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## tripping debt covenants

Don't trip! Hospitals should heed a covenant warning from the other side of the balance sheet.

Two hospitals weathered the economic crisis with strong financial ratios. Both had good leadership, and operations were running smoothly following debt offerings for major construction projects. Dedicated investment managers carried them through the rough markets in 2008.

But although one hospital remains strong and is in a position to finance another project, the other faces expensive fees and possible construction delays: What seemed like a responsible update to the latter's investment portfolio failed to consider existing debt covenants and inadvertently put the hospital in technical default, triggering penalties and wreaking havoc on what had been an affordable and flexible debt structure.

Taking on or restructuring debt should prompt a review of a hospital's investment portfolio in the context of the revised balance sheet. Too often, however, hospital leaders fail to consider the impact of the investment portfolio on new or newly restructured debt. Failure to build a bridge from the liability side to the asset side creates a dangerous disconnect and the potential to violate promises to maintain financial ratios.

With the still-recent and ongoing flurry of refinancing and restructuring in response to the near collapse of bond insurance and to tighter credit,

and with low rates and incentives to invest in health IT, many hospitals are changing their debt structures or taking on new debt. But in a down market, or in any market that fluctuates (read: all of them), failure to address the impact of investments on debt or of a financial restructuring on investments is like building a dam and changing the landscape without determining where the water will go.

### Promises and Portfolios

Debt covenants are financial or operational tests a hospital agrees to meet during the life of a financing transaction. They are negotiated during the debt structuring process and are different for every transaction. And the amount of leverage a hospital has in negotiating debt covenants depends on the hospital's financial strength. Examples include maintenance of a certain amount of days cash on hand held in unrestricted cash and investment accounts, maximum days in accounts receivable balances, and a minimum debt service coverage ratio. Operational covenants may include the placement of a negative pledge on certain assets or the requirement to report financial and operational statistics within a specific time frame.

To protect the bond investor, many bond and loan agreements contain provisions for corrective action and/or fees (e.g., requiring a defaulting hospital to engage a management consultant and implement any recommended strategies).

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In good markets, most hospitals tend not to view debt covenants as risks, so they may not think to address them within their investment portfolios. But one common financial covenant is maintenance of a certain liquidity level. If an organization is overexposed to equities and the stock market collapses, liquidity may drop and trip a financial covenant. An investment portfolio consisting of volatile asset classes will tend to put the liquidity ratios at a higher risk than a portfolio that is more conservatively allocated.

Even though long-term investors have historically accepted greater volatility in their investment portfolios in search of higher returns, the introduction of debt covenants puts a lower limit on the allowable losses of the investment portfolio. Further, since the most commonly used volatility measure—standard deviation—contemplates both upside *and* downside volatility, the addition of a debt covenant will limit portfolio volatility, which is most often a by-product of a growth-oriented portfolio. In sum, investors must be willing to accept slower portfolio growth where covenants exist.

### Realized Losses, Unrealized Impacts

The hospital mentioned earlier that triggered a technical default because of investments—call it Blue Stream Hospital—had a solid cash-to-debt ratio of 1:1, a debt-to-capitalization ratio in the low 40s, and a strong 350 days cash on hand. It also had debt enhanced by a bank's letter of credit and was required to maintain minimum financial ratios.

When the market tumbled, Blue Stream Hospital's investment manager, who had no knowledge of the existing covenants, sold underperforming assets. This sale caused a realized loss of \$4 million, and Blue Stream Hospital's debt service coverage ratio dropped below the level it had promised to maintain.

Blue Stream Hospital now faces high penalty costs to waive the covenant violation. Its letter of credit fee had been an excellent 75 basis points (0.75 percent), which will increase, costing thousands if not millions in long-term interest

expense. Further, the bank—which also controls draws on the hospital's construction loan—could stall Blue Stream Hospital's renovation project by refusing to pay out any funds to contractors until the violation is remedied. In the current market, finding another letter-of-credit (LOC) provider would be difficult, and the rate would be nowhere near as attractive as that originally obtained by the strong hospital.

