

A report from the Minnesota Department of Health



# Capital Improvement Needs of Minnesota's Small Rural Hospitals

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Minnesota Department of Health  
Community Health Services Division  
Office of Rural Health and Primary Care

office of   
**Rural Health & Primary Care**  
MINNESOTA DEPARTMENT OF HEALTH

# Capital Improvement Needs of Minnesota's Small Rural Hospitals

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### ***Executive Summary***

Since the enactment of the Rural Hospital Capital Improvement Grant Program (M.S. 144.148) in 1997, Minnesota's small rural hospitals have expressed their capital improvement needs to the Minnesota Department of Health through the 98 applications submitted to the grant program. Requests have far exceeded the funds available, and the program is scheduled to sunset June 30, 2001. In June, 2000, the Department of Health conducted a survey to collect data in a systematic manner on each eligible hospital's capital needs, planning, and financial performance. The purpose of this report is to inform decision-makers and interested parties about the breadth and depth of capital needs of the state's rural hospitals, to analyze hospital resources used to meet their capital improvement needs, and to examine the role that capital improvement grants play. The survey and analysis of Minnesota's 81 small rural hospitals shows a substantial need for resources to support capital investments. Specific findings include:

- Two thirds (53) of Minnesota's small rural hospitals were built in the 1960's or earlier and are being used to accommodate much different community needs and drastic changes in health care.
- Seventy per cent (58) of Minnesota's small rural hospitals are classified as "struggling" or "distressed" regarding the status of capital investments in their facilities and equipment to maintain their buildings and keep up with advances in medical technology.
- Hospitals reported needing \$99 million strictly for projects to correct code and related deficiencies and other urgent deferred needs. The total number of projects and costs to meet hospitals' overall capital improvement plans is even greater.
- The capital investment needs of Minnesota's small rural hospitals cannot be fully supported by the operating profits. In 1998, 48 hospitals did not reach the operating margin generally required to support ongoing capital investments.
- Minnesota's small rural hospitals face significant barriers – low operating margins, lack of cash, etc. – to borrowing for their capital improvement needs, leaving many unmet.

While meeting only a fraction of the overall demand for capital, hospitals report that the Rural Hospital Capital Improvement Grant Program has played a meaningful role in the following ways:

- Provided an alternative source of capital to hospitals with the most severe problems that lack other options.
- Supported major capital expenditures such as re-building, remodeling, and major renovations. Hospitals reported that grant awards have been necessary for projects to move forward.
- Supported minor renovations (less than \$300,000) and equipment purchases.

## ***Introduction***

### **Purpose of this Report**

Since the enactment of the Rural Hospital Capital Improvement Grant Program (M.S. 144.148) in 1997, Minnesota's small rural hospitals have expressed their capital improvement needs to the Minnesota Department of Health through the 98 applications submitted to the grant program. Requests have far exceeded the funds available, and the program is scheduled to sunset June 30, 2001. In June, 2000, the Department of Health conducted a survey to collect data in a systematic manner on each eligible hospital's capital needs, planning, and financial performance. The purpose of this report is to inform decision-makers and interested parties about the breadth and depth of capital needs of the state's rural hospitals, to analyze hospital resources used to meet their capital improvement needs and to examine the role that capital improvement grants play.

### **A Different Role for Small rural Hospitals**

A brief historical context is important to appreciate the situation faced by Minnesota's small rural hospitals. The infrastructure of rural hospitals in Minnesota, and the resulting expansion of access to healthcare, began 50 years ago. It was funded largely by a Federal program that provided resources to offset construction costs.

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*Demographic changes . . . combined with difficulties recruiting and retaining health care providers, public program reimbursement restrictions, and **aging facilities** [emphasis added], all affect the viability of Minnesota's small rural hospitals.*

*—Minnesota Rural Health Plan*

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Many changes in healthcare delivery occurred during these 50 years. Some of these improvements call for updating or replacing the hospital facility. Among the most notable changes are:

- Advancing technologies have reinvented community hospital care many times over;
- The average hospital inpatient today is older and sicker than in 1950; and
- The identity of the community hospital has shifted from solely inpatient care to a mix of inpatient, outpatient, and community services.

Although hospitals are no longer exclusively defined by their acute care mission, the hospital facility and physical plant was designed and built to provide only acute care services. This creates a substantial variance between what the hospital is designed to provide and what the community needs.

To date, hospitals have made minor renovations to accommodate their evolving programs. Many administrators are now saying that more major changes are needed, including substantial renovations or in some cases replacement of facilities.

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*Hospitals were once defined by their acute care mission. No more . . . Rather than wither away with their declining acute care patients base, rural hospitals redefined their mission and position in the community. Rural hospitals are no longer in the hospital business; they are in the health care business.*

*—University of Minnesota study*

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## The Minnesota Capital Improvement Grant Program

In 1997, the State of Minnesota began addressing the lack of capital in rural areas by enacting the Rural Hospital Capital Improvement Grant and Loan Program (M.S. 144.148). The program initially was targeted at the most geographically isolated and financially distressed hospitals. Under this program, five hospitals were eligible and each received \$1.5 million in loans.<sup>1</sup>

In 1999, the program was expanded to reach eighty-one hospitals.<sup>2</sup> Instead of loans, the program offers grants not to exceed \$300,000 per hospital.

Eligible projects include “modernization projects to update, remodel or replace aging hospital facilities and equipment necessary to maintain the operations of the hospital.”

An independent panel of reviewers evaluates grant requests according to requirements specified in the statute. This panel makes funding recommendations to the Department of Health, which retains authority on all program decisions.

### *Hospital Demand for the Grant Program*

In FY 2000, forty-eight (48) of the eighty-one (81) eligible hospitals applied for funding, requesting \$11 million in support of projects valued at \$70 million in total. The twenty-two (22) grants made in FY 2000 were approved for a total contribution of \$2.8 million. The number of applicants remained consistent in FY 2001. Although funding decisions for FY 2001 have not been made as of the date of this report, the number of applications and dollar amounts requested (see Table 1) reflects the high level of interest in this grant program.

### **Minnesota grant program expanded to 81 hospitals:**

- Licensed as nonfederal, general acute care hospitals with 50 or fewer beds;
- Located in a rural area according to the census bureau or a non-Twin Cities rural community of less than 5,000;
- Able to demonstrate that at least one quarter of any grant amount, which may include in-kind services, is available from non-state sources.

**Table 1: Summary of Capital Improvement Grant Program**

Fiscal Year	Eligible Hospitals	Applications Received	Total Dollar Value of Requests	Grants Approved (whole or part)	Total Dollar Value of Grants
2000	81	48	\$11 million	22	\$2.8 million
2001	81	44	\$9.5 million	Pending	\$2.8 million

<sup>1</sup> The loans are forgivable if the hospital fails to make greater than a 2% operating margin. To date, none of the hospitals have exceeded the 2% operating margin.

<sup>2</sup> See Appendix A for a complete listing of eligible hospitals.

### Projects Supported by the Grant Program

The projects supported in the FY 2000 grant cycle addressed the most severe physical plant and equipment problems. Grants were made for:

- Minor repairs including leaking roofs, handicap access ramps, and replacement of old windows and doors;
- Renovations ranging from small to major, such as co-locating a primary care clinic on the hospital campus or improvements in clinical areas such as obstetrics; and
- Capital purchases including computers, telephone systems, lab analyzers, and diagnostic imaging equipment.

See Appendix B for a complete and detailed listing of project requests in FY 2000.

### Indirect Program Benefits

In addition to the \$2.8 million in direct support, the grant program also provides indirect support. For example, the program's emphasis on thorough project planning and collaboration shows how the grant program supports local health system development. Additional detail on the indirect benefits of the grant program is provided in Table 2.

**Table 2: Three Examples of the Grant Program's Indirect Benefits**

<b>Emphasis</b>	<b>Criteria</b>	<b>Indirect Benefits</b>
<u>Need for grant funds</u>	Successful applicants document a clear rationale and specific financial need.	Emphasizing the importance of documenting need supports thorough project planning, market analysis, and financial assessment – all of which increase the likelihood of success.
<u>Collaboration and partnerships</u>	Collaboration and partnerships with other area providers are strongly encouraged.	Providing incentives to collaborate and develop partnerships targets grant dollars to where they have the greatest impact and supports efficient delivery systems.
<u>Strategic and facility planning</u>	Proposed projects are closely linked to the hospital's strategic and facility plans.	Valuing the linkage between strategic plans and proposed projects helps ensure the projects are mission-critical and a high priority for the organization's future success.

