

Government Insured Financing Available for Health Care Facilities—We’re From the Government and We’re Here to Help—Really!

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I. *Introduction to the Health Care Economy in the United States*

Money is honey, but health is wealth. – Traditional

Without health, what do we have? The march of scientific progress and technological advancement has enabled individuals in the developed world to enjoy long and productive lives. Today, with the help of new, innovative medicines, most Americans can look forward to being healthy and active well into their senior years. While our nation continues to make significant efforts in research and development, these health care initiatives do not come without a price. The health care sector of our economy is enormous. In 2007, 16.2 percent of the United States Gross Domestic Product was allocated to the health care sector, which amounted to approximately \$2.2 trillion.¹ Hospital services accounted for approximately \$697 billion,² long-term care accounted for approximately \$187 billion,³ and the rest was

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¹ AM. HOSP. ASS'N, THE ECONOMIC CONTRIBUTION OF HOSPITALS 1 (2009), <http://www.aha.org/aha/content/2009/pdf/011209-economic-contrib-hosp.pdf> [hereinafter THE ECONOMIC CONTRIBUTION OF HOSPITALS]; see also THE HENRY J. KAISER FAM. FOUND., HEALTH CARE COSTS: A PRIMER 2 (2009), http://www.kff.org/insurance/upload/7670_02.pdf [hereinafter HEALTH CARE COSTS: A PRIMER] (“By the year 2018, the Centers for Medicare and Medicaid Services (CMS) projects that health spending will be one-fifth of GDP (20.3 percent).”).

² THE ECONOMIC CONTRIBUTION OF HOSPITALS, *supra* note 1, at 1.

³ HEALTH CARE COSTS: A PRIMER, *supra* note 1, at 7. This figure represents the expenditures allocated to nursing home care (2.6 percent) and home health care (5.9 percent)—8.5 percent of the total national health expenditures (2.2 trillion) is 187 billion.

allocated to physicians, medicines, home care, and the like.⁴ The amount of energy and resources allocated to health care in the United States illustrates that without our health, we have nothing.

The health care arena has been subjected to rapid changes in technology and advances in treatments, both of which have led to the increased longevity enjoyed by Americans today. Consequently, the need for more health care options is increasing with the growing age of the population; one of the fastest growing demographic segments of the economy is the population of Americans older than age eighty-five.⁵ In order to continue to provide the most up-to-date treatment to the changing American population, the facilities in which health care is provided—hospitals and long-term care facilities, such as nursing homes—need to be updated and renovated on a regular basis.

From the beginning, religious and charitable organizations took the lead in providing comfort and assistance to the sick and infirm of all ages. While it is no longer the exclusive province of religious groups, today, many health care facilities are owned and operated by nonprofit organizations, such as Section 501(c)(3) charitable organizations. The United States has over 5,000 hospitals, and of those, over half are *not* government owned—2,923 are nonprofit, non-governmental hospitals and 982 are investor-owned hospitals.⁶ The United States also has 16,100 nursing homes with a total of 1.7 million beds, and of those homes, nonprofit organizations own 30.8 percent, proprietary investor owned companies own 61.5 percent, and the remaining 7.7 percent are governmentally owned.⁷ Nonprofit organizations, whether religious or secular, often face obstacles when seeking financing, particularly because many nonprofits do not have a financially strong parent organization that can guaranty debt and allow access to conventional finance markets.

⁴ *Id.*

⁵ Fam. Caregiver Alliance, *Fact Sheet: Selected Long-Term Care Statistics*, http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=440 (last visited Jan. 12, 2010).

⁶ AM. HOSP. ASS'N, *FAST FACTS ON US HOSPITALS 1* (2009), http://www.aha.org/aha/resource-center/Statistics-and-Studies/Fast_Facts_Nov_11_2009.pdf.

⁷ CTR. FOR DISEASE CONTROL AND PREVENTION, *2004 NATIONAL NURSING HOME SURVEY: FACILITIES*, TABLE 1, at 1 (2004), <http://www.cdc.gov/nchs/data/nhhd/nursinghomefacilities2006.pdf>.