If Blue Stream Hospital had held that sold asset, the investment losses would have been unrealized and may not have reduced the debt service coverage ratio. If the investment adviser had been aware of the covenants, or if an overseer had offered a warning when the portfolio was getting dangerously close to the floor the covenants imposed, Blue Stream Hospital would have been able to adapt its investment decisions and adjust its portfolio without damaging its debt structure. Indeed, a preemptive and ongoing review of the relationship between the investment portfolio and related debt covenants may have avoided this situation altogether.

Moreover, carefully calculated interest rate risk exposure can be thrown off by failing to cross-reference investment decisions. Say the investment committee hires aggressive money managers to achieve a high rate of return through a broader class of assets. Then say, at the same time, the hospital has issued floating-rate debt and executed a swap to essentially fix the interest rate on a portion of that debt. How much floating-rate debt is swapped would be based on the assumption that some portion of the investment portfolio would provide an existing natural hedge against interest rate increases. If the portfolio allocation changes such that it reduces the amount of short-term, fixed-income investments within the portfolio, it is no longer providing the predicted hedge, and the hospital has just unintentionally taken on more interest rate risk.

### Taking Action—Existing Debt

Understanding covenants and how they interrelate with investments and other cross-organizational risks can be considered an element of

## AT A GLANCE

- > In the current economy, many hospitals are changing their debt structure or taking on new debt.
- > Healthcare financial managers should avoid tripping their debt covenants by creating a risk budget that includes covenant considerations.
- > Tactical management of the risk budget may be necessary and requires understanding how decisions and market influences affect both sides of the balance sheet.

liability-driven investing, an enterprise risk management strategy. The asset side of the balance sheet does not operate in a vacuum. It should not be managed as if it did.

Responsible management starts with the investment policy statement, which answers the question, “Why is the hospital invested the way it is?” and guides investment decisions. Responsible management also reviews and understands the nuances and requirements of each debt covenant to know how each can be affected by investment elements.

A hospital will find its debt covenants detailed in all or some of the following documents:

- > Reimbursement agreement for LOC-enhanced bonds
- > Trust or master trust indenture
- > Loan agreement
- > Lease agreement

If they haven’t already done so, hospitals should run sensitivity analyses to ensure that changes in the financial markets will not put the organization at an unreasonable risk of violating an existing financial covenant. Sensitivity analysis would include a measure of volatility, such as standard deviation, a historical volatility measure that may be viewed over different periods, or a Monte Carlo simulation, which is a probabilistic model used to evaluate investments. It is possible to strategically rebalance a portfolio to adapt to changing markets if these numbers are run before decisions are enacted.

In addition to checking the impact of investment volatility on debt covenants, hospitals should also cross-reference risk in other areas, such as the implications of portfolio volatility on the ability to pay out all obligations from a defined-benefit pension plan. If the hospital must cut a check to make up for losses in these portfolios, it needs to know where those funds will come from and the

ripple effect of drawing from one account to pay another.

On completing these reviews, the reaction of many organizations may be to immediately revamp the investment policy and asset allocation to reduce exposure to volatile equity investments and other potentially illiquid assets such as hedge funds and real estate. Each hospital, however, should look at its investment policy and strategy in light of its long-term implications to the organization, the credit and debt profile, and the overall strategic plan. Some organizations may have taken on more risk than was prudent given the “everyone else is investing here” mentality of recent years, without thoroughly understanding the risk-reward of each asset class and the impact on the organization. Others with sufficient financial resources and diversity of revenue may be more able and willing to ride out a rough market.

