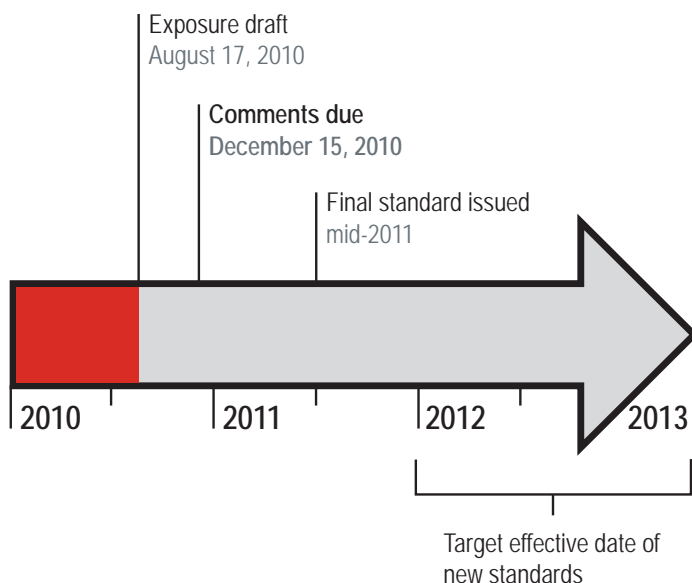


September 2010

What to make of new lease accounting by healthcare executives

The proposed changes in lease accounting released in August 2010 by the U.S. Financial Accounting Standards Board (FASB) will have unique and significant impact on healthcare providers. While the objective of the proposal is to put all leases on balance sheet, hospital systems will be significantly affected because of the substantial amount of real estate deployed in the delivery of healthcare services. Hospitals operate as both a landlord and tenant. Leasing of real estate has been a critical strategy to grow clinical and office facilities at a time when access to capital and concern about leverage and debt ratings are heightened. For these reasons, healthcare systems are particularly sensitive to the upcoming change. The new standard, which will apply to not-for-profit and for-profit organizations, will substantially increase balance sheets and increase reported occupancy expense at a time when operating margins of hospitals are already under pressure and may be exacerbated by healthcare reform.

Timeline of events



The Exposure Draft is the latest step in a long-running process to require capitalization of all real estate and equipment leases on balance sheets by recognizing the rights and obligations of lessees. The pressure to revamp the three-decade-old leasing standard is driven by the perceived lack of transparency around off-balance sheet obligations and the complexity of current lease accounting. Although a 120-day period of public comment follows the release of the Exposure Draft, the primary elements of the new rule are unlikely to change. A final standard is expected to be issued mid-2011 with an effective date yet to be determined but likely to be no sooner than January 1, 2013. It is not too early to anticipate and plan for these changes.

Today, enterprises choose between two methods for classifying leases—as operating or capital leases. Under the new approach, organizations will recognize a liability for obligations to pay rent and a corresponding asset representing the right to use the underlying leased property. The lease obligation will be the present value of payments required under the lease, but consideration will be given to inclusion of renewal periods and estimates of contingent rent payments.

Placing the full lease obligation on the balance sheet and the resulting negative drag on earnings will have a dramatic impact on hospitals' perceived financial performance. Changes in the financial reporting process will be daunting and cumbersome as new transactions and data points need to be captured and interpreted for capitalization based on internal evaluation of occupancy practices and use of property. Use of leasing will likely be re-evaluated in light of the financial reporting consequences for healthcare providers.

Healthcare providers may be faced with added pressure on leverage and credit ratings. Compliance with financial covenants will need to be evaluated based on the proposed changes. Debt ratings, however, are unlikely to be unaffected. Credit rating agencies have long capitalized operating leases and adjusted financial performance measures accordingly. The agencies have publicly stated they will continue to adjust as before. Given the potential inclusion of renewal periods and contingent rent in lease liabilities, it is likely that the effective debt on financial statements will exceed adjustments by the rating agencies.

Developments on lessor accounting in the proposed standard will impact hospitals substantially more than the typical organization due to the common practice of hospitals leasing property to unrelated parties. The proposed lessor accounting model has several potential outcomes in addition to the proposed use of fair value accounting for investment property concurrent with the final standard on leasing. At this time, it is unclear which of these paradigms a hospital's owned real estate may fall under and what shape it will take. The financial reporting implications of each potential outcome would be significantly different.

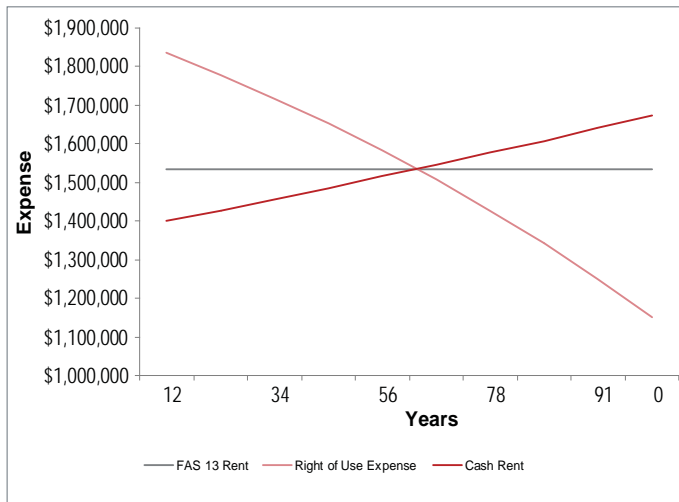
What's changing?

