2026 CAPITAL AND FACILITY PLANNING INSTITUTE

WHAT TO DO FIRST –

AND WHAT TO DO WHEN THE PLAN NO LONGER FITS

THE MOST COMMON CALL WE GET

> *We have the renderings. We love the design. Where do we get the money?*

And the project is 2–3× what they can actually finance.

This session covers what to do instead; and how to get a project back on track when it’s already gone too far.

YOUR PRESENTERS

Brian Haapala

CEO, Stroudwater Capital Partners

Capital project financing and advisory for rural healthcare organizations. Economics-first approach to facility planning and execution.

John Downes

Principal, Stroudwater Associates

Facility planning, master planning, and demand analysis for rural hospitals. Grounding capital decisions in market data and community need.

WHAT THIS SESSION COVERS

01

Economics First

What you can afford and why it has to come before the architect

02

Grounding Decisions in Data

Demand analysis, market realities, and projecting future space needs

03

When the Plan Doesn’t Fit

How to get a stalled or oversized project back on track

04

What Happens After Planning

The financing and execution steps that follow a realistic plan

05

Your Questions

Live polls and open Q&A throughout

POLL

Where are you in your capital project journey?

Still exploring — we have a need but haven’t defined the project

Developing the plan — working on scope, master planning, or board alignment

Building the case — we need financing analysis or a funding strategy

Ready to execute — we have a plan and are moving toward lenders and architects

We’ve stalled — the project was in motion but something stopped it

ECONOMICS FIRST

WHAT CAN YOU AFFORD?

THE QUESTION THAT COMES FIRST

NOT THIS

What do we want to build?

Starting with the vision leads to a design that is 2–3× what the organization can finance.

THIS FIRST

What can this organization afford to borrow?

Debt capacity is a planning input, not a financing question at the end.

THE SEQUENCE THAT WORKS

1

Financial Analysis

What can you borrow?

2

Facility Planning

What can you build within that number?

3

Architecture

Design what was scoped

In this order, the project is fundable before the first rendering is drawn.

ECONOMICS FIRST

WHAT LENDERS LOOK AT

DSCR

Debt Service
Coverage Ratio

Can you cover payments with a cushion?

DCOH

Days Cash
on Hand

Do you have adequate liquidity?

EXISTING DEBT

Current
Obligations

What do you already owe?

A debt capacity analysis translates your financials into one number: the project budget you can actually finance.

THE ALIGNMENT PROBLEM

CEO

Championed the project internally

Clinical Team

Designed around clinical needs

CFO

Hasn’t been asked for a number

Board

Seen slides, not financials

Financial alignment before planning begins prevents the project from fracturing when reality arrives.

FACILITY PLANNING

GROUNDING DECISIONS IN DATA

Demographics, actual utilization, and realistic market share assumptions

DIFFERENTIATING WANTS AND NEEDS

- Planning and designing for services the community wants versus services with demonstrated market need tends to bloat project size and cost
- Grounding decisions in demographics, actual utilization, and realistic market share assumptions
- Long-term facility planning needs to match the actual demand within a community

WE ALL WANT TO PROVIDE MORE CARE LOCALLY

- It is critical to balance:
  - Desire
  - Demand
  - Safety
  - Financial Viability

POLL

Where do you source reliable market data?

State / hospital association data repositories

Proprietary / subscription sources (e.g., Advisory Board, SG2, Intellimed, Merative, etc.)

Engage external advisors

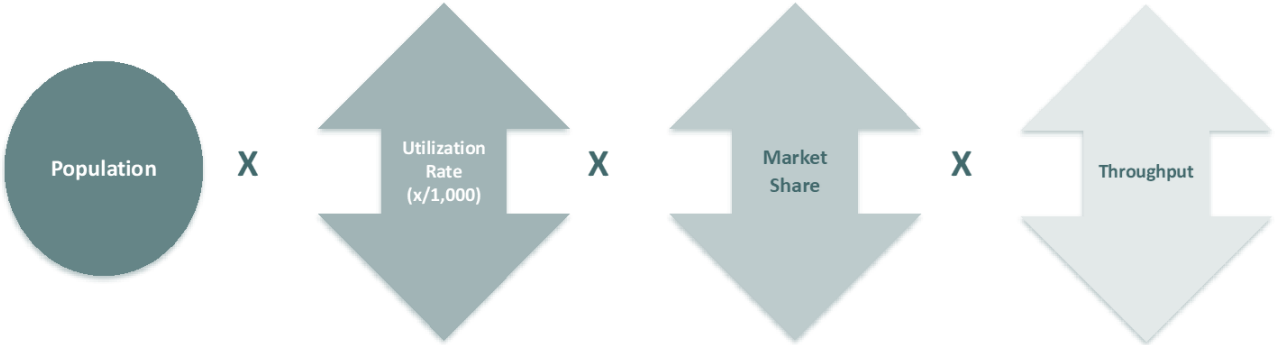
Other sources

We don’t / No idea!