## Capital Needs Survey

In June 2000, the Department of Health conducted a survey of the 81 hospitals eligible for grant funding. The goals of the survey were:

1. Characterize the existing status of the hospitals' facilities;
2. Review the capital projects that hospitals completed in the past three years; and
3. Determine the future capital needs of hospitals (by project type and cost) and their financial position to meet those needs.

The Department extracted data on each facility's financial status from the 1997 and 1998 Health Care Cost Information System (HCCIS) Hospital Annual Report and from previous applications for the Rural Hospital Capital Improvement Grant (where applicable). Each respondent validated the data for their hospital and self-reported additional information as needed. The Department then contracted for an independent analysis and report of survey findings.

The 81 hospitals eligible for grant funding represent:

- A full range of inpatient and outpatient services;
- A combined 2,484 beds; and
- Aggregate revenues in excess of \$740 million in 1998.<sup>1</sup>

A total of 62 hospitals answered the survey for a 77% response rate. The high response rate strengthens the validity of the report's findings and conclusions.

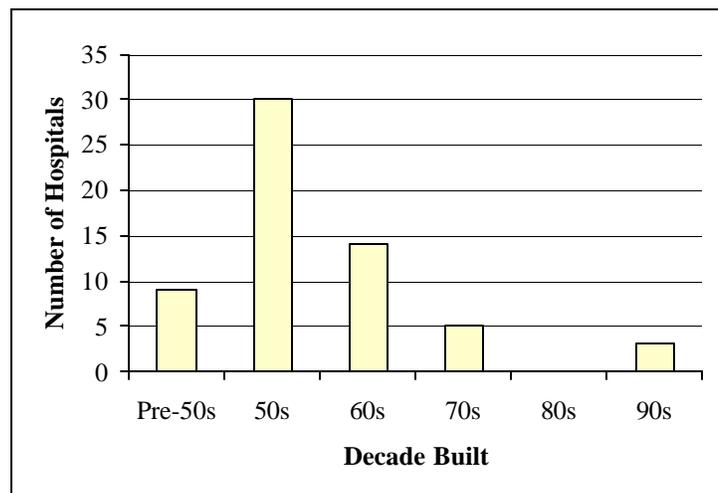
### Facility Status

Characterizing the existing status of small rural hospitals is an important first step in understanding their capital needs. This includes consideration of when the hospital was originally constructed, as well as investments that have been made to modernize the facility over time.

#### *Hospital Construction by Decade*

As shown in Figure 1, the majority of the hospitals were built in the 1950s and 1960s. Primarily supported by the federal Hill-Burton program, this era represents the establishment of the community hospital system that greatly expanded access to rural areas. Since that time, very little new facility construction has taken place. No construction occurred at all in the 1980s.<sup>3</sup>

**Figure 1: Small rural Hospitals by Decade Built**



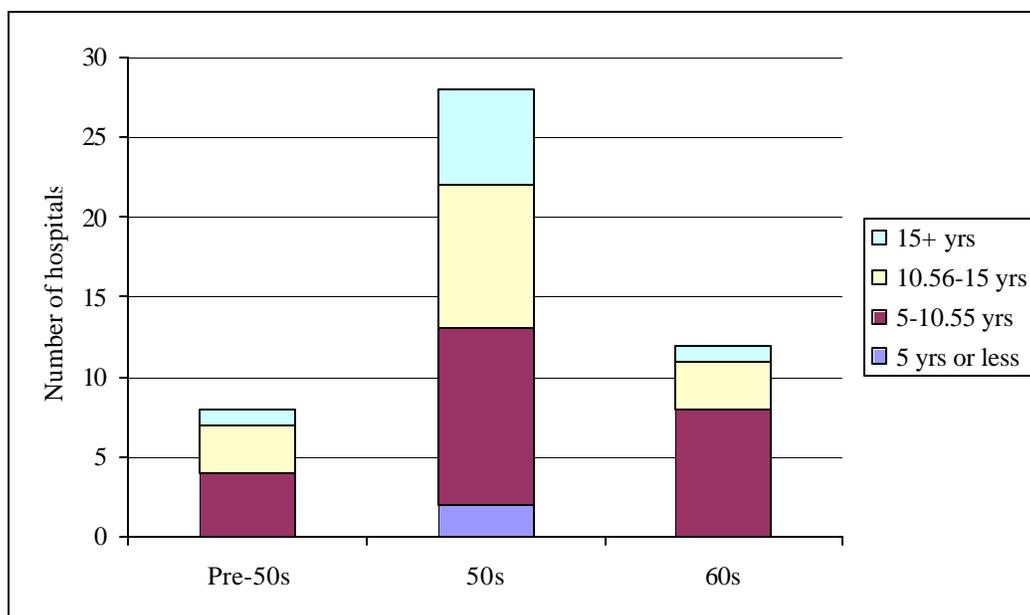
<sup>3</sup> Since the late 1980s, the State of Minnesota has placed a moratorium on additional inpatient beds; thus, any new construction would need to replace or reduce existing beds.

### Rate of Investments to Update/Upgrade Facility

Reduced payments negatively affect the ability of hospitals to make capital improvements. The impact of reduced Medicare and third party payments is not only reflected in the dates of hospital construction, but also in the amount of facility investments that have been made. These include investments in renovations, modernization, and capital equipment projects. The indicator used in examining all of the investments made in hospital facility and equipment, is the average age of plant.<sup>4</sup> The lower the average age of plant, the more investments have been made in the facility since its original construction date.

The average age of plant, as distinct from the facility's original construction date, is represented in Figure 2 for the small rural facilities built in the 1960s or earlier:

**Figure 2: Average Age of Plant by Decade Built**



Holding constant the original date of facility construction, some hospitals have been more successful than others in updating their plant and equipment. As shown in Figure 2, hospitals that were built in the 50s have an average age of plant anywhere from 5 to over 15 years.

The impact of technology is important in evaluating the average age of plant. Healthcare delivery is highly dependent on a wide range of diagnostic and therapeutic technologies. This equipment requires frequent updates or replacement. Replacing equipment requires regular investments (called “asset turnover”), which, in turn, result in a lower average age of plant. This does not appear to be the case for many of Minnesota's small rural hospitals.

<sup>4</sup> The formula for calculation the average age of the plant is: (Accumulated depreciation)/(Depreciation expense)

Comparing Facility Status

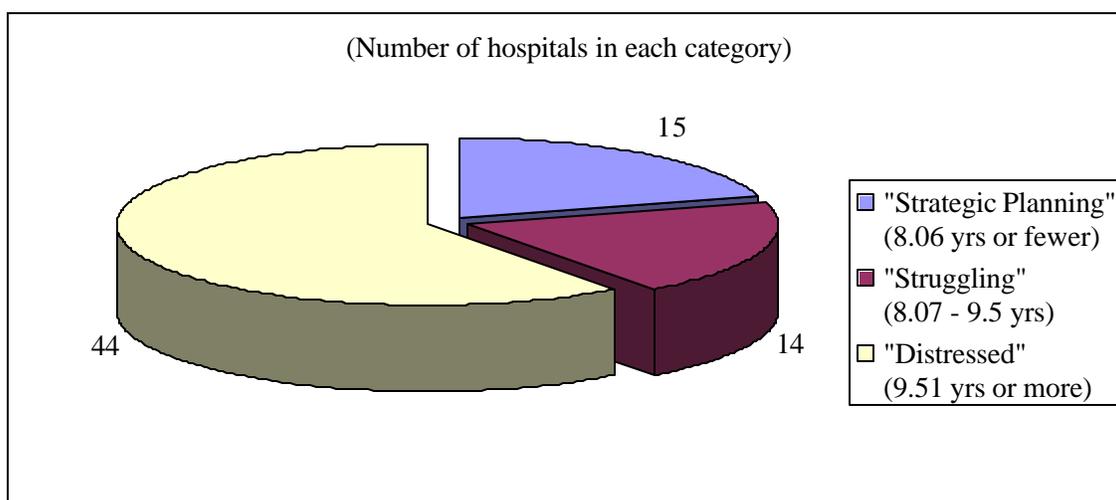
The American Hospital Association has developed three categories for classifying hospitals according to their average age of plant.<sup>5</sup> The categories are based on the premise that planning for replacing assets is tied to the age of the assets. Planning to replace equipment or renovate the facility should be started before its assets are “too old” to avoid overusing them.