- The distinction between operating leases and capital leases will be eliminated
- All leases, including existing arrangements, will go on balance sheet and rent will no longer be an operating expense
- Capitalization of leases based upon the present value of estimated net lease payments over the expected lease term, discounted at the lessee's incremental borrowing rate
- Capitalized value will include base rent, net of operating expenses, for the longest term of lease that is more likely than not to occur, with consideration of renewal periods and termination rights, and the expected value of contingent rent and other payment amounts over the same period
- Continuous remeasurement of estimates used in capitalizing lease liabilities
- All existing leases will be capitalized based on the remaining lease payments

What's the impact?

- Balance sheets will swell and selected companies will see their debt loads grow by 2-7 times
- Total occupancy expense will be higher and front-loaded over the first half of the lease, often 15-20 percent higher than today's straight-line rent (see comparison of rent expense), and possibly more for key leased real estate locations with a high probability of renewal
- Re-amortization of asset and finance expenses from remeasurement, albeit at the original discount rate, may result in a continuously front-loaded expense profile
- Financial covenants will need to be evaluated for prospective violation on the effective date
- Reimbursement may be out of sync with reported occupancy expense
- Reported capital spending will be higher
- Financial reporting will become more complex and cumbersome with added burden of continuous re-evaluation of assumptions

Comparison of rent expense



Unique impact on healthcare

Hospital systems will be uniquely affected by the proposed standard due to the current business model for healthcare. Leases of equipment and physician office space are standard operating procedure for today's modern healthcare system and have grown considerably in number and volume. Leasing has become an important vehicle for capital formation for fixed assets while systems are preserving capital for physician alignment strategies and routine maintenance of existing infrastructure. Leasing activity accelerated with impaired liquidity and challenges with access to traditional healthcare financial markets.

Hospitals face unique circumstances that may exacerbate the perceptions of financial strength as well as compound the administrative burden and complexity of financial reporting. Illustrations of this impact include:

- Higher reported lease obligation due to the greater likelihood of inclusion of renewal periods as certain facilities are viewed as core, long-term locations for operations. The hurdle to overcome the presumption of renewal with auditors will be high for healthcare providers.
- Common role as a landlord in owned facilities or sublandlord in master leased facilities to physicians and clinicians. Hospitals will need to deal with both lessee and lessor accounting with potential gross-up of the balance sheet and pro forma occupancy expense and income which are not symmetrical.

- Use of ground leases and air rights to third parties on hospital campuses will need to be reported under the new standard and will be more complex than the current reporting of period income from these activities today.
- Sale-leasebacks may be easier to achieve than under current restrictive standards and offer immediate gain recognition even though the leaseback will be on balance sheet. The proposal does away with restrictions on the amount of subleasing to third parties which would give hospitals more breathing room and be consistent with their operating model. Control of properties through purchase options will be allowed provided they are at fair value.
- Build-to-suit arrangements were not addressed but consistent with other concepts under the Exposure Draft, it is likely that leases with third party developers, especially those situated on-campus will face far less strenuous tests and ones that are more in line with the commercial objectives of parties. Control of property will likely be easier to achieve.
- Equipment leasing and financing has become commonplace with healthcare providers. Capital leases will be reported as acquisitions of property rather than leases. On the other hand, operating leases with features such as residual guarantees will require more scrutiny and potentially more capitalization.

How will healthcare providers respond?

A major open question is how dramatically companies will react and how significantly they will alter the use of leases and desired lease terms. A knee-jerk response may be for organizations to seek shorter term leases or favor ownership if property use goes on the balance sheet anyway. Certainly, the changes will push providers to articulate and validate the reasons for leasing such as flexibility in occupancy and preservation of capital for core activities.

Given the "principles-based" approach to the new leasing standard, certain transactions such as sale-leasebacks and build-to-suit arrangements could be easier to execute. Importantly, they may be achieved with better economic terms for tenants and more suited to their true business objectives. While the standard setters' concerns about financial engineering of leases frame much of the new approach, these transactions may better align with an organization's goals.

Although the transition date is not yet specified, the sweeping changes in financial reporting for leases will prompt organizations to begin planning for system modifications immediately. The immediate demands will be to:

- Assess the suitability of existing lease administration and reporting systems to accommodate the new accounting requirements
- Plan for enhancement of lease abstracts and processes for additional data capture for existing leases
- Create standards for assessment of obligations for lease term, net lease expenses and contingent rent that will survive audit review

How Should Healthcare Systems Prepare?

As the reality of the new standard approaches, understanding and knowledge of healthcare real estate portfolios will come into critical focus. For organizations with established real estate departments, professionals will need to be proactive in alerting finance executives about the changes and their likely impact. For organizations with no or small real estate groups, the proposed changes may point to the need to upgrade the professional focus on real estate. The requirements for administration and reporting of leases will become daunting for healthcare systems which have grown through consolidation of hospital systems and acquisition of physician practice groups, each with their own real estate portfolios and operations.

In recent months, organizations have faced the daunting challenge of preparing their existing lease portfolios and reassessing the process for structuring effective leases going forward. This reassessment has four essential components:

1. Understand and quantify the impact - test how negotiated lease terms drive the balance sheet and operating expense
2. Communicate with corporate treasury and accounting about the changes, decisions and reporting needs for the future
3. Anticipate and plan for new financial reporting – identify additional data acquisition and make changes to lease administration systems

4. Re-assess decisions about ownership versus leasing of real estate, much of which has been prompted by access to capital and liquidity

Sweeping changes in lease accounting will give healthcare organizations a valuable opportunity to articulate the fundamental business reasons for leasing. The value of access to real estate capital to support the growth of hospital systems will serve as an important reminder as organizations navigate through the undoubtedly challenging time ahead with new lease accounting.

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