EVALUATING MARKET DEMAND

- Service area definition and analysis
- Demographics and population trends
- Utilization patterns and projections
- Competitive landscape assessment
- Throughput and capacity analysis

FOUR LEVERS OF HEALTHCARE DEMAND



- Geography
- Total market
- Aging
- Gender
- Special populations

- Population health strategies
- Insurance issues
- Readmission rate
- IP/OP shift
- Technology

- Competition
- Service offerings
- Insurance Steerage
- Primary care alignment
- Affiliation strategy

- IP/OP shift
- Acuity
- Socioeconomic
- Clinical issues

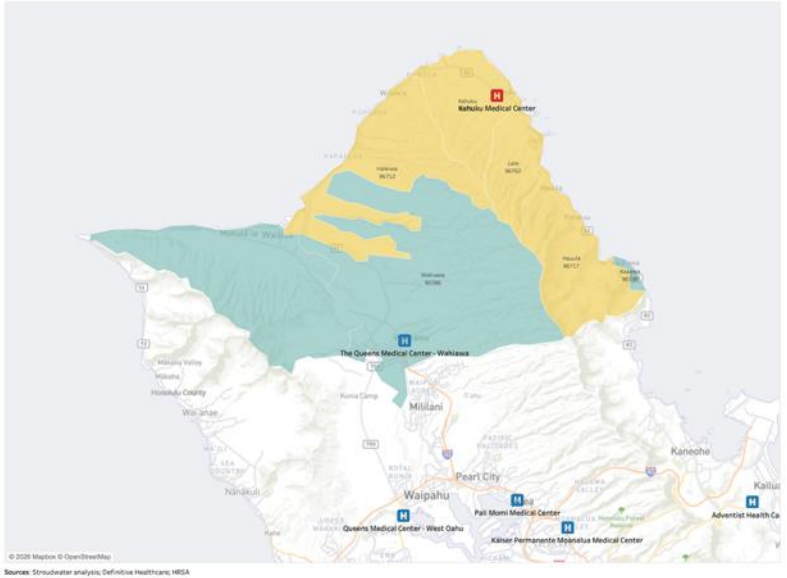
Operating Parameters

Random vs Scheduled | *Confidence Intervals vs Occ %* | *Distinct Unit Types*

Universal vs Specialty | *Observation*

SERVICE AREA ANALYSIS

- County vs. district vs. hospital-defined service area
- Are we the dominant provider?
- Should we “subdivide” the service area?
- Non-overlapping areas are critical!
- Who does the project benefit?