**Table 3: American Hospital Association’s Descriptions of Hospitals**

AHA Category	Average Age of Plant Values	Description
Strategic Planning	8.06 years or fewer	Mostly current technologies are being used to provide services with a somewhat modern facility
Struggling	8.07 to 9.5 years	Mix of new and dated technologies are being used to provide services in a relatively old facility
Distressed	9.51 years or more	Significant amounts of dated technologies are being used to provide services in an old facility

As reflected in Figure 3, the majority of the small rural hospitals in Minnesota are classified as struggling or distressed.

**Figure 3: American Hospital Association’s System of Classifying Hospitals**

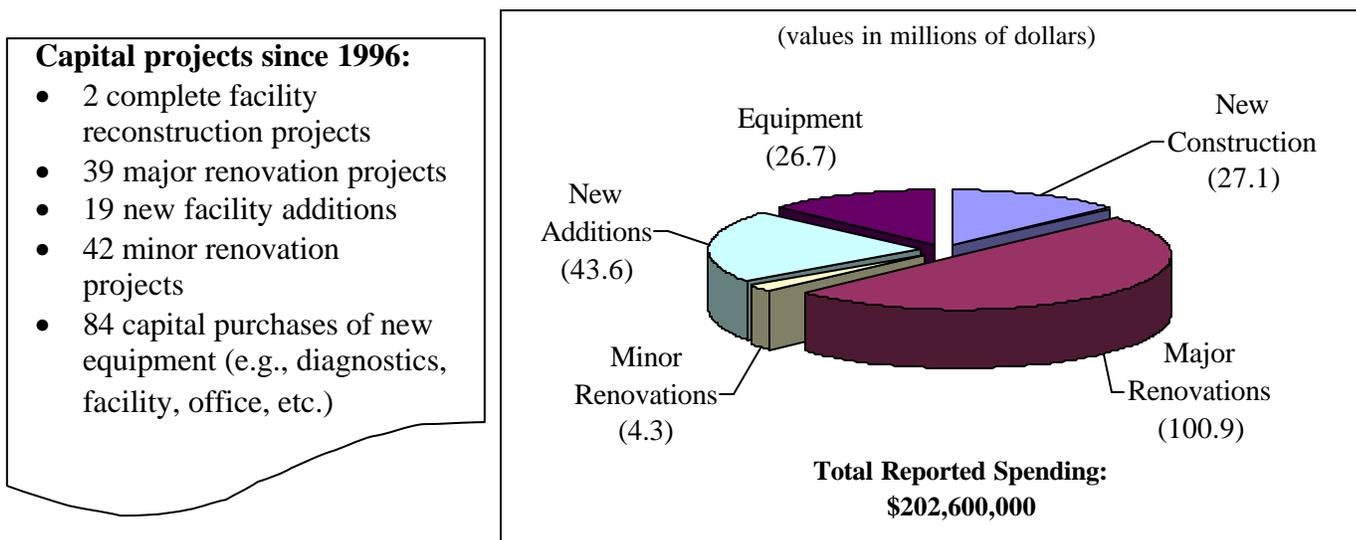


<sup>5</sup> AHA News, “Indicator 6: Age of Plant and Equipment,” April 28, 1998.

### Capital Projects Undertaken Since 1996

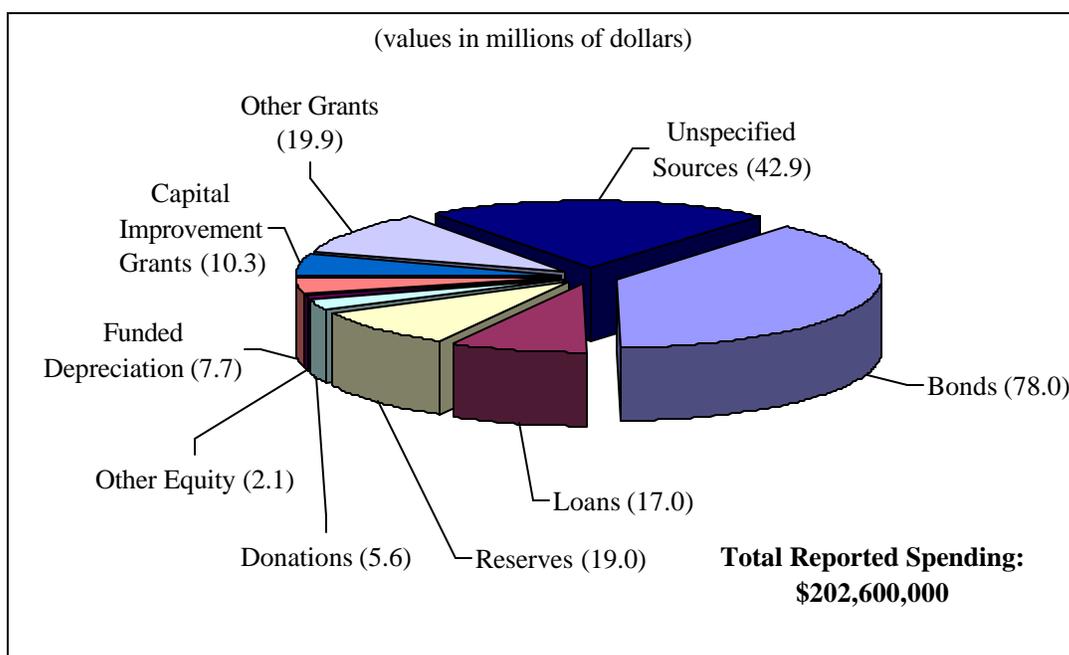
Hospitals surveyed identified a wide range of capital initiatives undertaken since 1996. **The total cost of all projects undertaken since 1996 was approximately \$202,600,000.** Figure 4 shows the breakout of these initiatives in each of the categories.<sup>6</sup>

**Figure 4: Capital Projects Since 1996 by Type**



The survey also explored the types of funding used to support these capital projects. Again, there is a wide range of responses, as shown in Figure 5:

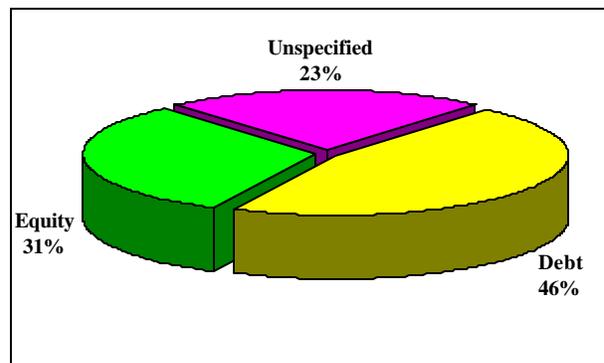
**Figure 5: Sources of Funding for Capital Improvements, 1996-2000**



<sup>6</sup> Minor renovations are those costing \$300,000 or less.

**Figure 6: Sources of Funding Consolidated**

Figure 6 consolidates the source of funding data in the nominal categories of debt or equity (the two options that hospitals have for financing capital projects). Of the funding sources known, nearly one-half of the projects are funded with debt (i.e., bonds or loans) and about one quarter are funded with equity (i.e., reserves, donations, etc.). The remaining projects were unspecified in their funding source.



As a general rule, non-profit hospitals have about a 50/50 mix of debt and equity. If the unspecified sources of funding are all considered to be equity, then the 50/50 principle holds true. If, however, the unspecified sources of funding were debt, then the hospitals would have more debt than normal practice. The high proportion of non-respondents to this question makes problematic any further inferences about the sources of financing.

