The Adventist Health System: Can It Carry A Billion Dollar Debt?

By Mike Scofield

The Adventist health care corporations continue their vigorous expansion and diversification into new, non-hospital activities. To provide capital funds for this diversification as well as the expansion of existing hospitals, the health care corporations (often with the assistance of government agencies) have incurred up to $987 million in long-term debt. This burden of debt has raised concerns by General Conference officers and outspoken laypeople. Opinions differ as to how precarious the financial situation is.

Adventist Health Systems/United States (AHS/US) is slowly emerging as a 'parent' corporation for nearly all Adventist health care activities in the United States. What were once regional corporations are now classified as "divisions" AHS/Eastern and Middle American, AHS/Loma Linda, AHS/North, AHS/Sunbelt and AHS/West. Although each division, so far, has remained functionally autonomous, the most visible form of the national system is a new headquarters office being built near Dallas, Texas.

Over the past 10 years, some growth has come from the acquisition of new hospitals (several in financial difficulty under previous owners) and from bringing management expertise and economies of centralized services to those smaller, distant facilities. A new source of growth over the past few years has been vertical diversification—entering other types of health care activities, attempting to gain new sources of revenue in health care activities not necessarily requiring in-hospital care. Typical new areas include long-term care facilities, health care at home programs, free-standing emergency rooms, retirement communities, and institutional food-service. Additional growth results from the expansion of existing hospitals.

The 1983 consolidated financial statement for AHS/US shows that gross operating revenues increased 16.4 percent to $1.81 billion. (Compare this with Humana's $2.6 billion or Hospital Corporation of America's estimated $4.2 billion.) Net operating revenues increased 13.4 percent and net income totalled $59,014,000. But it is the consolidated long-term debt (cited as $941 million at the 1984 Annual Council, but which has since grown another $46 million) which elicits some concern. This debt is nearly $94,000 for each acute care hospital bed.

Michael Scofield is a marketing systems project manager for Hunt-Wesson Foods in Fullerton, Calif. He received his masters degree in business administration from the University of California at Los Angeles.

This story is based on interviews with board members, officers, and/or employees of each of the five regional corporations, in-house newsletters, financial statements, and industry journals. All those interviewed asked not to be identified.

Historically, the growth of denominationally owned hospitals and sanitariums was often funded through private donations, loans from other church entities, and mortgage-secured loans from banks. In the United States, when the total growth of the family of hospitals was, on the average, slow, the General Conference could assist with some loans. However, in financing major construction, some hospitals incurred bank debt which exceeded General Conference guidelines.

Because the health systems corportaions and their subordinate hospitals are not-for-profit, they cannot issue stock—a common method of raising capital by rapidly-growing health care corporations (such as Humana and Hospital Corporation of America) listed on the public stock exchanges. The entire health-care industry has moved from labor-intensive to capital-intensive, and Adventist hospitals have had to borrow more money to finance their growth.

Nervousness about this debt of almost a billion dollars manifests itself at the General Conference and in the field. The cover letter of the final report of the President's Review Commission of the Davenport scandal expressed concern about the debt—a topic beyond the original scope of the commission. A special report expressing concern about this debt was issued by the General Conference treasury, and a response articulated at the 1984 Annual Council session by Donald W. Welch, President of AHS/US.

A less subtle expression of alarm can be seen in the banner headlines, "Adventist Hospital System Nears Bankruptcy" found on Vol. 2, No. 2 of the *SDA Press Release* published by the Adventist Laymen Council of Collegedale, Tennessee. This broadside distributed in November 1984 suggested there was "incomplete record keeping of debt service requirements" and "general tardiness in establishing internal audit reports." This was ultimately blamed upon "a very inept board made up of ninety (sic) percent ordained ministers," and indeed a significant theme of the paper was that ministerial domination of boards leads to financial disaster (as in the Davenport scandal).

Yet many AHS board members feel that the alarm is unwarranted. "It depends upon the kind of debt" says one board member of AHS/North. If most of the debt were interest-rate sensitive, a rise in the cost of funds could wipe out profits. The financial statement of one health care corporation fails to specify how much of its long-term debt package has changeable rates, but it does show a variety of debt instruments—some loans secured by first trust deed, mortgages upon property, some by seconds. Some loans are from various denominational entities; others are from banks or public bond issues.

