Rural Health Resource Guide
This online guide lists various Federal funding sources for rural capital projects, including those sponsored by USDA: http://www.nal.usda.gov/ric/ricpubs/capital_assistance.htm.

Appendix A: List of Replacement Critical Access Hospitals

As of October 2009, approximately 90 CAH facility replacements have been completed or are currently in process. Below is a list of replacement facilities based on information provided by each the 50 SORHs and by Stroudwater Associates. The list is organized by State. If you are considering facility replacement, you should contact and visit completed facilities.

Hospital Name	Address	City	State	Zip	Phone
Providence Valdez Medical Center	911 Meals Avenue - P.O. Box 550	Valdez	AK	99686	907-835-2249
Baptist Health Medical Center - Heber Springs	1800 Bypass Road	Heber Springs	AR	72543	501-206-3000
Booneville Community Hospital	880 West Main Street	Booneville	AR	72927	479-675-2800
Delta Memorial Hospital	811 Highway 65	Dumas	AR	71639	870-382-4303
Ozark Health Medical Center	2500 Highway 65 South - P.O. Box 206	Clinton	AR	72031	501-745-7000
Grand River Hospital and Medical Center	501 Airport Road	Rifle	CO	81650	970-625-1510
Heart of the Rockies Regional Medical Center	1000 Rush Drive	Salida	CO	81201	719-530-2200
Kit Carson Memorial Hospital	286 16 th Street	Burlington	CO	80807	719-346-5311
Melissa Memorial Hospital	1001 East Johnson Street	Holyoke	CO	80734	970-854-2241
Pikes Peak Regional Hospital	16420 West Highway 24 - P.O. Box 622	Woodland Park	CO	80863	719-686-0302
Rio Grande Hospital	1280 Grand Avenue	Del Norte	CO	81132	719-657-2510
Yuma Hospital District	910 South Main Street	Yuma	CO	80759	970-848-5405
Doctor's Memorial Hospital – Bonifay	2600 Hospital Drive	Bonifay	FL	32425	850-547-8000
Clinch Memorial Hospital	1050 Valdosta Highway	Homerville	GA	31634	912-487-5211
Moloka'i General Hospital	280 Puali Street	Kaunakakai	HA	96748	808-553-5331
Shoshone Medical Center	25 Jacobs Gulch	Kellogg	ID	83837	208-784-1221
Steele Memorial Medical Center	700 Van Dreff - P.O. Box 700	Salmon	ID	83467	208-756-5617
Kewanee Hospital	1051 West South Street	Kewanee	IL	61443	309-852-7500
Midwest Medical Center	1 Medical Center Drive	Galena	IL	61036	815-777-1340
Adams County Memorial Hospital	1100 Mercer Avenue	Decatur	IN	46733	260-724-2145
Blackford Community Hospital	410 Pilgrim Boulevard	Hartford City	IN	47348	765-348-0300
Community Hospital of Bremen	1020 High Road	Bremen	IN	46506	574-546-2211
Harrison County Hospital	1141 Hospital Drive NW	Corydon	IN	47112	812-738-8722