### Anticipated Capital Needs

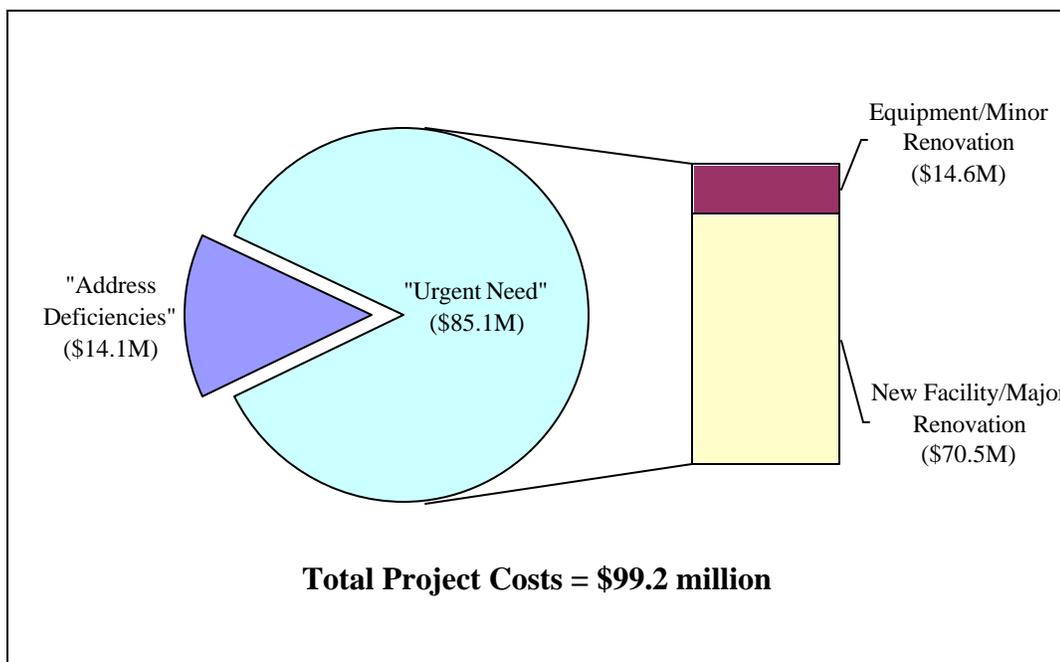
Capital needs anticipated for the future are as diverse as those pursued in the past four years. **The total capital cost of the hospitals' most pressing future needs is projected to total \$99.2 million.** This represents self-reported costs for projects that either directly address deficiencies or are considered by the hospitals' as "most urgent deferred needs." The wording of the survey questions<sup>7,8</sup> was intended to focus responses on highest priority needs.

Actual capital needs are likely even larger than \$99.2 million. First, the response rate to this question was 59%, leaving 61% of non-respondent hospitals that may have priority needs that were not included in the survey results. Secondly, a large number of projects identified in the survey (45 in total) did not include cost data – presumably because estimates had not been completed. The \$99 million should thus be considered a conservative estimate. A breakout by type of need is shown in Figure 7 on the following page.

<sup>7</sup> The deficiencies question was worded: "Are you currently aware of any deficiencies within your hospital that require renovation, modeling, or purchasing as mandated by law and enforced by agencies such as the Fire Marshall, the Minnesota Department of Health Facility and Provider Compliance division, or other similar agencies? If so, please list them and their estimated cost."

<sup>8</sup> The most urgent needs question was worded: "What are some of your hospital's most urgent needs, especially those you have continued to defer for whatever reason, and their approximate cost?"

**Figure 7: Summary of Capital Projects by Type of Need**



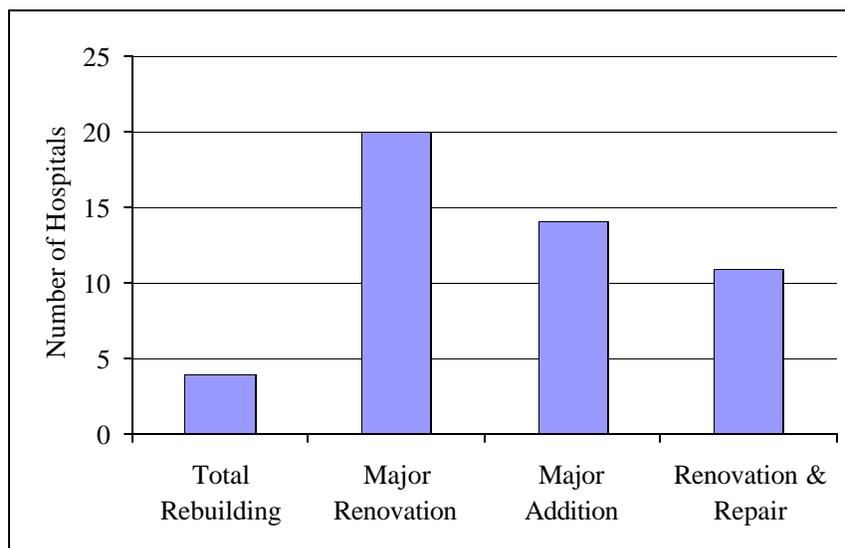
*Urgent Needs*

**Hospital administrators identified \$85.1 million in urgent capital needs – most of which are major facility renovations.** Using narrative descriptions provided in the survey, urgent needs were further divided into two categories: new facility/major renovation and equipment/minor renovation.<sup>9</sup> Of these, the new facility/major renovation projects represent the majority of the capital needs expressed by respondents. Further analysis of the new facility/major renovation projects reveals a large emphasis on total rebuilding, major renovations, or major additions.

**Figure 8: Urgent Need Projects - Building Renovations**

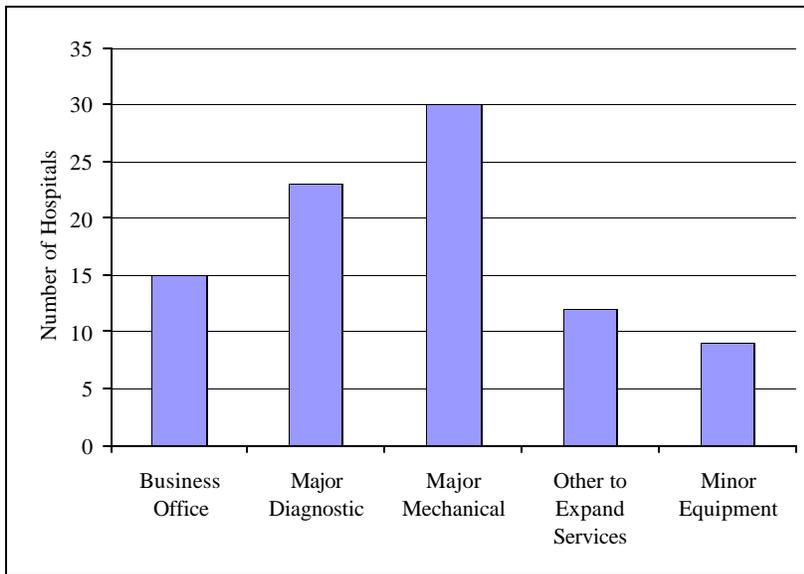
As shown in Figure 8, thirty-eight (38) hospitals indicated urgent needs that are considered “major” (i.e., total rebuilding, major renovation, and/or major addition).

Of the priority projects specified in the survey, almost 80% were large-scale.



<sup>9</sup> Minor renovations are those costing \$300,000 or less.

**Figure 9: Urgent Need Projects - Equipment purchase/replacement**



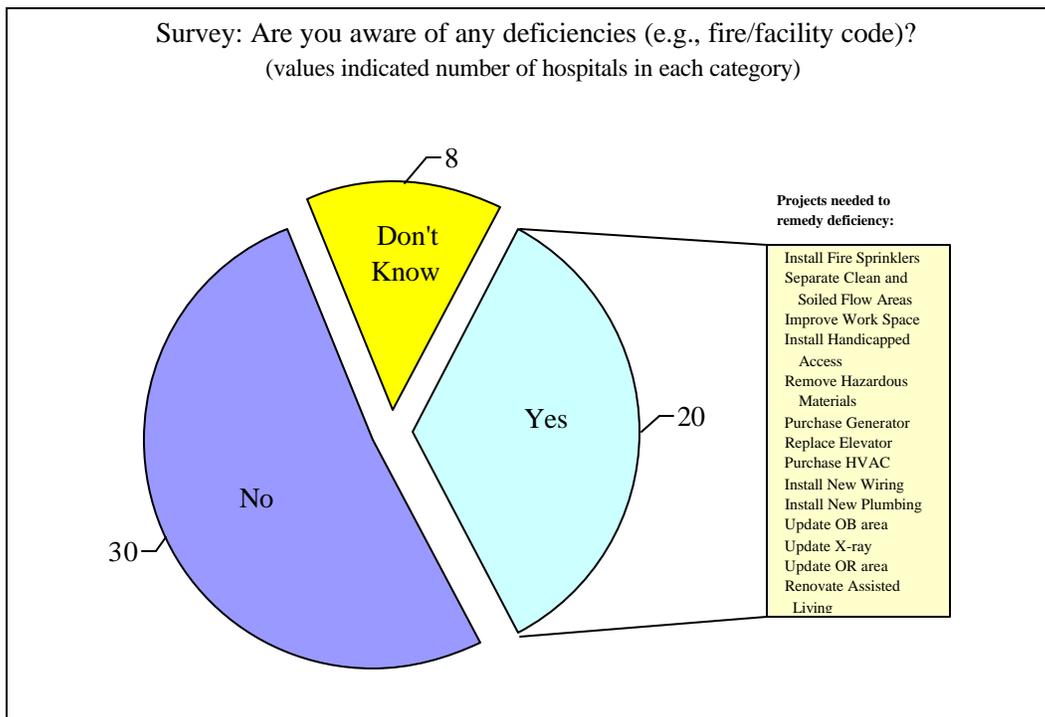
Approximately 20% of the urgent need projects identified related directly to the purchase of equipment. Figure 9 shows the breakout of these projects by type of equipment needed.