In past years, owners of health care facilities have used a wide variety of funding sources to finance improvements. Facilities owned by nonprofit organizations have been able to issue tax-exempt bonds with relatively low cost debt for acquisition, renovation and development. Proprietary facilities do not have access to the tax-exempt bond markets, but have been able to obtain commercial financing based upon the financial strength of their operations and the credit of their parent companies. One need only read the newspapers to realize that in today's economic market, the traditional avenues for financing have contracted. Since December, 2007, the United States has been in the worst recession since World War II.⁸ In the past, many organizations and health care companies were able to use commercial bank financing to support individual and corporate projects; however, such financing is no longer available due to tightened credit requirements, increased costs, or inability to access funds through interbank markets.⁹ With the shortage of available funding, health care entities are struggling to maintain even the status quo provision of services, nevermind acquiring funds for renovating facilities or upgrading technology.

The Federal Housing Administration (FHA) has provided federally supported financing programs since 1934,¹⁰ but in the past, many health care facility owners were reluctant to seek financing under these programs. Borrowers loved the product but hated the process. The "lore" among many owners was that FHA insured loans may appear attractive by the numbers, but getting to a successful closing was so difficult and painful that it was not a worthwhile investment of time and energy. Indeed,

⁸ Justin Lahart, *U.S. Economy Pulls out of Tailspin*, WALL ST. J., Aug. 1, 2009, at A1, available at <http://online.wsj.com/article/SB124904159680096697.html>.

⁹ See generally Neil Irwin, *Mutual Distrust Freezes Lending Among Banks*, WASH. POST, Oct. 1, 2008, at D01, available at <http://www.washingtonpost.com/wp-dyn/content/article/2008/09/30/AR2008093002629.html>.

¹⁰ LAWRENCE L. THOMPSON, *A HISTORY OF HUD 1* (2006), http://mysite.verizon.net/hudhistory/hud_history.pdf [hereinafter *A HISTORY OF HUD*].

The FHA began lending to hospitals in 1969. Press Release, U.S. Dep't of Housing & Urban Dev., *FHA to Begin Insuring Hospital Refinance Loans: New Policy Designed to Help Hospitals Falling Victim to the Credit Crisis* (Jul. 13, 2009), available at http://portal.hud.gov/portal/page/portal/HUD/press/press_releases_media_advisories/2009/HUDNo.09-114. However, it was not until July 2009 that FHA began providing mortgage loan insurance for hospital refinancing. *Id.* Program 232 was authorized under the National Housing Act. 12 U.S.C. § 1715w (2009).

these authors¹¹ have been known to counsel prospective borrowers that a prime requirement for FHA financing is a high pain tolerance. However, these programs offer loan terms that are very attractive in today's challenging financial market. Even the United States Department of Housing and Urban Development (HUD) recognizes the problems and has changed its processing to be more efficient and timely.

Given the recent market upheavals, it will be even more difficult to obtain financing. In many respects, the HUD insured programs are more important now than ever before, and may be particularly attractive to nonprofit borrowers. Thus, many owners are taking a new look at government insured or sponsored financing. Many FHA lenders have been sending excited messages to members of the health care community touting incredible improvements in the FHA lending process, and suggesting that low-interest, fixed-rate loans are available without much of the time consuming government paperwork of the past, due to the newly launched "*Lean*" processing. Is this too good to be true? What are the advantages and disadvantages of these programs?

This article provides an overview of the types of FHA insured financing that may be available to owners of health care facilities and discusses some of the more significant issues that are important to borrowers exploring whether one or more of these programs will meet their needs. This article also highlights certain specific concerns of nonprofit borrowers. Additionally, this article offers Practice Pointers, based on the authors' personal experiences, to help borrowers navigate the complexities of borrowing from HUD and survive in this tenuous financial market. Ultimately, by knowing the facts and the programs available to borrowers, health care provider entities can acquire the funding necessary to improve their facilities and provide for the ever-changing and aging American population.

II. Brief History of HUD and the FHA

We're from the Government, and we're here to help!

¹¹ This article references the joint experiences of its co-authors.