Appendix A: List of Replacement Critical Access Hospitals

Hospital Name	Address	City	State	Zip	Phone
Parkview LaGrange Community Hospital	207 North Townline Road	LaGrange	IN	46761	560-463-2143
St. Vincent Randolph Hospital	473 Greenville Avenue	Winchester	IN	47394	765-584-0004
White County Memorial Hospital	720 South Sixth Street	Monticello	IN	47960	574-583-7111
Orange City Municipal Hospital	1000 Lincoln Circle Southwest	Orange City	IA	51041	712-737-4984
Ellsworth County Medical Center	1604 Aylward Avenue	Ellsworth	KS	67439	785-472-3111
Holton Community Hospital	1110 Columbine Drive	Holton	KS	66436	785-364-2116
Meade District Hospital	P.O. Box 820 - 510 East Carthage	Meade	KS	67864	620-873-2141
Wilson County Hospital	2600 Ottawa Road	Neodosha	KS	66757	620-325-8385
Fort Logan Hospital	110 Metker Trail	Stanford	KY	40484	606-365-4600
Franklin Foundation Hospital	1501 Hospital Avenue, P.O. Box 577	Franklin	LA	70538	337-828-0760
St. James Parish Hospital	1645 Lutcher Avenue	Lutcher	LA	70071	225-869-5512
Bridgton Hospital	10 Hospital Drive	Bridgton	ME	04009	207-647-6000
Calais Regional	24 Hospital Lane	Calais	ME	04619	207-454-7521
Bell Memorial Hospital	901 Lakeshore Drive	Ishpeming	MI	49849	906-486-4431
Munising Memorial Hospital	1500 Sands Point Road	Munising	MI	49862	906-387-1440
LakeWoods Health Center	600 Main Avenue South	Baudette	MN	56623	218-634-2120
Lakewood Health System Hospital	49725 County Road 83	Staples	MN	56479	219-894-1515
River's Edge Hospital and Clinic	1900 North Sunrise Drive	St. Peter	MN	56082	507-931-2200
Riverwood Health Center	200 Bunker Drive	Aitkin	MN	56431	218-927-5501
Saint James Medical Center, Mayo Health System	1207 Sixth Avenue South	Saint James	MN	56081	507-375-3261
Sanford Hospital-Luverne	1600 North Kniss Avenue	Luverne	MN	56156	507-283-2321
Barton County Memorial Hospital	29 NW 1 st Lane	Lamar	MO	64759	417-681-5100
I-70 Medical Center, Inc.	105 Hospital Drive	Sweet Springs	MO	65351	660-335-7408
Iron County Hospital	301 North Highway 21	Pilot Knob	MO	63663	573-546-1260
McCune-Brooks Regional Hospital		Carthage	MO		417-358-8121
Mountainview Medical Center	16 West Main Street	White Sulphur Springs	MT	59645	406-547-3321
North Valley Hospital	1600 Hospital Way	South Whitefish	MT	59937	406-863-3500
Phillips County Hospital and Family Health Center	311 South 8th Avenue East	Malta	MT	59538	406-654-1100
Oakes Community Hospital	1200 North Seventh Street	Oakes	ND	58474	701-742-3291

Appendix A: List of Replacement Critical Access Hospitals

Hospital Name	Address	City	State	Zip	Phone
Crete Area Medical Center	2910 Betten Drive, P.O. Box 220	Crete	NE	68333	402-826-2102
Saunders Medical Center	1760 County Road J	Wahoo	NE	68086	402-443-4191
Desert View Regional Medical Center	360 S. Lola Lane	Pahrump	NV	89048	775-751-7500
Mesa View Regional Hospital	1299 Bertha Howe Avenue	Mesquite	NV	89027	702-346-8040
Bertie Memorial Hospital	1403 South King Street	Windsor	NC	27983	252-794-6600
Chatham Hospital	475 Progress Boulevard	Siler City	NC	27344	919-799-4000
The Outer Banks Hospital	4800 South Croatan Highway	Nags Head	NC	27959	252-449-4500
Mountrail County Medical Center	P.O. Box 399 - 615 6th Street S.E.	Stanley	ND	58784	701-628-2424
Adams County Hospital	230 Medical Center Drive	Seaman	OH	45693	937-544-5571
Bucyrus Community Hospital	629 North Sandusky Avenue	Bucyrus	OH	44820	419-562-4677
Community Memorial Hospital	208 North Columbus	Hicksville	OH	43526	419-542-5560
Drumright Hospital	610 West Truck Bypass	Drumright	OK	74030	918-382-2300
Okeene Municipal Hospital	207 East E F Street, P.O. Box 489	Okeene	OK	73763	580-822-4417
Weatherford Regional Hospital	3701 East Main Street	Weatherford	OK	73069	580-772-5551
Cottage Grove Hospital	1515 Village Drive	Cottage Grove	OR	97424	541-942-0511
Harney District Hospital	557 West Washington	Burns	OR	97720	541-573-7281
Southern Coos Hospital and Health Center	900 11th Street SE	Brandon	OR	97411	541-347-2426
Wallowa Memorial Hospital	601 Medical Parkway	Enterprise	OR	97828	541-426-3111
Fulton County Medical	214 Peach Orchard Road	McConnelburgh	PA	17233	717-485-3155
Jersey Shore Hospital	1020 Thompson Street	Jersey Shore	PA	17740	570-398-0100
Abbeville Area Medical Center	420 Thompson Circle	Abbeville	SC	29620	864-366-5011
Faulkton Area Medical Center	911 Saint John Street	Faulkton	SD	57438	605-598-6263
Hancock County Hospital	1519 Main Street	Sneedville	TN	37869	423-733-5030
Rhea Medical Center	9400 Rhea County Highway	Dayton	TN	37321	423-775-1121
Iraan General Hospital	600 Hwy 349 North	Iraan	TX	79744	432-639-2871
Mitchell County Hospital	997 West Interstate 20	Colorado City	TX	79512	325-728-3131
Winkler County Memorial Hospital	821 Jeffee Drive	Kermit	TX	79745	432-586-8299
Morton General Hospital	521 Adams Street	Morton	WA	98356	360-496-5112
Pullman Regional Hospital	835 Southeast Bishop Boulevard	Pullman	WA	99163	509-332-2541
Amery Regional Medical Center	265 Griffin Street East	Amery	WI	54001	715-268-8000
Bond Health Center	820 Arbutus Avenue	Oconto	WI	54153	920-835-1100