Thirty (30) hospitals indicated the need for capital to address major mechanical issues, followed closely by twenty-three (23) identifying urgent need projects to purchase major diagnostic equipment.

*Deficiencies*

**The cost associated with addressing deficiencies in the small rural hospitals surveyed totals \$14.1 million.** One may argue that these capital needs are the highest priority for hospitals as they represent the investment required to bring Minnesota's small rural hospitals into compliance with federal and state regulations. Figure 10 provides additional detail on the types of projects listed by respondents to address these deficiencies:

**Figure 10: Noted Deficiencies among Small rural Minnesota Hospitals**



## Conclusion

The review of capital projects completed since 1996, as well as those anticipated for the future, presents a clear picture. The investment over the past four years has been significant – over \$200 million in project costs have been incurred. In the future, the level of investment will accelerate to meet future demands, approximately \$100 million for addressing deficiencies and meeting urgent needs alone. The total number of projects and costs to meet hospitals' overall capital improvement plans is likely to be even greater.

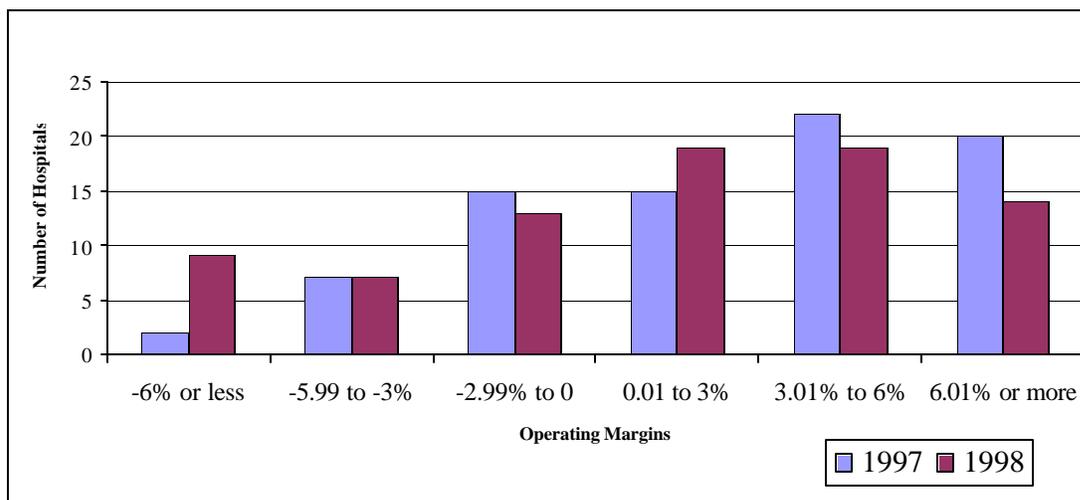
## Financial Status

Accumulating the capital needed in the face of lower reimbursement is a monumental challenge for the small rural hospitals. Nearly all of the hospitals have documented capital needs that are major and highly urgent. These include very short term and immediate needs to address current deficiencies, as well as plans to complete major renovations or additions.

### Operating Margin

**The expected level of capital investment cannot be fully supported by the current operating margins of the hospitals.** Operating margin is the most important measure of a hospital's financial status because it indicates how well the organization is performing in its core business – healthcare services. The 1997 and 1998 operating margins for the hospitals surveyed is indicated in Figure 11, using audited financial data from the Health Care Cost Information System (HCCIS).

**Figure 11: Small rural Minnesota Hospitals' Operating Margins**



The average (median) operating margin for these hospitals was 3.4% in 1997 and 1.3% in 1998. Twenty-nine (29) hospitals had negative operating margins in 1998 versus twenty-four (24) in 1997. Also, substantially more hospitals had net operating losses of 6% or less in 1998 than in 1997. This may be related to a reduction in Medicare payments to hospitals during this period by the Balanced Budget Act.

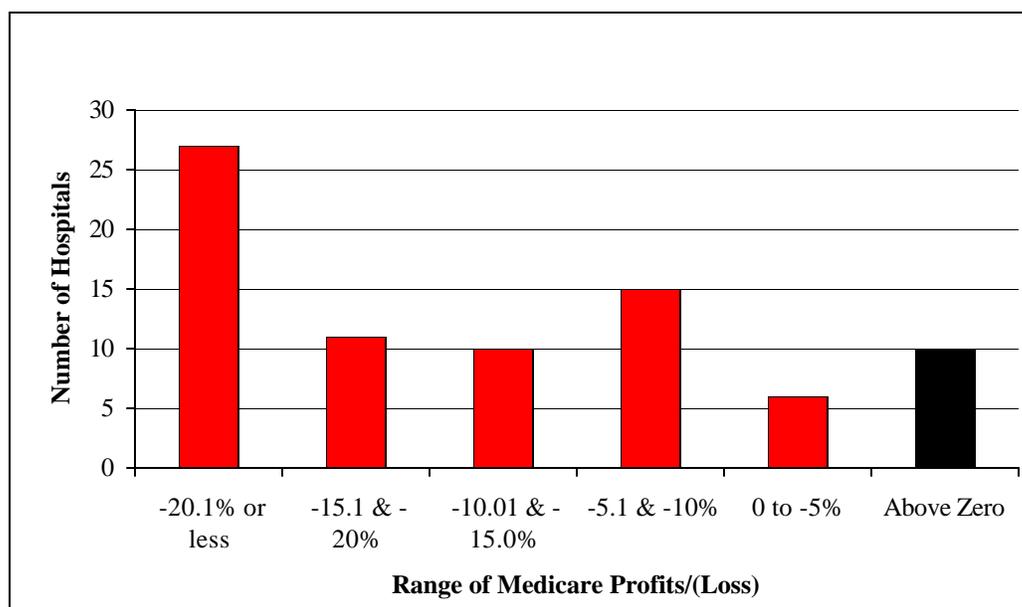
Because operating margin is limited to the profit (or loss) directly associated with patient care activities, it does not take into account other sources of revenue, such as tax subsidies or investment income. In some cases, outside funding is required to subsidize operations. Of the 29 hospitals that had negative operating margins in 1998, ten subsidized their losses fully with other revenues, such as contributions from local government, community members, or investments.

Hospitals need to generate an operating profit to support ongoing investments in capital needs. **Unfortunately, the majority of the 81 small rural hospitals were not able to reach this goal.** As a general rule, a 3% operating margin is required to support ongoing capital investments. In 1997, 37 hospitals were below this mark. In 1998, this number rose to 48.

### Medicare Margin

Understanding the payer mix is an important consideration in evaluating why the operating margin is in decline. Rural communities in Minnesota have a disproportionate share of the state's Medicare population. In fact, more than one-third of rural hospitals across the state depend on Medicare for more than 50 percent of their revenue.<sup>10</sup> As reflected in Figure 12, only 10 hospitals indicated a positive margin on Medicare business. Most hospitals surveyed indicated losses exceeding 20 percent.

**Figure 12: Profit (Loss) from Medicare, 1998**



### Conclusion

The trend in hospital reimbursement continues to decline for both public and private payers. In addition, hospitals are facing increasing cost pressures, including labor shortages for nursing and other professional staff. This places tremendous strain on hospital budgets, limiting their ability to pursue capital improvements. Non-operating sources of revenue (e.g., investment income,

<sup>10</sup> Minnesota Rural Health Plan, July 1998.

reserves, local taxes) are being used to subsidize operations, but not all hospitals can rely on these sources of income.

### ***Small rural Minnesota Hospitals' Access to Capital***

Small rural hospitals in Minnesota face significant barriers to accessing capital for facility improvements and/or equipment purchases. The capital needs survey asked the following open-ended question:

*“What factors have in the past, and currently, prevented your hospital from undertaking necessary or desired capital improvements?”*

Answers to this question are examined in detail in the following sections under the categories “equity” and “debt” financing options.