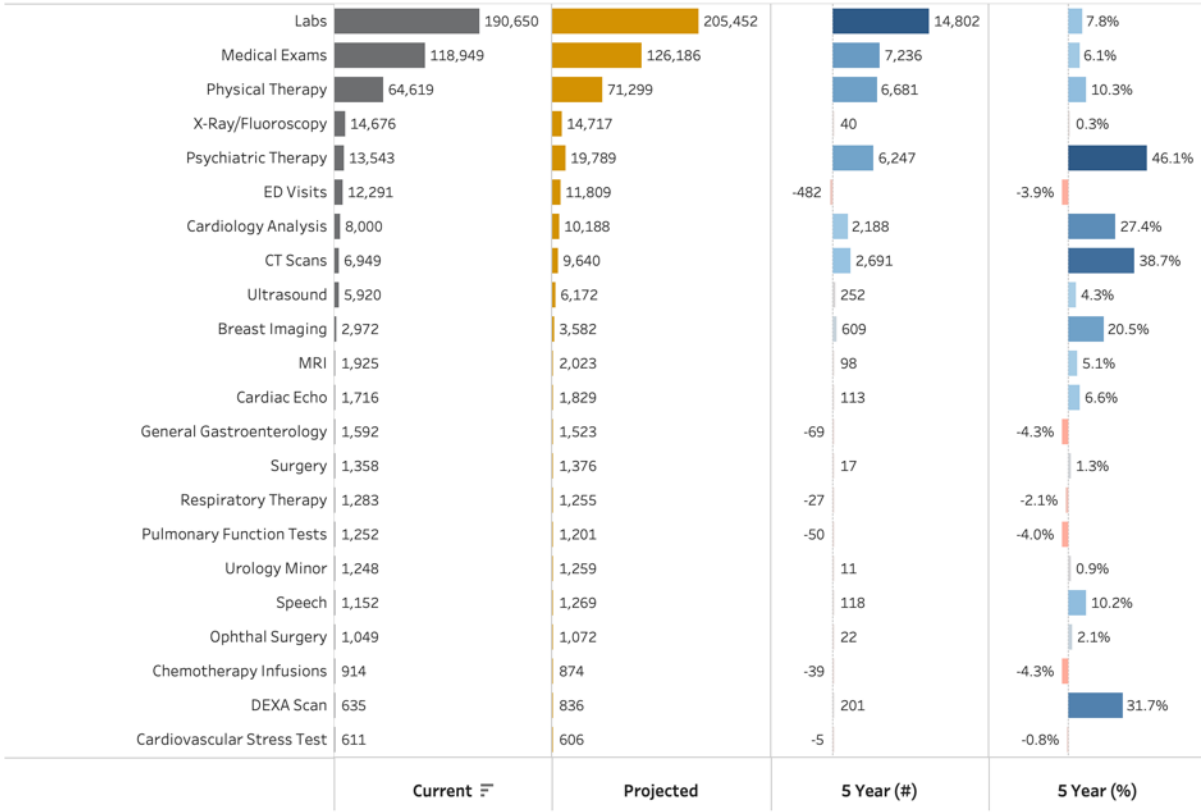


FACILITY PLANNING

DEMOGRAPHICS AND POPULATION TRENDS

- Population projections
- Age distribution
- Special groups
- Market dynamics
- Health equity

UTILIZATION AND MARKET SHARE



Source: Merative. "Stroudwater Procedure Group" is Merative procedures grouped by Stroudwater to better reflect hospital facility demand. Detail available on request.

- What is the market demand for services?
- What would be required if we met ALL of the demand?
- What is our share today?
- What is projected to happen in the future?
- What can we deliver?

PROJECTING FUTURE SPACE NEEDS

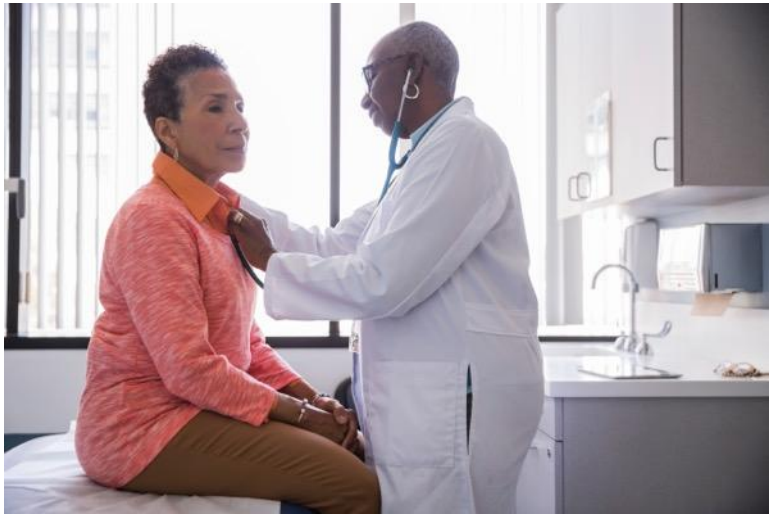
- Defining key planning units (KPU)
- High-level space estimates tied to demand projections
- Realistic construction cost projections for rural markets
- Don’t forget the “other” project costs: equipment, IT, site work, contingency

HOW MANY DO WE NEED (KEY PLANNING UNITS)?

- Volume Targets

- Throughput parameters are where we have flexibility
  - Hours per day
  - Days per year
  - Procedure / Visit length
  - Efficiency factors

- Focus on the primary drivers of space
  - Beds
  - ED
  - Imaging
  - Procedures
  - Ancillaries
  - Clinic exam rooms



HOW BIG WILL IT BE?

- **Net Square Feet (NSF)**
  (the rooms themselves)
- **Departmental Gross Square Feet (DGSF)**
  (rooms + internal corridors + interior walls)
- **Building Gross Square Feet (BGSF)**
  (departments + major corridors + vertical circulation + exterior walls + infrastructure)

Add up all of the BGSF values for all the departments (including support departments that don't have traditional KPUs), mechanical spaces, stairs, elevators, shell spaces, etc. and that is what has to be built (and paid for!)

WHAT WILL IT COST?

- BGSF x Construction Cost per square foot will vary by:
  - Department type
  - Region of the country
  - Accessibility and skill of local contractors / subcontractors
  - Competition

- On top of the construction cost, must account for "project costs"
  - Fixtures, furniture and equipment (FFE)
  - Fees
  - Contingencies
  - Financing

WHEN THE NUMBERS CHANGE THE PLAN

Phased approaches, asset reuse, and reallocating capital to highest impact

POLL

How long should the facility master planning process take?

< 1 month

1-3 months

3-6 months

> 6 months

No idea!