Appendix A: List of Replacement Critical Access Hospitals

Hospital Name	Address	City	State	Zip	Phone
Hayward Area Memorial Hospital	11040 North State Road 77	Hayward	WI	54843	715-934-4244
Hudson Hospital	405 Stageline Road	Hudson	WI	54016	715-531-6000
Osceola Medical Center	2600 65 th Avenue	Osceola	WI	54020	715-294-2111
Our Lady of Victory Hospital	1120 Pine Street, P.O. Box 220	Stanley	WI	54768	715-644-5571
Sacred Heart Hospital	401 West Mohawk Drive	Tomahawk	WI	54487	715-453-7700
Southwest Health Center	1400 East Side Road	Platteville	WI	53818	608-348-2331
Tomah Memorial Hospital	321 Butts Avenue	Tomah	WI	54660	608-372-2181

Appendix B: Federal Government Programs

U.S. Department of Housing and Urban Development (HUD) Federal Housing Administration (FHA) Section 242 Hospital Mortgage Insurance Program

The FHA Hospital Mortgage Insurance Program provides mortgage insurance for CAHs in connection with new construction, expansions, substantial rehabilitation, modernization, remodeling, equipment and debt refinance. This program provides a mortgage insurance commitment that FHA-approved lenders utilize as a credit enhancement to issue debt securities on behalf of hospital borrowers. Applications are processed and approved by HUD's Office of Insured Health Care Facilities (OIHCF). FHA has made it a priority to increase the availability of mortgage insurance to CAHs.

Mortgage insurance provides most hospitals the opportunity to issue "AAA"-rated debt, which allows borrowers to experience substantial debt service savings. For example, a \$20 million nonprofit hospital project could potentially reduce the interest rate by 2 percent using the mortgage insurance program to enhance its tax-exempt bonds (versus an alternative funding source of unrated tax-exempt bonds). In this example, the hospital could realize interest expense savings of \$400,000 annually and more than \$8 million over the life of the bond issue.

