NJHCFFA
NEW JERSEY HEALTH CARE FACILITIES FINANCING AUTHORITY

AUTHORITY NOTE$

2017 Series B SUMMER

MESSAGE FROM THE EXECUTIVE DIRECTOR

In our constantly changing world of health care, the Authority has demonstrated the flexibility to adapt to the prevailing financial trends and needs of our health care providers. In recent years we have assisted many institutions to finance desperately needed facility expansions and new construction projects. More recently, with all of the mergers and acquisitions, we have assisted in the consolidation of debt and bond refunding to free up cash.

The mega-merger phase may have plateaued for the time being, however the Authority still has much to offer. We can do much more than for you than issue hundreds of millions of dollars of bonds. We provide other financial options available to help you achieve your operational and technical goals.

Continued on page 2

The Cost vs. Care Challenge

As we enter yet another era of health care reform, the primary concerns of healthcare providers remain constant: controlling costs and improving the quality of patient care. To providers, these objectives cannot be addressed independently, nor should one be accomplished at the expense of the other. Patients today conduct their own research before seeking treatment. They want the best treatment possible, but they also shop around for the best prices.

In the past decade, many hospitals have opted to merge with, or acquire, other hospitals to improve their purchasing power and expand their talent pool. Some believe that these mergers will eventually result in higher costs to the patient because there are fewer systems and, therefore, less competition. Conversely, it can also be argued that the long-term consequence will be lower costs due to more intense competition among the mega-systems.

The recent healthcare trends and industry standards now encourage shorter hospital stays and a greater emphasis on reducing hospital-acquired infections and eliminating hospital readmissions. Pursuant to these objectives, many hospitals are striving to make all necessary hospital admissions more comfortable, safer, personal and, definitely more marketable. Hospitals now invest huge sums of money into consumer-friendly initiatives such as private rooms and family suites, as well as hiring executive chefs and providing gourmet menus.

Such consumer amenities come with a cost. The challenge all hospital executives face is providing the comfort and safety patients expect while keeping their costs competitive with neighboring hospitals and systems. In fact, a recent survey sponsored by Prudential of 301 hospital executives indicated that rising costs are their main concern. The data, as recently reported in ***The Economist,*** revealed that 78% of the responding CEOs regarded rising costs as a critical or an extremely critical factor for 2017.

In addition to patient care, hospitals face even more daunting financial demands: reduced Medicaid reimbursements and rising labor costs. Under the Affordable Care Act (ACA), many states expanded their Medicaid programs to include more Americans. However, the

Continued on page 5

Continued from page 1

The Authority has other programs specifically designed for smaller financings and equipment purchases. Specifically, there is the Equipment Revenue Note Program (ERN) and the Capital Asset Program (CAP.)

Last year the Authority approved increasing the maximum amount of the Equipment Revenue Note program from $15 million to $60 million. This adjustment was made not only because of the increasing cost of medical equipment, but to allow for the procurement of Electronic Health Records (EHR) systems and enable hospitals to develop network integration and data-sharing capabilities for health records and clinical applications.

Over the past year, cyberattacks and ransomware invasions have proliferated. Internet criminals have developed ways to hack into government and corporate computer systems and access personal data. This data is either released to the public or held as ransom for a financial payout. Unfortunately, institutions like hospitals and insurance companies have become the prime targets of these attacks. The primary reason is because they possess a tremendous amount of personal data on millions of people. The second reason is because their systems are usually not very secure.

Information technology (IT) spending now consumes a large portion of a hospital's budget. IT is becoming the second biggest spending category for hospitals after wages and benefits. The new systems and system integration will require additional levels of cybersecurity. We hope that having a higher cap on the ERN Program will assist you in fulfilling your Electronic Health Records requirements and better secure your data.

Another convenient program the Authority offers to organizations is the Capital Asset Program (CAP). The CAP offers borrowers a cost effective, efficient and flexible vehicle to meet their capital needs, including financing the acquisition and installation of capital equipment and minor construction and renovation projects. The CAP may also be used to refinance existing debt or provide bridge financing until permanent financing can be put in place.