PHASED APPROACHES

- What can realistically be done within the affordable budget?
- Avoid throwing good money after bad — invest where impact is greatest, into facilities that will be part of the long term
- Where can the impact be greatest?
  - # of patients
  - Significant financial improvement to drive additional capacity in the future
  - Operational improvement or mission critical investments
- Initial phases must be complete and functional on their own

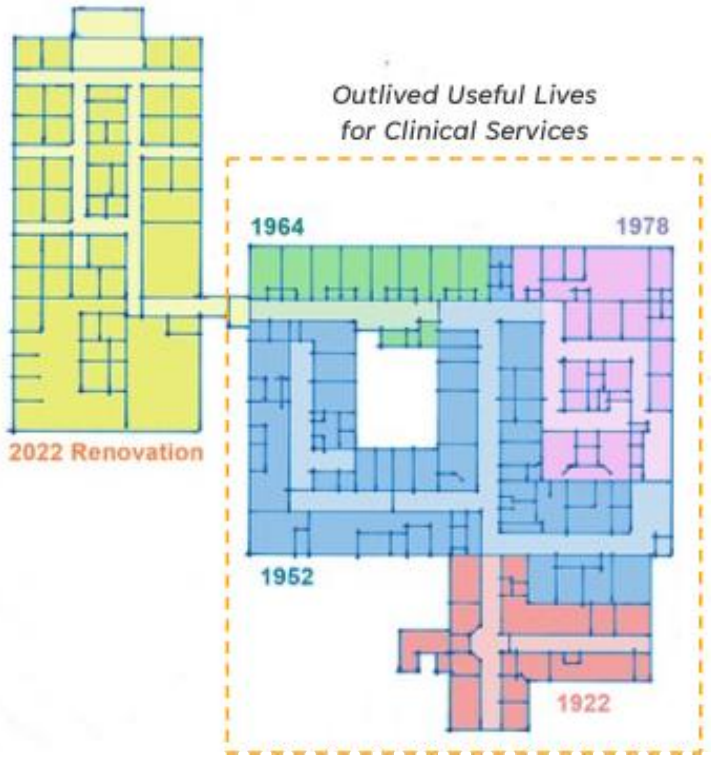
BUILDING ALL NEW IS SOMETIMES IMPOSSIBLE

- We can't always afford a replacement…especially when costs are often > $1,000 per square foot.
  - Example:
    - Inpatient nursing unit…assume it's $1,000 per square foot project cost
    - Single room + toilet = 350 net square feet = $350,000 per room
    - Corridors, storage and support bring the DGSF per room to 750sf…so a total of $750,000 per inpatient room
    - Assume 15 patient beds = 7,500 DGSF = $7.5M
    - Assume building gross factor of 20% (exterior walls, mechanicals, etc.) which brings the 7,500sf unit to 9,000sf
    - 9,000 BGSF = $9M

CHARRETTE MASTER FACILITY PLANNING

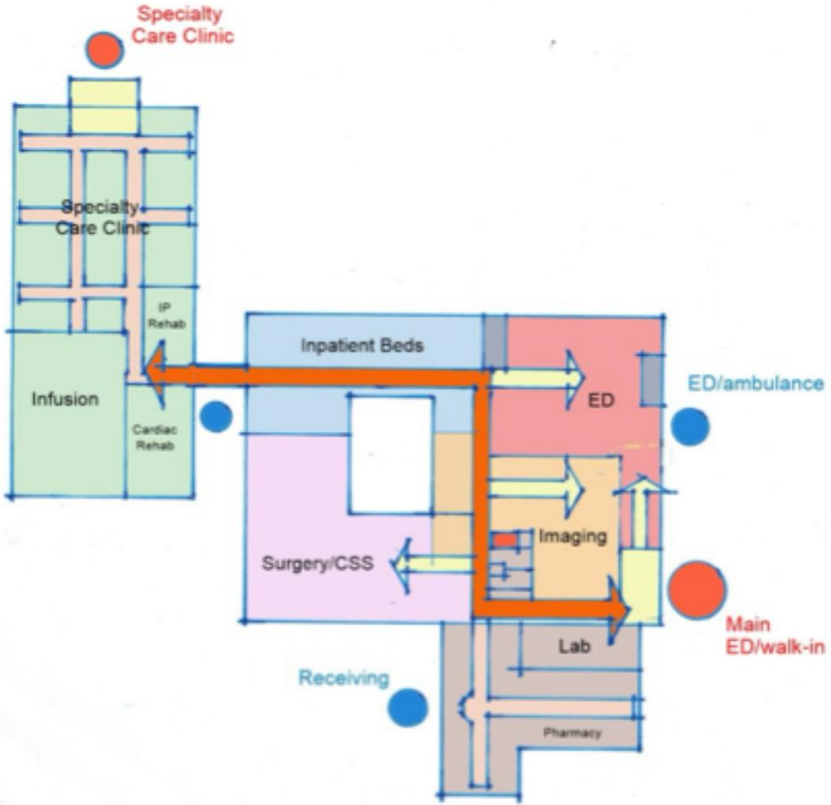
Element	Traditional Master Facility Plan (MFP)	Charrette MFP
Time	3 to 6+ months	4-6 weeks start to finish
Intensity	Moderate but prolonged– • On site every 3-4 weeks • Present – receive comments – revise	High but short – • Consultant and client involvement in 1 week of on-site education, evaluation and solution development
Focus	Broad • Interview all departments • Develop solutions for all departments • Minimal incorporation of financial modeling	Targeted • Solving for major issues and high-level clinical needs • Long term needs in a phased approach • Financially sustainable