Features of the Hospital Mortgage Insurance Program:

- Approved FHA Mortgage Banker must secure FHA insured mortgage commitment
- No Maximum Loan Amount
- Loan-to-Value May Be Up To 90 percent
- FHA Insures 99 percent of Loan Amount
- Broad investor market, excellent liquidity
- Low Cost Fixed Rates
- Estimated Timing: 3 to 12 months
- Funded through Tax Exempt Bonds or Taxable Ginnie Mae Securities
- 25 Year Maximum Term
- HUD controls upon Default

CAH-designated hospitals can take advantage of FHA's Streamlined Application Process:

- Fast-Track Processing Available
- Reduced Documentation Requirements
- Median Application Processing Time of 51 days in 2007

Other FHA Advantages:

- Design-Build Form of Contracting Allowed for Projects Under \$30 Million
- Enable Flexible Loan Covenants
- Professional Staff Focused on Customer Service

FHA insurance enables clients to enhance their creditworthiness because their debt is backed by the United States Government. Additionally, can be used in conjunction with tax-exempt bond issues and Ginnie Mae securities, and it enables quicker turnaround. One time fees total 0.8 percent of loan amount; Fixed annual mortgage insurance premium is 0.5 percent of remaining mortgage balance. Additional information about the FHA Hospital Mortgage Insurance Program, including the steps for applying, may be accessed at:

http://portal.hud.gov/portal/page?_pageid=73,1826910&_dad=portal&_schema=PORTAL.

U.S. Department of Agriculture (USDA) Rural Development Community Programs Guaranteed and Direct Loan Programs

USDA's Rural Development Community Programs includes the Community Facilities Guaranteed and Direct Loan Programs. Community Programs can make and guarantee loans to develop essential community facilities in rural areas and towns of up to 20,000 in population. Loans and guarantees are available to public entities such as municipalities, counties, and special-purpose districts, as well as to non-profit corporations and tribal governments.

Generally for CAHs, Guaranteed Loans are recommended and can be made in combination with a Direct Loan. Loans are available for construction, expansion, renovation and improvements, and equipment. Under this program, the USDA is able to loan money directly or guarantee loans made by such lenders as banks, savings and loan associations, mortgage companies and Farm System Credit Banks. USDA does not guarantee tax-exempt bonds.

For more information about USDA Community Facilities Programs.

<http://www.rurdev.usda.gov/rhs/cf/cp.htm>. Applications are handled by USDA Rural Development field offices, which can be located at http://www.rurdev.usda.gov/recd_map.html.

Features of the USDA Loan Guarantee:

- Applicable to community health care projects for non-profit and public entities
- 90 percent Net Loss Reimbursement Guarantee and Lender (10 percent)
- Eligible USDA lender will secure the USDA Guarantee Commitment and fund your Loan
- Facility must be located in a Rural Designated Area
- 40 Year Maximum Term Lender and USDA approval required
- 90 percent maximum Loan-to-Value with No Maximum Loan Amount
- USDA Guarantee applies to permanent loan only, separate construction financing required
- Fixed or Variable Rates with Low Upfront Costs
- Generally used for Smaller Projects (i.e., \$25 million and less)
- Estimated Timing: 3 to 8 months
- USDA and lender control upon Default
- Upfront Costs: One-time 1 percent fee due at closing
- Hospitals should seek a combination of funding, including Guaranteed and Direct Loans

Additional information: There is a two-stage procedure including the pre-application and application processes. Estimate approximately 45 days to determine applicant eligibility, project priority status, and funding availability. In most cases, the borrower must secure independent construction financing. Guaranteed loans are usually variable and USDA customarily guarantees only the permanent loan.

USDA also offers small Direct Loans that have eligibility criteria similar to that of the Guarantee Program, but availability is limited. Interest rates for the Direct Loan Program are established by USDA. Borrowers may pursue a Direct Loan to supplement other funding.

Participants

Site Visit Participants

Please note that the site visit participants are listed based on their affiliation at the time of the site visit. Some affiliations have since changed. Many of the consultants have updated contact information on the Work Group and Consultation Group Members on the following page.