## **Equity Financing Options**

**Table 4: Barriers to Using Equity for Capital Investments**

<i>Barriers to Accessing Capital – Survey Responses</i>
<b><u>Equity Financing</u></b>
<i>“Cash flow hinders most improvements other than local fund drives for smaller capital expenditures”</i>
<i>“Reserves [are] inadequate”</i>
<i>“Grant dollars [are] limited”</i>
<i>“Lack of available funds due to low operating margins resulting from declining Medicaid and Medicare reimbursements”</i>

Using equity is the preferred way of financing for many hospital administrators. Equity represents the total free cash (e.g., reserves, fundraising, etc.) that is available to pay for a capital project. This is often described as “paying out-of-pocket.” **Survey respondents, however, indicated that the availability of equity to pay directly for their capital projects is limited.**

Declining Medicare and Medicaid reimbursements are cited as reasons why hospitals' profits are not available for capital. Declining reimbursement rates also sap dollars that are held in reserves. More and more hospitals are using their reserves – e.g., retained earnings from previous years – to subsidize hospital operations.

Minnesota's small rural hospitals tend to be located in impoverished areas that have, by definition, a small population base. As a result, there are limited resources in the communities from which to draw substantial hospital donations. As one respondent indicated, fundraising meets only needs for “minor capital expenditures.”

## Debt Financing Options

**Table 5: Barriers to Using Debt for Capital Investments**

<i>Barriers to Accessing Capital – Survey Responses</i>
<b><u>Debt Financing</u></b>
<i>“Affordable financing [is not available]”</i>
<i>“Lack of sufficient cash flow to fund debt for improvements”</i>
<i>“Lack of ability to retire additional debt”</i>
<i>“Leverage risk becoming too great due to BBA [Balanced Budget Act, which cut federal funding levels] ”</i>

Survey responses (Table 5) show some of the reasons that hospitals cannot simply borrow all the money to meet their needs. Critical issues include “affordable financing” and “leverage risk.” Explanations about these important financial terms are provided below.

### *Affordable Financing*

Public debt is issued through bonds, which are “rated” according to the specific financial condition of the hospital. Ratings reflect the level of risk for the bond purchaser; if the bond is poorly rated (i.e., there is a high risk of default), then the purchaser requires higher returns to make their investment risk worthwhile. This means the bond “holder,” such as the hospital or the county, must pay higher interest rates. These debt payments must be financed by the hospital through operating cash flow. Hospitals not having sufficient cash to fund the higher interest payments results in a lack of “affordable financing” in the bond market.

Hospitals face a similar challenge in accessing private debt (e.g., bank loan). **Considered as a high risk, banks have begun to charge high interest rates to hospitals.** The level to which a local bank can support a significant capital project is another factor that may limit a hospital’s access. Lending millions of dollars to the hospital may represent the majority of available funding for a community bank, placing it at too much risk and limiting the availability of funds for other businesses or individuals.

### *Leverage Risk*

A hospital’s leverage risk relates specifically to the proportion of assets financed using debt versus equity. The more debt used in purchasing equipment or renovating the facility, the higher the “leverage.” Hospitals – like individuals – must meet the total sum of all principal and

interest payments (known as the “debt service”) or the assets will be repossessed. Hospitals, as reflected in Table 5, are concerned about their ability to meet these payments in light of declining reimbursement.

## Financial Ratios

Lenders use ratio analysis to evaluate the financial condition of a hospital using purely objective information. The basis for this analysis is the audited financial statements of the hospital. Judging the ability of hospitals to make capital investments is moved beyond anecdotal reports by calculating financial ratios. The most widely used indicators and a short explanation of their use are shown in Figure 13.

*Ratio analysis does not look at only one of these indicators, but instead considers the “big picture” – each of the ratios is examined in relation to the others.*

Audited 1997 and 1998 financial statement data in the Health Care Cost Information System (HCCIS) was used to compute ratios for each of the 81 small rural hospitals.<sup>11</sup> Individual hospital financial performance was not examined in this analysis. Instead, hospitals were separated into three general groups based on their performance on each of the ratios (high, middle, and low).

**Figure 13: Common Financial Ratios**

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***Operating Margin*** – measures profitability on healthcare business

***Current Ratio*** – indicates the risk of failing to meet short term obligations

***Days Cash on Hand*** – number of days that cash is available to meet expenses

***Long-Term Debt to Equity*** – shows how assets are financed (debt or equity)

***Debt Service Coverage*** – ability to pay total principal and interest payments

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<sup>11</sup> Formulas and aggregate results are shown in Appendix C.

**Figure 14: Financial Ratios for Surveyed Hospitals**

		Financial Ratios				
		Operating Margin	Current Ratio	Days Cash on Hand	Long Term Debt to Equity	Debt Service Coverage
Ratio Groups	Highest	Green	Green	Yellow	Green	Green
	Middle	Yellow	Green	Yellow	Green	Green
	Lowest	Red	Yellow	Red	Yellow	Yellow

Each group includes 27 hospitals that showed similar performance on selected ratios.

**Status Key:**  
 Acceptable  
 Questionable  
 Poor

Considering the ability to support additional capital investments, Figure 14 can be interpreted like a traffic light – green areas indicate a “go” (acceptable performance), yellow areas are a caution (questionable performance), and red areas are the stop light (poor performance).

*Conclusion*

While lending decisions are made on a case-by-case basis, all of Minnesota’s small rural hospitals have questionable performance on one or more financial ratios. **The amount of cash on hand is an issue for even the most successful hospitals.** The middle third of hospitals are questionable on the cash on hand, as well as the operating margin issue. The lowest one-third of hospitals face problems getting loans based on their performance in all of the ratios, with the most significant deficits related to cash and operating margin.

**The Roles of Grant Funding**

Grant funding from government or private foundations takes many forms and can serve as either debt or equity, depending on how the grant is structured and for what purposes funding is allowed. The most common type of grant would be characterized as “equity”; dollars are provided to pay for or subsidize equipment or construction costs directly. Other approaches provide organizations with loans at below market rates or insure against losses to make loans more affordable.

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Although grants may not be the complete solution to the problem of rural hospitals’ access to capital, they can play a substantial role in smaller projects and make larger projects more possible to carry out.

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There is a wide difference between what hospitals need and what grants can provide. Hospital administrators are thankful for any grant dollars they can find, remarking that “every little bit helps.” Grants that are focused on meeting smaller, more specific needs clearly play a valuable role. These dollars are often used to replace clinical equipment, repair a roof, or upgrade the information system. However, as reflected in Table 5 on the following page, grants that reduce the amount to be borrowed do not substantially help achieve better bond rating or lower interest.

**Table 6: Impact of grant that reduces the amount to be borrowed**

	<b>Without Grant</b>	<b>With Grant</b>
Capital need	\$ 5,000,000	\$ 5,000,000
Grant		\$ 300,000
Amount to borrow	\$ 5,000,000	\$ 4,700,000
Total loan interest (assumes 15 yr. loan at 8%)	\$ 3,762,216	\$ 3,536,483
Interest savings		\$ 225,733
<b>Total return on grant</b>		<b>1.75</b>

Using a grant to purchase mortgage insurance reduces the interest rate to 6.5% in the example given in Table 6. This leads to \$786,000 in savings over the life of this loan. A hospital pursuing this strategy would turn every dollar of grant funding into 3.62 dollars.

**Table 7: Impact of Grant that Reduces the Interest Rate**

	<b>Without Insurance</b>	<b>With Insurance</b>
Capital need	\$ 5,000,000	\$ 5,000,000
Grant for mortgage insurance		\$ 300,000
Loan interest rate	8.0%	6.5%
Total loan interest (assumes 15 yr. loan)	\$ 3,762,216	\$ 2,976,459
Interest savings		\$ 785,757
<b>Total return on grant</b>		<b>3.62</b>

### ***Survey Findings and Study Conclusions***

Findings and conclusions regarding both hospital capital improvement needs and the role of the Rural Hospital Capital Improvement Grant Program resulted from this survey and analysis project, as follows:

**Small Rural Hospital Capital Improvement Needs:** The capital needs survey commissioned by the Minnesota Department of Health shows a substantial level of need among Minnesota's small rural hospitals. Key findings include:

- Half of Minnesota's small rural hospitals were built in the 1950's or earlier; two thirds were built in the 1960's or earlier. These hospitals are using the same 50-year-old facilities to meet today's needs despite drastic changes in health care and community needs.
- Hospitals need to make investments in their facilities and equipment to maintain their buildings and keep up with changes in medical technology. However, 58 of Minnesota's small rural hospitals are classified as "struggling" or "distressed," according to the American Hospital Association's description of capital investment status.
- Many capital improvement needs remain unmet in Minnesota's small rural hospitals. Hospitals reported needing \$99 million strictly for projects to correct code and related deficiencies and other urgent deferred needs. The total number of projects and costs to meet hospitals' overall capital improvement plans is even greater.
- Capital investment needs of Minnesota's small rural hospitals cannot be fully supported by the operating profits of the hospitals. In 1998, over half of these hospitals did not reach the operating margin generally required to support on-going capital investments. In addition, Minnesota's small rural hospitals face significant barriers to borrowing for their capital improvement needs.