During the Great Depression the high rate of unemployment and myriad bank failures in the early 1930s had essentially collapsed the housing industry.¹² To combat the economic crisis, the New Deal was penned and ushered into existence by then President Franklin Roosevelt.¹³ Many government programs, which have long since become established institutions, found their origins in the New Deal—the FHA and HUD being among them.¹⁴

In 1934, Congress created the FHA in the National Housing Act of 1934, which was signed into law by President Roosevelt as part of his New Deal.¹⁵ The FHA home mortgage insurance program was aimed at restoring stability to the nation’s housing market by easing the mortgage credit crunch.¹⁶ At the time the FHA was enacted, the housing industry was stagnant; loan terms were strict and difficult for homebuyers seeking mortgages to meet.¹⁷ More specifically, “[m]ortgage loan terms were limited to 50% of the property’s market value, with a repayment schedule spread over three to five years and ending with a balloon payment.”¹⁸ The FHA does not issue mortgages. Rather, the FHA insures approved mortgages issued by private lenders against the risk of default by homeowners, thus encouraging lenders to extend credit.¹⁹ By insuring mortgages, the FHA reinvented the United States housing industry by establishing concepts of the low down payment and the long-term mortgage.²⁰ The FHA transformed America from a nation of renters²¹ to a nation of homeowners.²²

A few years later, Congress enacted the United States Housing Act of 1937, which was also a New Deal initiative.²³ During the 1940s, in the midst of the Great Depression, nearly fifty per-

¹² See A HISTORY OF HUD, *supra* note 10, at 2.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ U.S. Dep’t of Housing & Urban Dev., *The Federal Housing Administration (FHA)*, <http://www.hud.gov/offices/hsg/fhahistory.cfm> (last visited Oct. 6, 2009) [hereinafter *The FHA*].

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ A HISTORY OF HUD, *supra* note 10, at 3.

²¹ “Only four in 10 households owned homes.” *The FHA*, *supra* note 17.

²² A HISTORY OF HUD, *supra* note 10, at 3.

²³ *Id.* at 4.

cent of all housing units lacked adequate plumbing, and another twenty percent were in need of significant repairs.²⁴ Under the United States Housing Act of 1937, the Public Housing Program was created to foster economic development via expanded housing construction.²⁵

Although the FHA and HUD were both New Deal initiatives aimed at economic stimulation for the housing market, the FHA did not formally become a part of HUD's Office of Housing until 1965 when President Lyndon Johnson signed the Department of Housing and Urban Development Act.²⁶ This HUD Act simultaneously elevated HUD to a cabinet level department while placing the FHA underneath HUD's umbrella.²⁷

Over time, HUD has slowly developed five core missions:

- Increasing Homeownership (1934)
- Assisting Low-Income Renters (1937)
- Improving the Physical, Social, and Economic Health of Cities (1949)
- Fighting Discrimination in Housing Markets (1968)
- Assisting Homeless Persons with Housing and Support Services (1987).²⁸

One means in which HUD furthers these goals is through FHA mortgage insurance. Presently, the "FHA insures mortgages on single family and multifamily homes including manufactured homes and hospitals."²⁹ An FHA insured loan must meet strict FHA established requirements in order to meet approval qualifications.³⁰ However, there are many benefits that offset such requirements, such as low down payment requirements and "flexibility in calculating household income and payment ratios."³¹

An interesting note: the FHA is the only government agency that is entirely self-funded—the revenues generated from mortgage premiums fund the program.³² The FHA and HUD have

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.* at 7.

²⁷ A HISTORY OF HUD, *supra* note 10, at 7.

²⁸ *Id.* at 2. The dates in parenthesis are the dates of origin for each mission.

²⁹ *The FHA*, *supra* note 17.

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

insured over thirty-four million home mortgages and nearly 50,000 multifamily project mortgages since their inception in the 1930s.³³ The FHA “has 4.8 million insured single family mortgages and 13,000 insured multifamily projects in its [current] portfolio.”³⁴

III. *Loans Offered by the FHA and HUD—Attractive Terms for Eligible Deals*

Why, sometimes I've believed as many as six impossible things before breakfast. – Lewis Carroll

As discussed above, the FHA and HUD primarily serve the residential housing market. Thus, owners of health care facilities may not immediately think about these agencies when they are pondering their financing choices. However, health care facilities are, in some sense, hybrids between housing (after all, the patients are residing in some of these facilities for many months) and service providers. Thus, long-term health care providers are considered “multifamily” projects by the FHA, and hospitals, which are not considered “multifamily projects,” have their own program designed for them.³⁵ Taken together, the two programs offering FHA insurance for health care projects are Section 242 of the National Housing Act (for hospitals),³⁶ and Section 232 of the National Housing Act (for skilled nursing homes, intermediate nursing homes, board and care homes, and assisted living facilities).³⁷ While the great majority of insured multifamily projects are not health care based, in fiscal year 2006, the FHA insured mortgages for 222 long-term care projects totaling \$1.3 billion³⁸ and insured mortgages for nine hospitals totaling \$943 million.³⁹

³³ *Id.*

³⁴ *The FHA*, *supra* note 17.