<i>Role</i>	<i>Name and Organization</i>
Drumright Regional Hospital, Drumright, OK (Visit: April 2007) Replacement Completed: 2005	
Hospital Leadership Team	<ul style="list-style-type: none"> • Darrel Morris, CEO, Drumright Regional Hospital • Danny Cooper, Former Board Chair and Owner's Representative • Jim Martin, Vice Chair of Drumright Health Care Authority
Community Leadership Team	<ul style="list-style-type: none"> • Wendell Bookout • Ron Dyer • Chuck Watson • Phil Waul
Consultants	<ul style="list-style-type: none"> • Bruce Anderson, J.E. Dunn (Construction Contractor) • Larry Arthur, Hospital Management Consulting, LLC (Feasibility Consultant) • Larry Diehl, ACI/Boland (Architect)
CAH Resources	<ul style="list-style-type: none"> • Terry Hill, Rural Health Resource Center • Val Schott, Oklahoma Office of Rural Health
Kewanee Hospital, Kewanee, IL (Site Visit – August 2007) Replacement Completed: 2008	
Hospital Leadership Team	<ul style="list-style-type: none"> • Margaret Gustafson, CEO • Lynn Fulton, COO • Willard Carroll, Kewanee Board Chair • David Boswell, Kewanee Development Council Chair
Consultants	<ul style="list-style-type: none"> • Chuck Wells, Health Care Financial Advisors (Financial Advisor) • Kelly Arduino, Pine Creek (Lender) • Ed Anderson, Marshall Erdman Associates (Design-Build Firm)
CAH Resources	<ul style="list-style-type: none"> • Pat Schou, Illinois CAH Ne2rk (ICAHN)
Franklin Foundation Hospital, Franklin, LA (Site Visit – August 2007) Replacement Completed: 2007	
Hospital Leadership Team	<ul style="list-style-type: none"> • Calvin Green, CEO • Marshall Guidry, Board Chair • Clegg Caffery, Jr., Board Member • Allan VonWerder, Board Member
Consultants	<ul style="list-style-type: none"> • Janet Rack, Capital One Mortgage (Lender) • Richard Hoffpauir, USDA Rural Development (Lender/Enhancer) • Chris Kohlenberg, CPA (Feasibility Analyst) • Scott LaTulipe, Hammes Co. (Project Manager) • Bruno Skovdal (Architect) • Mark Wilson, Woodrow Wilson Construction Company (Contractor)
Shoshone Medical Center (SMC), Kellogg, ID (Site Visit – October 2007) Replacement Completed: 2003	

Hospital Leadership Team	<ul style="list-style-type: none"> • Gary Moore, Quorum Health Resources (SMC CEO during facility replacement) • David Selman, CEO • Joan Head, Board Chair • Jerry Cobb, Board Member • Joe Huston, Board Member
Community Leadership Team	<ul style="list-style-type: none"> • Mac Pooler, Mayor of Kellogg • Chuck Reynolds, Shoshone County Sheriff • Vince Rinaldi, Silver Valley Economic Development Corp. • Joe Morris, CEO, Kootenai Medical Center • Dr. Fred Haller, Internist with SMC Privileges
Consultants	<ul style="list-style-type: none"> • Phil Brummel, BKD, LLP (Feasibility Consultant) • John Albert, American Health Facilities Development (Owner Representative) • David Brown, Johnson, Johnson and Crabtree (Architect) • Les Kiblinger, Medical Construction Group (Contractor)
CAH Resources	<ul style="list-style-type: none"> • Neil Moss, Former Director of Idaho Health Facilities Authority during replacement)

Work Group and Consultation Group Members

Many of our advisory group members were gracious enough to participate in interviews with the project team. Interviewees are noted with an asterisk (*) in front of their name.