CHARRETTE MASTER FACILITY PLANNING



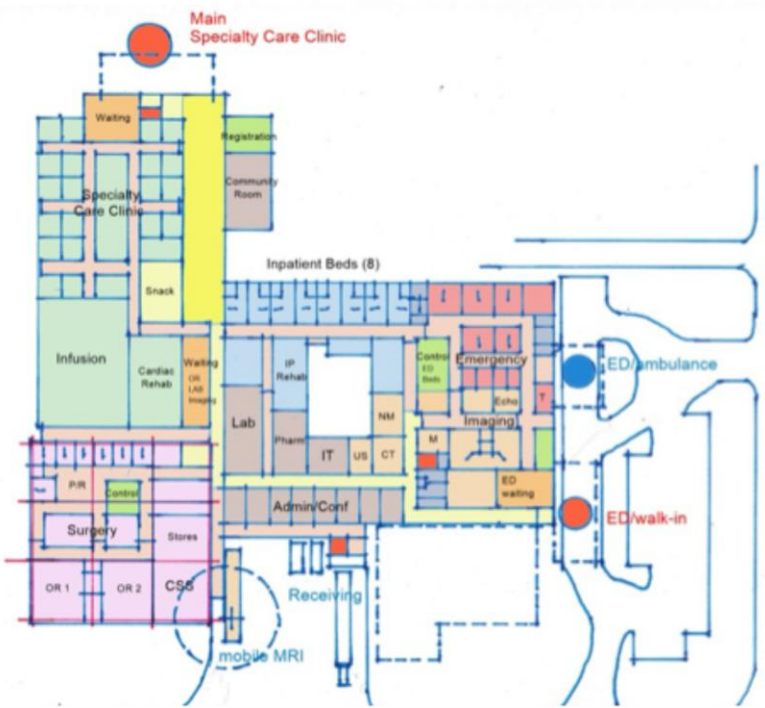
- Maximize utilization of newer assets.
- Minimize investment in outdated structures.
- Ensure options are realistic.
- Provide the greatest positive impact to the organization.

CHARRETTE MASTER FACILITY PLANNING



- **Option 1**
  - Remained siloed
  - Invest in 1952 building renovation for surgery, while keeping surgery up and running.
  - Significant cross traffic between outpatients and inpatients / back of house

CHARRETTE MASTER FACILITY PLANNING



- **Option 2**
  - Reasonable phasing
  - New construction for surgery
  - 1952 building remains for support services and inpatient.
  - Dramatically improved circulation.
  - Financially viable.

WHEN VALUE ENGINEERING ISN'T THE ANSWER

VALUE ENGINEERING WORKS

10–15%
gap

Scope adjustments, material substitutions, and phasing can close a manageable gap.

VALUE ENGINEERING DOES NOT WORK

2–3×
gap

If the project is unaffordable, it is not a project yet. The team needs a strategic reset.

GETTING BACK ON TRACK

A stalled project needs a reset, not an autopsy.

1. (Re-)confirm what the organization can afford
2. (Re-)convene planning inside that constraint
3. (Re-)design a project that will actually happen

The reset is not failure. Redesigning inside affordability is the job.

WHAT HAPPENS AFTER PLANNING?

The financing and execution steps that follow a realistic plan

THE EXECUTION SEQUENCE

1. **Finalize Scope and Program**
   Bridge from planning to design
2. **Architectural Contract**
   RFQ/RFP with rural healthcare criteria
3. **Financing Structure**
   USDA CF / bonds / HUD 242 / combination
4. **Lender Engagement**
   Financial package and underwriting
5. **Construction**
   Close financing, break ground, manage through completion

The sequence matters.

Going to lenders before scope is defined wastes time.

Selecting an architect without regard for how financing is structured creates misalignment leading to wasted time and resources.

FINANCING OPTIONS

USDA Community Facilities

12–18 months

Long-term, low-rate financing for rural organizations. Requires USDA eligibility and a defined project.

Tax-Exempt Bonds

Varies

Faster in some cases. Often requires a rating or credit support, such as through system affiliation. Works well for larger projects.

HUD 242

Restrictive eligibility

Mortgage insurance for hospitals. Requires three years of operating profitability.