³⁵ 12 U.S.C. § 1715z-7 (2009).

³⁶ *Id.*

³⁷ 12 U.S.C. § 1715w (2009).

³⁸ U.S. DEP'T OF HOUSING & URBAN DEV., FED. HOUSING ADMIN., ANNUAL MANAGEMENT REPORT FISCAL YEAR 2006 13 (2006), <http://www.healthlawyers.org/Events/Programs/Materials/Documents/LTC09/barach.pdf>.

³⁹ U.S. DEP'T OF HOUSING & URBAN DEV., FED. HOUSING ADMIN., HEALTH CARE FACILITIES, ELA MARCH 2007 CONFERENCE, FINANCING AMERICA'S HOSPITALS TODAY 14 (2007), http://portal.hud.gov/portal/page/portal/FHA_Home/lenders/lenders_health_care_facilities/documents/ela.pdf.

As previously mentioned, FHA insured loans are loans made by private lenders but insured by the FHA.⁴⁰ The loans are non-recourse to the borrower.⁴¹ The mortgage insurance from the FHA enhances the credit of the borrower, which lowers the interest rate charged by the lender.⁴² Thus, the owner of a health care facility can lower its debt service cost and make more revenue available to serve its patients and enhance its operations. The FHA (acting through HUD) must approve any private lender that participates in the program.⁴³ HUD requires its participating lenders to perform the underwriting and loan administrative tasks needed to ensure that each FHA loan conforms to HUD's program requirements and the lenders go through specialized training in the procedures to be followed for these loans.⁴⁴

The FHA's mortgage insurance is a guaranty to the lender that, should the borrower fail to pay its loan obligations, HUD will assume the loan and bring it current.⁴⁵ Because the lender knows that it is taking much less risk when making the loan, the lender is willing to give the borrower much more favorable terms. So how favorable are the terms?

All FHA insured loans are fixed rate, fully amortizing loans,⁴⁶ with terms ranging from twenty-five to forty years.⁴⁷ Interest rates are typically quite low. As of August, 2009, rates were between 5.0 percent and 5.5 percent.⁴⁸ A fixed rate loan for

⁴⁰ *The FHA*, *supra* note 17.

⁴¹ *Id.*

⁴² See *id.*

⁴³ See generally U.S. DEP'T OF HOUSING & URBAN DEV., FED. HOUSING ADMIN., HOW TO BECOME AN FHA-APPROVED LENDER (2009), <http://www.hud.gov/offices/hsg/sfh/lender/20020902.pdf>.

⁴⁴ *The FHA*, *supra* note 17.

⁴⁵ The exact mechanics are beyond the scope of this article—this is a somewhat simplified discussion.

⁴⁶ U.S. DEP'T OF HOUSING & URBAN DEV., GUIDE TO MULTIFAMILY ACCELERATED PROCESSING (MAP), CH. 3: ELIGIBLE MULTIFAMILY MORTGAGE INSURANCE PROGRAMS §§ 2(D), (E) (2002), <http://www.hud.gov/offices/hsg/mfh/map/mapguide/chap03.pdf> [hereinafter MAP GUIDE].

⁴⁷ In determining this range, we took the shortest and longest terms of the various loans. The Section 242 Program has a twenty-five year term. See U.S. DEP'T OF HOUSING & URBAN DEV., MORTGAGE INSURANCE FOR HOSPITALS HANDBOOK 4615.1 1-5 (Jan. 30, 1973), <http://www.hud.gov/offices/adm/hudclips/handbooks/hsg/4615.1/46151trnHSGH.pdf>. The Section 232 Program has a term of up to forty years. See MAP GUIDE, *supra* note 46, ch. 3 § 4(D).