**Role of the Rural Hospital Capital Improvement Grant Program** While meeting only a fraction of the overall demand for capital, the state's Rural Hospital Capital Improvement Grants Program has played a meaningful role in the following ways:

- Providing an alternative source of capital to hospitals with the most severe problems that lack other options
- Supporting major capital expenditures such as re-building, remodeling, and major renovations have made the most significant difference where the grant award is necessary for the project to move forward
- Playing a significant role in supporting minor renovations (less than \$300,000) and equipment purchases

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## *Appendices*

**Appendix A: List of Minnesota's Small rural Hospitals**

Bridges Medical Services	Ada
Arnold Memorial Health Care Center	Adrian
Riverwood HealthCare Center	Aitkin
Albany Area Hospital and Medical Center	Albany
Appleton Municipal Hospital and C & NC	Appleton
Arlington Municipal Hospital	Arlington
White Community Hospital Corporation	Aurora
Clearwater Health Services	Bagley
Lakewood Health Center	Baudette
Swift County-Benson Hospital	Benson
Northern Itasca Health Care Center	Bigfork
United Hospital District	Blue Earth
St. Francis Medical Center	Breckenridge
Canby Community Health Services	Canby
Cannon Falls Community Hospital	Cannon Falls
Cloquet Community Memorial Hospital	Cloquet
Cook Hospital	Cook
Cuyuna Regional Medical Center	Crosby
Johnson Memorial Health Services	Dawson
Deer River HealthCare Center	Deer River
Grant County Health Center	Elbow Lake
Ely Bloomenson Community Hospital	Ely
First Care Medical Services	Fosston
Glencoe Area Health Center	Glencoe
Glacial Ridge Hospital District	Glenwood
Graceville Health Center	Graceville
Cook County Northshore Hospital	Grand Marais
Granite Falls Municipal Hospital	Granite Falls
Kittson Memorial Healthcare Center	Hallock
Hendricks Community Hospital	Hendricks
International Falls Memorial Hospital	International Falls
Divine Providence Health Center	Ivanhoe
Jackson Medical Center	Jackson
Lake City Hospital	Lake City
Minnesota Valley Health Center	Le Sueur
Meeker County Memorial Hospital	Litchfield
St. Gabriel's Hospital	Little Falls
Long Prairie Memorial Hospital	Long Prairie
Luverne Community Hospital	Luverne
Madelia Community Hospital	Madelia
Madison Hospital	Madison
Mahnomen Health Center	Mahnomen
Weiner Memorial Medical Center	Marshall
Melrose Area Hospital - CentraCare	Melrose

**Appendix A: List of Minnesota's Small rural Hospitals – Cont'd**

Chippewa County-Montevideo Hospital	Montevideo
Monticello Big Lake Comm. Hosp. District	Monticello
Mercy Hospital & Health Care Center	Moose Lake
Kanabec Hospital	Mora
Northfield Hospital	Northfield
Renville County Hospital	Olivia
Mille Lacs Health System	Onamia
Ortonville Area Health Services	Ortonville
St. Joseph's Area Health Services	Park Rapids
Paynesville Area Health Care System	Paynesville
Perham Memorial Hospital	Perham
Pipestone County Medical Center	Pipestone
Fairview Northland Regional Hospital	Princeton
Redwood Falls Municipal Hospital	Redwood Falls
Roseau Area Hospital and Homes, Inc.	Roseau
Pine Medical Center	Sandstone
St. Michael's Hospital	Sauk Centre
Murray County Memorial Hospital	Slayton
Sleepy Eye Municipal Hospital	Sleepy Eye
Tweeten/Lutheran Health Care Center	Spring Grove
Springfield Medical Center - Mayo Health	Springfield
St. James Health Services, Inc.	St. James
St. Peter Community Hospital and Health	St. Peter
Lakewood Health System	Staples
Minnewaska District Hospital	Starbuck
Tracy Hospital	Tracy
Lake View Memorial Hospital	Two Harbors
Tyler Healthcare Center, Inc.	Tyler
St. Elizabeth's Hospital	Wabasha
Tri-County Hospital	Wadena
North Valley Health Center	Warren
Waseca Area Medical Center - Mayo Health	Waseca
Westbrook Health Center	Westbrook
Wheaton Community Hospital	Wheaton
Windom Area Hospital	Windom
Fairview Lakes Regional Medical Center	Wyoming
Zumbrota Health Care	Zumbrota

**Appendix B: FY 2000 Capital Grant Requests and Awards****Projects Funded through Capital Improvement Grants**

<b>Summary</b>	<b>Total Project Cost</b>	<b>Award</b>
Major renovation and addition	\$1,750,000	\$300,000
Major renovation	\$1,500,000	\$300,000
Roof, lobby, parking construction; new call system	\$323,000	\$200,000
Renovate obstetrics & outreach clinic, radiology equipment	\$879,000	\$200,000
Major renovation	\$2,140,000	\$200,000
Renovate obstetrics area, surgery, other	\$2,217,000	\$175,000
Renovation, co-locate hospital & clinic	\$5,300,000	\$150,000
Replace & upgrade equipment	\$267,000	\$150,000
Renovation with obstetrics emphasis	\$534,000	\$130,000
Urgent equipment & facility improvements, long range plan	\$169,000	\$130,000
Replacement equipment, minor renovations	\$293,000	\$125,000
Replace 42 year old windows and doors	\$160,000	\$119,000
Total rebuilding of facility	\$18,510,000	\$100,000
Replace/upgrade equipment	\$272,000	\$100,000
Comprehensive renovation	\$1,154,000	\$88,000
Replace boiler, radiology, telephone equipment	\$119,000	\$75,000
Major renovation and addition	\$1,240,000	\$75,000
Upgrade rehabilitation area	\$200,000	\$59,000
Comprehensive renovation/addition	\$3,300,000	\$49,000
Equipment replacement/upgrades; roof repair	\$417,000	\$34,000
Computer upgrade	\$40,000	\$25,000
Addition and renovation	\$163,000	\$16,000
<b>Total</b>	<b>\$40,947,000</b>	<b>\$2,800,000</b>

**Appendix B: FY 2000 Capital Grant Requests and Awards – Cont'd****Project Applications Received but Not Funded**

<b>Summary</b>	<b>Total Project Cost</b>	<b>Funding Request</b>
Radiology equipment	\$309,000	\$300,000
Expand and relocate outpatient services	\$3,293,000	\$300,000
Radiology equipment	\$630,000	\$300,000
Renovate/redesign acute care area	\$400,000	\$300,000
Operating suite renovation	\$394,000	\$300,000
Radiology equipment	\$635,000	\$300,000
Major renovation	\$549,000	\$300,000
Operating room, laboratory, and emergency room equipment	\$541,000	\$300,000
Renovation & relocation of hospital departments	\$5,478,000	\$300,000
Expand outpatient, obstetrics, surgery	\$6,000,000	\$300,000
Major renovation	\$1,552,000	\$300,000
Major renovation	\$9,643,000	\$300,000
Various repairs and renovations	\$391,000	\$293,020
Replace chiller & cooling tower, upgrade air handling units	\$354,000	\$265,110
Radiology equipment	\$326,000	\$260,000
Obstetrics equipment	\$310,000	\$259,700
Major renovation	\$734,000	\$250,000
Equipment upgrades	\$303,000	\$223,764
Computer and technology upgrade	\$212,000	\$205,682
New boiler, windows, ultrasound	\$275,000	\$200,000
Renovate patient rooms & pharmacy	\$394,000	\$197,150
Lab equipment & computer system upgrade	\$267,000	\$175,008
Teleradiology and laundry equipment	\$215,000	\$161,542
Ultrasound and anesthesia equipment	\$210,000	\$152,860
Equipment upgrade and minor renovation	\$200,000	\$150,184
Equipment upgrades	\$195,000	\$144,497
Radiology equipment	\$464,000	\$132,562
Upgrade outreach specialty services	\$145,000	\$99,500
Education room and elevator	\$99,442	\$74,582
Replace roof and gutters	\$101,000	\$73,700
Lab equipment	\$78,000	\$58,745
<b>Total</b>	<b>\$34,697,442</b>	<b>\$6,977,606</b>