The CAP is best suited for loans ranging from $1 million to $20 million and the term of the loans will depend on the useful life of the assets being financed (not to exceed 10 years.) Security for loans is generally provided by a lien on the asset being financed or a Master Note. The CAP utilizes bonds issued prior to the 1986 tax law changes, allowing additional flexibility and a low monthly variable interest rate supported by a TD Bank letter of credit.

Both the ERN and the CAP programs are tax-exempt and offer easy applications and streamlined processes for a quick turnaround.

I know we talk primarily about hospitals, but these programs are also available to skilled nursing facilities, assisted living facilities CCRCs as well as visiting nurse associations and blood banks. I believe these programs are perfect for the smaller facilities and providers that do not have major capital construction projects or equipment needs. Moreover, they enable quick financing for pressing needs.

Whatever your needs are, reach out to us. We will be work with you to find the best fit for your needs.

- Mark E. Hopkins

According to the ***Economist Intelligence Unit*** survey of U.S. healthcare executives:

38% plan to review and optimize current clinical and operational processes;

35% believe they may have to eliminate unprofitable services;

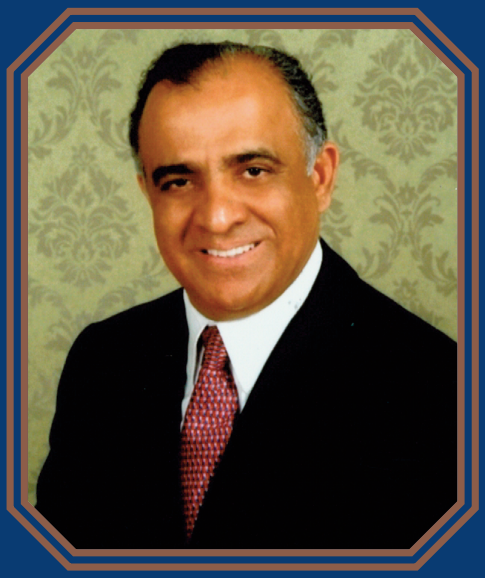
35% will seek lower-cost suppliers;

29% will partner with other hospitals/systems to create economies of scale;

29% plan to increase efforts in preventative/primary care

AUTHORITY NEWS

Reappointed!



On June 19, 2017, the New Jersey State Senate confirmed the Governor's reappointment of Dr. Munr Kazmir as a Member of the Authority.

Congratulations Dr. Kazmir!

Happy Anniversary!

On July 30, Jessica Lucas celebrated her ***10th Anniversary*** working at the Authority.

Congratulations!

Take your Child to Work Day!

On April 22, Account Administrator Jessica Lucas was accompanied to work by her daughter, Mackenzie and her son, Noah.

Capital Asset Program Update

The **CAP** is a revolving loan program for ***all 501 (c) (3) organizations***. **CAP** was designed to take advantage of bonds issued prior to the 1986 law changes. Loans made under the **CAP** program are continuously repaid, making fresh funds available for other borrowers.

Earlier this year, the Authority engaged **a new letter of credit from TD Bank**. **TD Bank has** indicated a willingness ***to provide credit for more borrowers.***

To explore how the CAP can best help your institution, contact:

Jessica Lucas at (609) 789-5639 or **jlucas@njhcffa.com**

Equipment Revenue Note Program Update

On May 25, 2017, the Authority voted to renew the **Equipment Revenue Note Program (ERN.)**

The program is specifically designed to offer ***an easy and efficient way to finance and refinance equipment purchases.***

Last year, the Authority approved ***increasing the maximum bond amount*** from **$15 million to $60 million.**

To find out more about the ERN, contact:

Michael Solidum at (609) 789-5617

Continued from page 1

government also increased the Medicaid reimbursement rates until 2018, after which they would begin a gradual roll back to the normal rates.

Congress is currently working on a replacement to the ACA which will, at the very least, impact the long-term financial planning that hospitals have undertaken since the ACA began. The Congressional Budget Office (CBO) projects an upsurge in the uninsured population which will increase the amount of charity care hospitals provide and the amount of uncollected debt they carry.