An increasingly popular debt mechanism is tax-exempt bonds issued in conjunction with government agencies. Most of these are revenue bonds, and therefore not secured by mortgages on hospital property. This provides the hospitals (and regional corporations) with considerable funding at very low interest rates. At least 15 governmental jurisdictions around the country are aiding Adventist hospitals with this type of bond issue. While waiting to spend such funds on construction, the AHS corporations can even reinvest these funds at higher market rates and make a tidy profit.

Here is where the Adventist health care corporations differ significantly in balance sheet policy from the rest of the denomination. This type of government-aided funding is generally unavailable to the rest of denominational institutions. Hospitals and their corporations not only have these low-interest funds available, they also have a generally stable flow of revenue to secure these loans. Because they can borrow the money easily, they do, and are inclined to use the leverage of long-term debt more than other denominational entities (such as conferences and unions) which lack the government-backed low-interest source of loans, and rely only on member donations (including tithe) for income.

The balance sheet strategies of conferences, by policy and tradition, are much more conservative in the use of debt, and denominational administrators at the General Conference who were groomed in such a climate may naturally be uncomfortable with debt asset rations which are more common in the non-profit health care industry. "When you consider the assets and anticipated revenue," says one member of a regional board, "the debt is not the risk which the General Conference men perceive."

Ultimately, perhaps the best method of analysis is to compare those debt-critical financial ratios to the corresponding ratios of similar non-profit hospital chains. The Healthcare Financial Management Association provides aggregated and stratified ratios for "voluntary chains" of hospitals. The discussion below uses 1984 figures for 33 chains.

Perhaps the most significant ratio is that of long-term debt to equity. A high debt/equity ratio means a hospital is leveraged, and may be at greater risk if it cannot pay off the principal of the debt. The industry median for this ratio is 0.981. The AHS/US combined is 1.912—high in the upper quartile of the range of voluntary chains. AHS/North has a long-term debt/equity ratio of 2.12 and Sunbelt has the worst, with a rather precarious 2.79.

A highly leveraged position is not necessarily bad if there is significant cash flow to cover servicing the debt and paying off the principal when required. The cash flow to total debt ratio measures this ability. The industry median is 0.175. All AHS regional corporations are significantly below this median, with AHS/North and Sunbelt placing well in the lower quartile (an unfavorable position).

AHS/US places significantly below the median on the times interest earned ratio. (The median for voluntary chains of hospitals is 3.19.) AHS/North places in the lowest (unfavorable) quartile here also.

These calculations are based on operating income. Many of the regional corporations generate significant non-operating income, but even if these are included in cash flow projections, the cash flow to total debt ratio is still below the industry median. Hence, there may indeed be grounds for concern regarding the debt ratios of parts of the Adventist hospital system.

Financial Report for Adventist Health Systems

	E&MA	LL	North	Sunbelt	West	AHS/US
Net Revenue[1]	392	180	202	314	368	1,457
Net Income[1]	18	9	1.5	14	16	59
Current Assets[2]	125	78	73	71	86	432
Total Assets[2]	554	137	272	432	383	1,777
Current Liability[2]	50	31	38	62	80	260
Long-Term & Other Debt[2]	345	59	159	271	153	987
Fund Balance[2]	150	47	75	97	148	516
No. Hospitals[3]	23	2	11	24	15	71
Selected Ratios:[2] current	2.51	2.54	1.90	1.15	1.08	1.66
Debt to Total Assets (%)	71.3	65.7	72.5	77.0	60.8	70.2

Source: *AHS/US 1983 Annual Report.*
Dollars in millions. Most figures for FY'83 (fiscal year ends vary with regional corproations).

[1]Income and revenue figures from 1983 Annual Report.
[2]Balance sheet figures and ratios from AHS combined financial statement for September 30, 1984.
[3]Hospitals owned, managed or leased as of year-end 1983.