Combination Structures

Project-specific

Often projects blend USDA with New Markets Tax Credits (NMTC) or other sources. Structuring the capital stack is part of the advisory work.

The right instrument depends on your financial position, project size, and timeline.

FINANCIAL PHASING

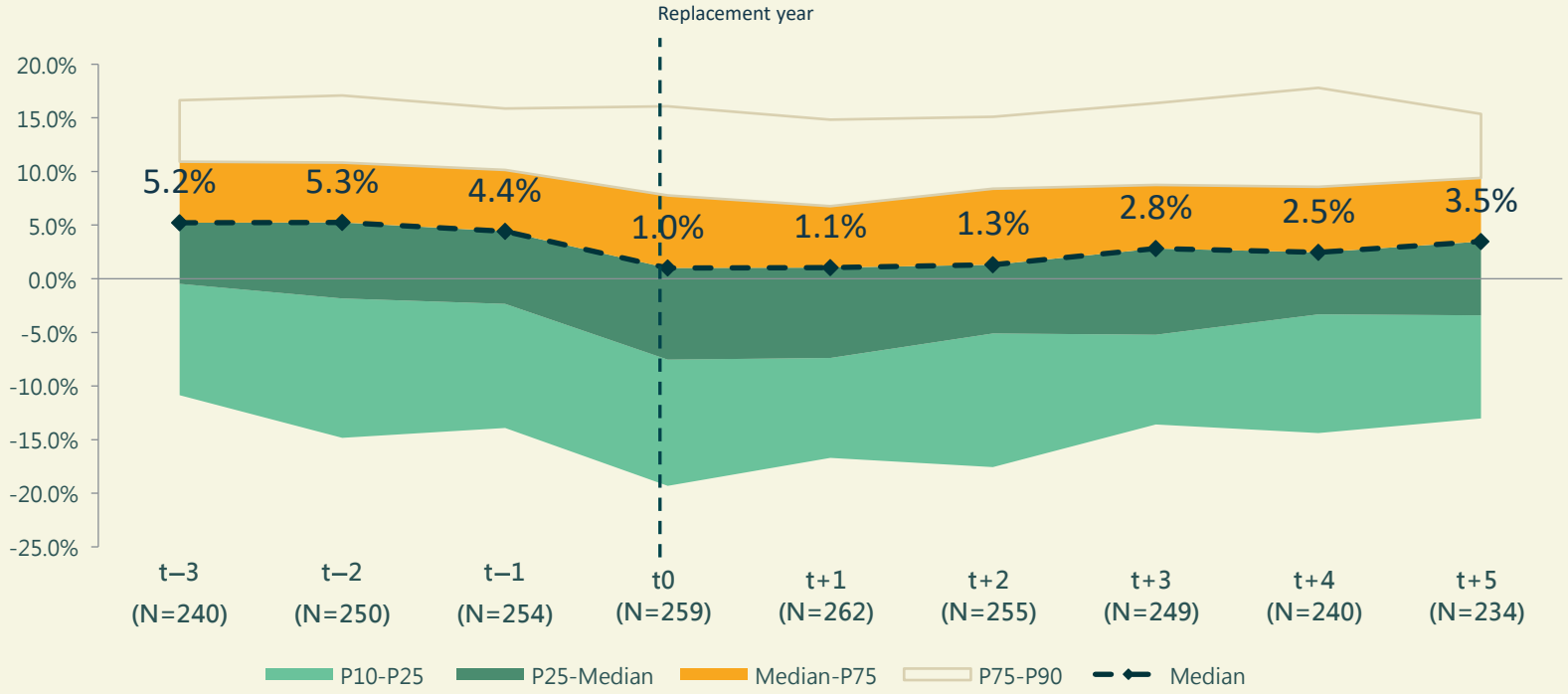
Today's affordability is not a permanent ceiling.

Incremental improvement in operations and financial performance may provide different facility options in the future. Building a fundable Phase 1 today positions the organization for expanded capacity as financial position strengthens.

Phase 1: What you can afford now | **Phase 2:** What improved performance enables