Appendix C: Financial Ratio Detail<sup>12</sup>

	<b>Operating Margin (OM)</b>		<p>“Operating Margin” = Net Operating Income ÷ Total Operating Revenue</p> <p><i>Measures the hospital's profitability on its healthcare business</i></p> <p>Preferred value = OM &gt; 3%</p>
	98	97	
25th percentile	(2%)	(1%)	
50th percentile	1%	4%	
75th percentile	5%	6%	
90th percentile	7%	11%	

	<b>Current Ratio (CR)</b>		<p>“Current Ratio” = Current Assets ÷ Current Liabilities</p> <p><i>Indicates the risk of failing to meet short term obligations</i></p> <p>Preferred value = CR &gt; 1.5</p>
	98	97	
25th percentile	1.62	1.51	
50th percentile	2.06	2.03	
75th percentile	2.94	2.98	
90th percentile	3.77	3.68	

	<b>Days Cash on Hand (DCOH)</b>		<p>“Days Cash on Hand” = Cash ÷ ((Total Operating Expenses - Depreciation) ÷ 365)</p> <p><i>The total number of days that cash is currently available to meet expenses</i></p> <p>Preferred value = DCOH &gt; 38</p>
	98	97	
25th percentile	7.98	9.08	
50th percentile	16.38	19.23	
75th percentile	29.75	38.88	
90th percentile	53.33	67.09	

	<b>Long Term Debt to Equity (LTDE)</b>		<p>“Long Term Debt to Equity” = Long term debt ÷ equity</p> <p><i>Shows the proportions in which debt and equity are used to finance assets</i></p> <p>Preferred value = LTDE &lt; 40%</p>
	98	97	
25th percentile	12%	11%	
50th percentile	33%	27%	
75th percentile	61%	72%	
90th percentile	118%	152%	

	<b>Debt Service Coverage (DSC)</b>		<p>Debt Service Coverage = (Net income + depreciation + interest expense) ÷ (Debt principal + interest expense)</p> <p><i>Indicates the hospital's ability to pay total principal and interest payments</i></p> <p>Preferred value = DSC &gt; 2</p>
	98	97	
25th percentile	1.14	1.07	
50th percentile	2.02	1.80	
75th percentile	4.42	3.31	
90th percentile	16.12	15.25	

<sup>12</sup> Percentiles indicate the rank of hospitals; i.e., “75% of hospitals have a operating margin of 5% or less.” The “preferred values” to the right are generalizations. Each lender uses slightly different values in evaluating a loan.

## Appendix D: Capital Needs Survey



Office of Rural Health and Primary Care  
Metro Square Building  
121 East Seventh Place, Suite 460  
St. Paul, Minnesota 55101

June 21, 2000

Dear ,

Enclosed you will find the survey currently being conducted by the Minnesota Department of Health's Office of Rural Health and Primary Care, in consultation with the Minnesota Hospital and Healthcare Partnership.

The goal of the survey is to help us collect information to document what need there is for additional state funding of the Rural Hospital Capital Improvement Grant Program. Our results will be available to the 2001 legislature as it develops its next biennial budget. To produce the most accurate and comprehensive picture, it is necessary for all hospitals eligible for this grant program to participate in the survey.

We will not be publishing any specific information about individual hospitals by name. Our plan is to aggregate data and analyze capital improvement needs of the set of all 81 small rural hospitals.

You will note that some of the questions in the survey have been answered. These answers are based on data collected on the 1998 Health Care Cost Information System (HCCIS) Hospital Annual Report form, and from previous applications for the Rural Hospital Capital Improvement Grant. This is an effort to reduce the burden on you as a survey respondent; please make any necessary changes and complete the remaining questions.

Please return the survey in the enclosed envelope no later than **Friday, July 7, 2000**.

Thank you for your assistance and cooperation. Feel free to call me with any questions or concerns regarding the survey, at 651-282-3837.

Sincerely,

Michele T. Thieman

**These first six questions are basic demographic and contact information:**

- (1) Hospital Name:
- (2) Your Name:
- (3) Your Position:
- (4) Your Phone Number:
- (5) Administrator or CEO:

**These questions relate to the identity of your hospital:**

- (6) What year was your hospital built?
- (7) What hospital is closest to your hospital?
  - (a) Hospital:
  - (b) Distance:
- (8) What is the ownership status of your hospital?
  - County (1)
  - City (2)
  - City and County (3)
  - Non-profit affiliation (4)
  - District (5)
- (9) (a) Does your hospital have an affiliation with a Health Care Organization or System? (ie. Allina, Fairview, etc.)
  - Yes       No       Don't Know
  - (b) If yes, what System?
  - (c) What is the type of affiliation?
    - Owned
    - Managed
    - Leased
    - Other:

**The next set of questions ask you to describe the previous Capital Improvement activities of your hospital:**

**(10)** Please list any Capital Improvement projects which the hospital has undertaken **since FY 1996 up until the present**, including what the project was, the dates over which the project took place, the approximate cost, how the project was funded, and the goals and objectives behind the improvement.

PROJECT 1:

(a) What:

(b) Date:

(c) Approximate Cost:

(d) How Funded:

(e) Goals/Objectives:

PROJECT 2:

(a) What:

(b) Date:

(c) Approximate Cost:

(d) How Funded:

(e) Goals/Objectives:

PROJECT 3:

(a) What:

(b) Date:

(c) Approximate Cost:

(d) How Funded:

(e) Goals/Objectives:

PROJECT 4:

(a) What:

(b) Date:

(c) Approximate Cost:

(d) How Funded:

(e) Goals/Objectives:

PROJECT 5:

(a) What:

(b) Date:

(c) Approximate Cost:

(d) How Funded:

(e) Goals/Objectives:

**(11)** What of the following key equipment has the hospital replaced, substantially improved, or purchased during or since FY 1996:

- Facility Shell (roof, walls, etc.) (1)
- Heating, Ventilation, or Air Conditioning Equipment (HVAC) (2)
- Back-up Power Source (ie. generator) (3)
- Radiology Equipment (4)
- Operating Room Equipment (5)
- Delivery Room Equipment (6)
- Other:
- Other:

**(12)** What factors have in the past, and currently, prevented your hospital from undertaking necessary or desired Capital Improvements?

**The next questions ask you to discuss the Capital Improvement projects in which your hospital may be involved in the future.**

**(13)** Are you currently aware of any deficiencies within your hospital that require renovation, remodeling, addition, or purchasing as mandated by law and enforced by agencies such as the Fire Marshall, the Minnesota Department of Health Facility and Provider Compliance division, or other similar agencies?

- (a)  Yes (1)                       No (2)                       Don't Know (3)

If so, please list them and their estimated cost:

**(b)** Deficiency:  
**(c)** Approximate Cost:

**(b)** Deficiency:  
**(c)** Approximate Cost:

**(b)** Deficiency:  
**(c)** Approximate Cost:

**(14)** What of the following key equipment is the hospital planning to replace, substantially improve, or purchase in the next five years?

- Facility Shell (roof, walls, etc.) (1)
- Heating, Ventilation, or Air Conditioning Equipment (HVAC) (2)
- Back-up Power Source (ie. generator) (3)
- Radiology Equipment (4)
- Operating Room Equipment (5)
- Delivery Room Equipment (6)
- Other:
- Other:

**(15)** What are some of your hospital's most urgent needs, especially those you have continued to defer for whatever reasons, and their approximate costs?

**(16)** Of the following list of possible capital improvements, please mark the five (5) that would be priority projects for your hospital:

- total rebuilding
- major renovation/remodeling
- major addition
- co-location of the hospital and clinic
- small renovation/addition/remodeling
- laboratory renovation/update
- consolidation of services
- equipment to expand services
- relocation of a department or service
- renovation with OB emphasis
- remove asbestos/air quality
- renovate to include assisted living/nursing home
- replace major mechanical equipment (ie. boiler, air conditioning, heating system)
- replace major diagnostic equipment (ie. X-ray, mammography machine, CT scanner, etc.)
- replace major business equipment (ie. new telephone system, many computers/server)
- replace major facility units (ie. windows, doors, etc.)
- replace equipment (not major, less costly)
- parking construction
- build therapy centers (ie. wellness, physical, occupational, burn, etc.)
- purchase laboratory equipment
- purchase generator
- purchase diagnostic equipment (i.e. endoscopy video system, CT scanner)
- Other:
- Other:

(17) What sources of funding do you currently rely on for capital improvements, in order of their importance?

(1) SOURCE:

(2) SOURCE:

(3) SOURCE:

(4) SOURCE:

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