Besides the acquisition or restructuring of debt, another risk period for hospitals can be the hiring of a new investment manager. New managers may understandably want to rebalance the portfolio and start with a clean slate so that investment results reflect their own strategy and style. The hospital or a delegated overseer should communicate any debt covenants, while risks to other portfolios need to be considered in all investment management moves. It’s probably not a good thing if the pension fund portfolio allocations look like the foundation portfolio, and the foundation portfolio looks like the hospital portfolio. An investment manager may treat all portfolios as isolated pools of funds if hospital financial leaders do not communicate, for example, that a dip in the pension fund portfolio can trigger an actuarial demand for a supplemental contribution from operations.

### **Taking Action—New Debt**

Debt covenants are negotiated to levels the hospital should be able to maintain based on past perform-

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ance. The best time to make these negotiations is before the debt offering closes. After this time, the hospital loses considerable leverage.

Stronger hospitals can use their ability to meet higher covenants to negotiate for lower interest rates or enhancement costs. Conversely, weaker hospitals may pay a higher interest rate or enhancement cost, but the covenants agreed to within the financing documents may be less burdensome than those of hospitals with higher credit profiles. Financial covenants are always relative to the borrowing entity's existing credit profile but need to be aligned in close proximity to industry norms to gain access to capital. Requesting covenants too far removed from industry norms may limit access to capital because investors will either not partake in the transaction, or they will require higher interest rates in exchange for the more lenient covenants.

Covenants set close to current performance may be too restrictive, e.g., a debt service coverage covenant of 1.4 for a hospital with an existing ratio of 1.5. These provide no wiggle room. Language that is inclusive and restrictive and provides limited long-term operating flexibility is to be avoided. Covenants that do not consider noncash items such as derivative market valuations and unrealized investment gains and losses may also lead to technical covenant defaults the hospital cannot directly control. A borrower should ensure that the financial covenants included in the debt documents are authored in a way that does not penalize the organization for unrealized investment losses or a negative market-to-market value associated with an interest rate swap or other derivative. The inclusion of such language ensures unpredictable fluctuations in the financial markets do not affect the measurement of the borrower's financial performance. For example, the debt service coverage ratio requirement can be worded such that it includes

net income plus depreciation, amortization, and interest expense, but excludes all other noncash items, such as unrealized gains or losses on investments, and derivative instruments, such as swaps.

Additional debt tests should be flexible enough to accommodate new debt issuances without creating a "must-refinance" scenario. Using a master trust indenture structure allows one set of covenants to be used for multiple financings in the future with all the same covenants applicable to each transaction.

### **Building a Bridge from Assets to Liabilities**

Healthcare financial leaders should create a risk budget that includes covenant considerations and should codify the risk budget within policy, such as the investment policy statement. They should also recognize that risk comes in many forms, including interest rate risk, credit risk, liquidity risk, and volatility risk. Risk, in all forms, cannot be budgeted at a single point in time, but must be continuously monitored. Changes in the markets have proven that tactical management of the risk budget may be necessary.

Hospital financial leaders can manage the risk budget in a number of ways, from targeting certain asset classes to ensuring an ongoing review of balance sheet risk as a result of capital markets and investment decisions. Items of interest include a review of debt covenants that are sensitive to asset valuations, and awareness of the volatility of assets in the investment portfolio. The asset allocation decision may also be guided by the outstanding or contemplated debt structure: Issuing floating-rate debt may prompt a different asset allocation than issuing fixed-rate debt.

As liabilities are introduced, the asset allocation decision is even more constrained. Recognizing the risk associated with each asset class is an

important part of diversification. Investors should know that allocating resources to a new asset class in the name of diversification introduces a new risk. If investors do not look at the hospital's liabilities, which may also be in a state of change, the new assets could actually increase the organization's costs by causing an inadvertent debt covenant violation.

In summary, hospitals often have complex balance sheet structures, and isolating the risks on each side of the balance sheet is not the most prudent way to comprehensively manage interest rate risk. "Balance the balance sheet" by understanding how decisions and/or market influences can affect overall operating results, future strategies, and both assets and liabilities now and in the future. ●

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