EBITDA MARGIN LESS DEBT SERVICE %

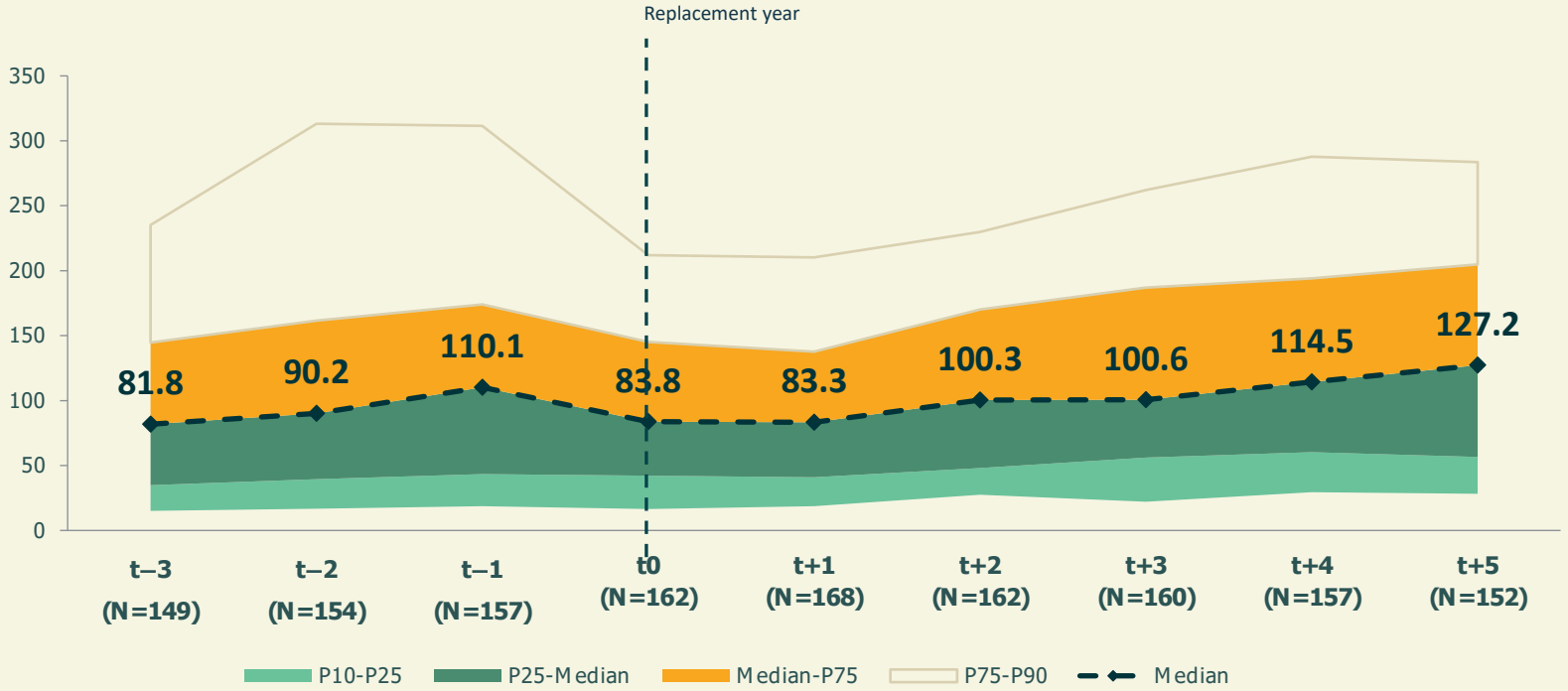
EBITDA MARGIN LESS DEBT SERVICE VALUES BY YEAR Chart shows median performance across 264 replacement CAHs



Source: CMS-2552 Cost Reports | Stroudwater Capital Partners and Stroudwater Associates