According to the data from American Hospital Association, labor costs represent approximately 60% of all inpatient hospital expenses. After a brief period of stagnation, salaries are again on the rise and the prices for health benefit plans have increased an average of 6-7% per year over the past five (5) years (PricewaterhouseCoopers.) Among additional concerns are the current nursing shortage and the projected lack of physicians, particularly specialists, within the next ten years. Providers fear that a shrinking talent pool will cause a demand for higher salaries, thereby further driving up costs.

Health executives also point to high cost of pharmaceuticals as a main contributor to increasing hospital costs. According to the latest Premier Health survey, 64% of the respondents stated that their inpatient spending has increased significantly over the past five years. Also contributing to this trend are the rise in the use of expensive specialty medications and the uptick in patient acuity - patients who suffer from increasingly severe conditions and multiple ailments.

Health systems, hospitals and insurance companies are constantly negotiating with the pharmaceutical industry for lower prices. Success in this area has been very limited. Other strategies being employed to address this situation include: encouraging the use of generic drugs; tightening up the hospital's drug formulary; and identifying expensive drug use patterns for alternative treatments.

Further complicating matters is the fact that a small percentage of the population is responsible for a large portion of healthcare spending. Researchers examining the results of *Medical Expenditure Panel Survey from Agency for Healthcare Research and Quality* discovered that 41% of all healthcare spending can be attributed to only 12% of the population. This segment of the population is comprised of individuals who have five or more chronic conditions. In other words, a relatively small fraction of the population is causing a disproportionate amount of stress on hospital budgets.

Finally, our healthcare officials point to the high cost of technology as another critical factor in escalating costs. The federal push for Electronic Health Records, along with data sharing capability and clinical quality fall into the plus column for customer service and patient care, but they come at a high cost. Information Technology systems can account for 25-35% of a hospital's budget, plus the recent spate of cyberattacks is forcing many institutions to boost their IT budgets.

58% of hospitals are adopting at least one of three strategies:

1. **Outsourcing services**
2. **Restricting pay increases**
3. **Changing care pathways to lessen the need for high-cost talent**

45% of hospital executives put transformating technology lower on their priority list than many other items citing costs as a barrier

Continued on back page

Continued from page 5

Obviously there is no single answer or a ***"magic bullet"*** that solves the problem. As the ***Economist Intelligence Unit*** survey in February found, hospitals are implementing multiple strategies to reduce their costs.

Among the cost-containment and reduction procedures under consideration are: reviewing and optimizing operational and clinical processes; eliminating unprofitable services; seeking lower cost suppliers; continuing to partner and/or merge with other hospitals or systems to further expand their purchasing power and create additional economies of scale; and increasing preventative care, primary care and integrated care, that is, reducing costs through value-based and population health initiatives.

New Jersey is among the leaders in confronting the cost issue. In the past five years there have been many mergers, acquisitions and partnerships. Plus, the New Jersey Department of Health just received accreditation from the Public Health Accreditation Board for its promotion of population health. New Jersey's hospitals are consumer-oriented and are making patient comfort and convenience a priority. And, it is important to note that our hospitals provide the highest quality of medical treatment and highest levels of patient care.

New Jersey's healthcare leaders and executives have consistently demonstrated their commitment to improving the quality of care while controlling costs. And, if history holds true, they will succeed in the current challenge as well.

45% of the ***Economist*** respondents cited cost as the barrier in moving to valued-based care

NJHCFFA

NJHCFFA MEMBERS

Ex-Officio Members

Cathleen D. Bennett
Commissioner of Health

Elizabeth Connolly, Acting
Commissioner of Human Services

Richard J. Badolato, Esq.
Commissioner of Banking & Insurance

Public Members

Suzette T. Rodriguez, Esq.
Munr Kazmir, M.D.

The Authority currently has two Public Member vacancies.

NJHCFFA SENIOR STAFF

Mark E. Hopkins
Executive Director

Frank Troy
Director, Division of Research, Investor Relations & Compliance

Ron Marmelstein
Director, Division of Operations, Finance & Special Projects

William McLaughlin
Director, Division of Project Management

New Jersey Health Care Facilities Financing Authority

Mailing Address:	P.O. Box 366 Trenton, NJ 08625-0366
Delivery Address:	22 South Clinton Avenue Trenton, NJ 08609-1212
Telephone:	609.292.8585
Fax:	609.633.7778
Web:	www.njhcffa.com