⁴⁸ Lenders used to set the rate at a multiple of the ten-year Treasuries, but in the

such a long term is truly “permanent financing” and is a huge contrast from the three to five year financing often offered elsewhere. Owners of health care facilities are experts in providing care, not in managing their financial risk and assessing the credit markets. If an owner can obtain fixed rate financing for thirty years, fixed debt service payments allow a provider to focus on what it does best—provide care to its patients—without fear of future interest rate adjustments or a future need to refinance at unknown rates and terms.

Most HUD lenders will require some lock-out period (a period after closing in which no prepayment is allowed) and thereafter will have a declining prepayment premium. Thus, for example, a loan may be closed to prepayment in the first ten years, and thereafter may be prepaid with a five percent premium in the eleventh year, a four percent premium in the twelfth year, etc., such that the loan may be prepaid at par (without any premium) starting in the sixteenth year after closing. Other lenders may require only a two or three year lockout period but with higher premiums. The prepayment lockout period is negotiable with the lender, although a borrower should realize that elimination of the lockout period will result in a higher interest rate, perhaps as much as one-half of one percent higher.

Another attractive feature of an FHA financed loan is its assignability.⁴⁹ Very few commercial loans are assignable, and thus, when an owner sells a facility, the buyer must obtain new financing and pay off the seller’s existing financing. On the other hand, FHA financing is assignable upon certain terms and with the consent of HUD. There is a process, known as Transfer of Physical Assets (TPA), which sets forth a detailed checklist of requirements for approval of a transfer.⁵⁰ While approval of a transfer is not guaranteed, HUD has a track record of granting TPA requests on a more or less routine basis. To an owner, this means that it may be able to sell its facility to a buyer (who can

current market the rates are set in different ways; yet, they continue to be very favorable.

⁴⁹ U.S. DEP’T OF HOUSING & URBAN DEV., TRANSFER OF PHYSICAL ASSETS (TPA) – CHANGE IN PROPERTY OWNERSHIP (2010), <http://www.hud.gov/local/shared/working/r10/mf/tpahome.cfm?state=wa>.

⁵⁰ *Id.* See also, U.S. DEP’T OF HOUSING & URBAN DEV., FULL REVIEW OF TRANSFER OF PHYSICAL ASSETS (TPA) (2010), <http://www.hud.gov/local/shared/working/r10/mf/tpafull.cfm?state=wa>.

qualify under the TPA process) even at a time and in a market in which obtaining new financing is very difficult.

The loans will be nonrecourse to the borrower, with the consent of the lender.⁵¹ In a nonrecourse loan, the only security is the project, without guaranties or sureties from the parent entities of the owner, or any other sort of credit enhancements. The maximum allowable loan amounts vary by the type of program but may be up to ninety percent of value.⁵² As those who have been working in the commercial lending community are aware, these terms are very favorable indeed. It is quite possible to refinance commercial financing and obtain substantial interest savings, and even higher debt service savings when the longer term of the mortgage is taken into account.

Practice Pointer: An owner should select its loan underwriter carefully. Most FHA financings involve multifamily housing, and as a result, many FHA underwriters have limited experience with health care facilities. An owner should seek an underwriter with a proven track record of Section 232 and/or 242 loans that have successfully closed and one who understands the nature of the health care industry and operational challenges facing owners of health care facilities.

IV. *Loan Programs, Eligibility and Requirements—Into the Nitty Gritty*

There are no secrets to success. It is the result of preparation, hard work, and learning from failure. – Colin Powell

A. *Eligible Project*

To qualify for one of the FHA financing programs, the project being financed must qualify as an eligible project⁵³ and have

⁵¹ MAP GUIDE, *supra* note 46, ch. 3 § 2(C).

⁵² *Id.* ch. 3 § 5(D).