Work Group and Consultation Group Members
<p>Community Engagement</p> <ul style="list-style-type: none"> • *Darlene Bainbridge, DD Bainbridge and Associates, Inc. (Cuba, NY) • *Gerald Doeksen, National Center for Rural Health Works (Stillwater, OK) • Michelle Rathman, Impact Communications, Inc. (St. Charles, IL)
<p>Feasibility Studies/Business Planning</p> <ul style="list-style-type: none"> • *Kelly Arduino, Wipfli, LLC (Chicago, IL) • Larry Arthur, Hospital Management Consulting, LLC (Kansas City, MO) • Tommy Barnhart, Dixon Hughes, PLLC (Winston-Salem, NC) • *Brian Haapala, Stroudwater Associates (Portland, ME) • David Hoffman, Wipfli, LLC (Madison, WI) • Steve Wendt, TREO Solutions (Albany, NY)
<p>Financing/Mortgage Banking</p> <ul style="list-style-type: none"> • James "Chris" Alsop, USDA Rural Development (Washington, DC) • Matt Andrea (Washington, DC) • Raymond Brooks, Jr., Pine Creek Health Care Capital (Nashville, TN) • Mike Coiro, Capital Funding Group, Inc. (Baltimore, MD) • *Charles Ervin, Dougherty Mortgage LLC (Bozeman, MT) • Tanya Hahn, Lancaster Pollard (Columbus, OH) • Phyllis Karno, Greystone Servicing (New York, NY) • Jim LaVigne, TYLL and LaVigne, Inc. • Mike Mazer, Krooth and Altman (Washington, DC) • Lorraine McLaren, Goldman Sachs (New York, NY) • Eric Mestemaker, Red Capital Group (Columbus, OH) • Roger Miller, HUD's Office of Insured Health Care Facilities (Washington, DC)

<p>Architecture</p> <ul style="list-style-type: none"> • Lee Buckner, BBH Design (Morrisville, NC) • Larry Diehl, ACI/Boland (Leawood, KS) • Larry Fleming, USDA Rural Development (Washington, DC) • Emilio Pucillo, HUD Office of Insured Health Care Facilities (New York, NY) • Michael Scherbel, Plunkett Raysich Architects (Milwaukee, WI)
<p>Construction</p> <ul style="list-style-type: none"> • Bruce Anderson, JE Dunn Construction (Kansas City, MO) • Michael Curtis, Neenan Company (Denver, CO)
<p>Hospital Leadership</p> <ul style="list-style-type: none"> • Larry Davy, Tillamook County General Hospital (Tillamook, OR) • Lynn Fulton, Kewanee Hospital (Kewanee, IL) • Tanya Hoar, Schoolcraft Memorial Hospital (Manistique, MI) • *Colleen Spike, River's Edge Hospital and Clinic (St. Peter, MN)
<p>Full Project Coordination/ Consultants</p> <ul style="list-style-type: none"> • *Ira Chilton, ProjX, LLC (Nashville, TN) • *Danny Cooper, Hospital Management Consulting, LLC (Kansas City, MO) • *Scott LaTulipe, Milestone Project Management (Houston, TX) • *Gary Moore, Moore Management (Meridian, ID) • Neil Moss, Consultant (Boise, ID) • Michelle Rathman, Impact Communications, Inc. (St. Charles, IL) • *Chuck Wells, Health care Financial Advisors (Shawnee Mission, KS)
<p>CAH Resources</p> <ul style="list-style-type: none"> • *Terry Hill, Rural Health Resource Center • Allison Hughes, National Organization of State Office of Rural Health (Tucson, AZ) • Alan Morgan, National Rural Health Association (Alexandria, VA) • Val Schott, Oklahoma Office of Rural Health (Oklahoma City, OK) • Pat Schou, Illinois CAH Ne2rk (ICAHN) (Princeton, IL) • John Supplitt, American Hospital Association (Chicago, IL)

CAH Replacement Manual Project Team Members (Washington, DC)
<ul style="list-style-type: none"> • Jerry Coopey, Office of Rural Health Policy • Chris Boesen, Tiber Creek Associates of Capital Hill, Inc. • Mike Seymour, Independent Consultant • Jenine Jenkins, Phineas Consulting, LLC

Document

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CAH Replacement Manual Project Team

The Office of Rural Health Policy and CAH Replacement Manual Project Team would sincerely like to hear your feedback about the manual. Please contact the Office of Rural Health Policy at (301) 443-0835 or Bridget Ware, bware@hrsa.gov

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