DAYS CASH ON HAND

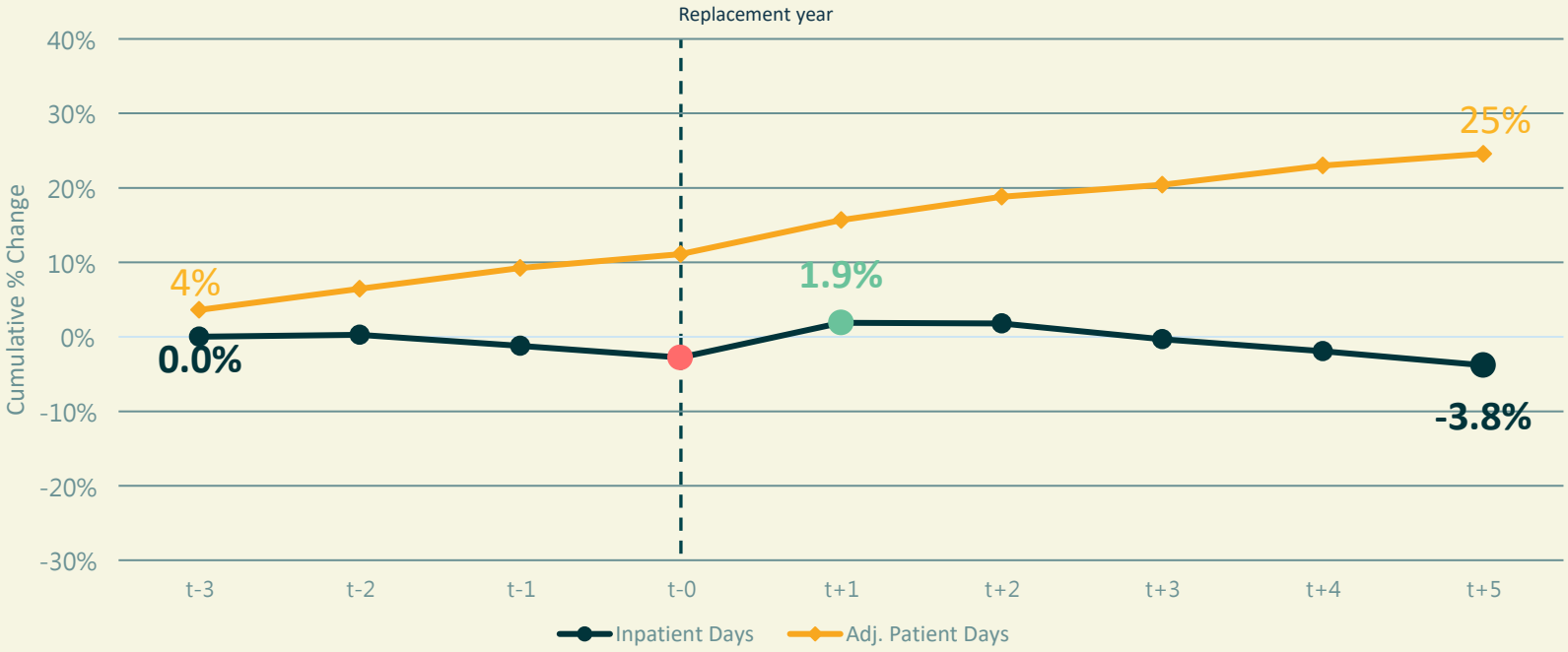
CASH ON HAND VALUES BY YEAR Chart shows median performance across 264 replacement CAHs



Source: CMS-2552 Cost Reports | Stroudwater Capital Partners and Stroudwater Associates

VOLUME CHANGES OVER TIME

CUMULATIVE EFFECT OF ANNUAL CHANGES Chart shows median performance across 264 replacement CAHs



Source: CMS 2552 Cost Reports | Stoodley Capital Partners and Stoodley Associates

INVESTMENT WORKS, WITH A PREDICTABLE VALLEY

Median performance across 264 replacement CAHs confirms a consistent pattern: a 1-to-2 year financial decline followed by recovery that exceeds pre-replacement baselines

HEADLINE FINDING

Margins turn negative at replacement, but cash flow stays positive throughout.

The median CAH sees EBITDA margin less debt service fall to **1%**at replacement (t0), and then margins slowly grow to a median of 3.5% by year five (t+5). Cash flow remains positive through each period even when measures including the depreciation expense is temporarily negative.

SERVICE VOLUMES

Inpatient declines offset by outpatient growth.

Median inpatient volume increased only first year of replacement and declines overall by Year 5. Median adjusted patient days, reflecting total volume, increased over year, growing 25% by Year 5.

STAFFING GROWTH

Consistent staffing and efficiency gains reported each year.

Year over year increases in median increases were reported between 3% in Year 1 (t+1)and then decreasing to 0.5% by Year Five (t+5). Staffing grew at a rate than volumes reflected in decreases FTEs per unit of service from -1.1% in Year 1 (t+1) to -1.9% by Year Five (t+5).

LIQUIDITY

Cash reserves dip 27 days, recover by Year 3 (t+3).

Median DCOH falls from 110 days at t-1 to 83 days at t+1, then rebounds to 101 days by t+3 and reaches 127 days by t+5, surpassing the pre-replacement baseline.

YOU ONLY DO THIS ONCE (OR TWICE)

Most rural executives navigate one major capital project in a career.

The sequence is not intuitive.

The timelines are long.

The decisions are high-stakes.

Getting support through the process is how projects get built.

POLL

What is your biggest concern about your capital project?

Board alignment — we can’t get aligned on the project or the budget

Affordability — we don’t know if we can afford what we actually need

Stalled project — our project was in motion but something stopped it

Financing options — we don’t understand which path is right for us

Getting started — we haven’t begun and don’t know where to start

THREE THINGS TO TAKE WITH YOU

1

Economics first.

Debt capacity is a planning input, not a financing question at the end.

2

A stalled project is not a dead project.

There are real paths forward when the plan no longer fits.

3

After planning, there is a sequence.

You don’t have to figure it out alone.

Let's Continue the Conversation

Brian Haapala, CEO

Bhaapala@stroudwatercapital.us
207.221.8264

John Downes, Principal

Jdownes@stroudwater.com
207.221.8275

1685 Congress St. Suite 101, Portland, Maine 04102

stroudwatercapital.com | stroudwater.com

We are available for questions today and for individual conversations after the Institute.