⁵³ 24 C.F.R. § 242.1 (2009). Project is defined as

[T]he construction (which may include replacement of an existing hospital facility) or substantial rehabilitation of an eligible hospital, including equipment, which has been proposed for approval or has been approved by HUD under the provisions of this subpart, including the financing and refinancing, if any, plus all related activities involved in completing the improvements to the property. However, in particular closing documents, “project” may be used to mean the mortgagor entity, the operation of the mortgagor,

no prior liens attached to it.⁵⁴ For the purposes of this article, four entities are classified as health care facilities: hospitals, nursing homes, assisted living facilities, and senior independent housing. We will define these facilities as follows: (1) “hospital” is an acute care inpatient facility, which includes an emergency room;⁵⁵ (2) “nursing home” is a long term care facility that provides health care services to its patients in a licensed health care setting;⁵⁶ (3) “assisted living facility” is a long-term care facility that provides assistance with activities of daily living—such as bathing, dressing, eating, using the toilet, etc.—as well as assistance in medication management and, in certain facilities, limited health care services;⁵⁷ and (4) “senior independent housing project” is a multifamily rental apartment project, which is designed for the physical needs of elderly residences and in which residence is limited to elderly tenants.⁵⁸

Generally, any health care facility interested in FHA financing must determine if it meets the requirements for the particular loan program. Hospitals are financed under Section 242, if they meet the requirements for that program. Nursing homes and other long-term care projects are financed under Section 232. Certain types of independent living housing projects for the elderly are financed under Section 221.

the facility, or all of the mortgaged property, depending on the context in which it is used.

Id.

⁵⁴ Michael E. Mazer et al., *FHA 242 Hospital Mortgage Insurance: An Affordable Source of Construction Capital in a Turbulent Market*, 1(7) BLOOMBERG HEALTH L. REP. 1, 2 (2008), available at http://portal.hud.gov/portal/page/portal/FHA_Home/lenders/bloomberg_law_report_highlights_fha_hospital_program/fha%20242%20hospital%20mortgage%20insuran2.pdf [hereinafter Mazer].

⁵⁵ See 24 C.F.R. § 242.1 (2009); see also 12 U.S.C. § 1715z-7(b)(1) (2009) (defining the term “hospital”).

⁵⁶ 12 U.S.C. § 1715w(b)(1) (1998) (defining the term “nursing home”).

⁵⁷ Consumer Consortium on Assisted Living Frequently Asked Questions: What is Assisted Living?, http://www.ccal.org/consumers_care.htm#1 (last visited Jan. 12, 2010) [hereinafter CCAL FAQ]. ‘Assisted living’ is a state-determined designation and “[t]here are over 26 designations that states use to refer to what is commonly known as ‘assisted living.’” *Id.* While “there is no single uniform definition of assisted living,” the Consumer Consortium on Assisted Living (CCAL) “and a large number of national organizations support” the following definition: “Assisted living is a state regulated and monitored residential long term care option. Assisted living provides or coordinates oversight and services to meet the residents’ individualized scheduled needs, based on the residents’ assessment and service plans and their unscheduled needs as they arise.” *Id.*

⁵⁸ While there is no standard definition of a senior independent housing project, the community of practitioners generally accepts this as a working definition.

i. Hospitals

Loans under Section 242 provide funds for eligible hospitals.⁵⁹ Unless it is a “critical access facility,”⁶⁰ it must be an acute care hospital where the following services constitute no more than fifty percent of the total patient days:⁶¹ (i) chronic convalescent and rest; (ii) drug and alcohol treatment; (iii) treatment of epilepsy; (iv) mental health treatment; or (v) tuberculosis care.⁶² In other words, when the types of services being provided to each patient in each day of the inpatient admission are analyzed, the total of the five listed types of services comprise less than one-half of all inpatient admission days. In addition, the hospital must have a history, over the past three years, of a positive operating margin and debt service coverage ratios over 1.25.⁶³ Assuming the hospital qualifies, the Section 242 loan program permits a fixed interest loan on a non-recourse basis, for up to a twenty-five-year term.⁶⁴ The loan funds may be used to pay for

⁵⁹ 24 C.F.R. § 242.1 (2009). The code reads:

Hospital means a facility that has been proposed for approval or has been approved by HUD under the provisions of this subpart, and: (1) That provides community services for inpatient medical care of the sick or injured (including obstetrical care); (2) Where not more than 50 percent of the total patient days during any year are customarily assignable to the categories of chronic convalescent and rest, drug and alcoholic, epileptic, mentally deficient, mental, nervous and mental, and tuberculosis, except that the 50 percent patient day restriction does not apply to Critical Access Hospitals (hospitals designated as such under the Medicare Rural Hospital Flexibility Program) between January 28, 2008 and July 31, 2011; (3) That is a facility licensed or regulated by the state (or, if there is no such state law providing for such licensing or regulation by the state, by the municipality or other political subdivision in which the facility is located) and is: (i) A public facility owned by a state or unit of local government or by an instrumentality thereof, or owned by a public benefit corporation established by a state or unit of local government or by an instrumentality thereof; (ii) A proprietary facility; or (iii) A facility of a private nonprofit corporation or association.

Id. See also 12 U.S.C. § 1715z-7(b)(1) (2006).

⁶⁰ A critical access hospital is defined as a hospital “with 25 beds or less which has received designation by states and the Department of Health and Human Services.” U.S. DEP’T OF HOUSING & URBAN DEV., PROGRAMS OF HUD 69 (2006), <http://www.huduser.org/resources/hudprgs/ProgOfHUD06.pdf>; see also 42 U.S.C. § 1395i-4(e) (2008).

⁶¹ In the health care community the term “patient days” is used to refer to the total number of inpatients treated in the facility multiplied by the number of days each patient stayed—this is a common term in the industry.

⁶² 24 C.F.R. § 242.1 (2008); see also 12 U.S.C. § 1715z-7(b)(1) (2006).

⁶³ Mazer, *supra* note 54, at 2.

⁶⁴ *Id.* at 1.

acquisition, renovation or refinancing costs.⁶⁵ Under HUD guidelines, loan proceeds may also be used for construction and renovation.⁶⁶

In the past, the Section 242 program required all eligible hospitals to have a certificate of need (CON).⁶⁷ By the 1980s, many states had abolished CON programs; accordingly, Section 242 now permits loans in non-CON states, so long as the borrower furnishes a feasibility analysis to demonstrate the level of need in the relevant market.⁶⁸

Historically, the northeast region of the country was the center of Section 242 loans.⁶⁹ At one point eighty-nine percent of the portfolio was located in New York.⁷⁰ Today, the concentration of loans in the New York area has dropped, although the program still remains more common in that area of the country.⁷¹ In part, this may have been due to the prior requirement for CON, which eliminated markets such as California, Texas and Florida from the program.⁷² Now, given the ability to use a feasibility analysis if a CON is not available, borrowers in all regions may qualify for Section 242 loans.

While in the past Section 242 may have functioned as a “niche” lender to stand-alone northeastern hospitals with little exposure or familiarity elsewhere, HUD has expressed the strong desire to diversify the portfolio and make the program attractive to a wider population of hospitals. At the same time, the current economic climate is challenging hospital owners’ ability to receive the type of alternative financing they have historically favored. Thus, owners of hospitals should take a closer look at the Section 242 program to evaluate whether it can be a useful source of financing.

ii. Long-term Care Facilities

In order to qualify for a Section 232 loan, the facility to be financed must be a licensed facility regulated by a state, municipi-

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.* at 6.

⁶⁸ Mazer, *supra* note 54, at 6.

⁶⁹ *Id.* at 2.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.* at 6.

pality or other political subdivision and must have a license or certificate of compliance as one of the following: (i) Nursing Home;⁷³ (ii) Intermediate Care Facility;⁷⁴ (iii) Board and Care Home;⁷⁵ or (iv) Assisted Living Facility.⁷⁶ A long-term care facility will qualify under Section 232 if it accommodates “20 or more residents who require skilled nursing care and related medical services, or those who while not in need of nursing home care, are in need of minimum but continuous care provided by licensed or trained personnel.”⁷⁷ A facility may contain independent living units, but only if they do not exceed twenty-five percent of the total number of beds or units.⁷⁸

iii. Senior Living Facilities—Independent Living

A senior living facility is really an apartment property, which is suitable for, and marketed to, elderly tenants. Section 221(d)(4) provides financing for multifamily projects, in general, and in particular it includes elderly housing. Elderly housing is housing consisting of apartments specifically designed for the elderly (ages 62 and older) with units that include full kitchens. To qualify under Section 221(d)(4), the residents may not

⁷³ 24 C.F.R. § 232.505 (2009) (“for the purposes of this definition, the terms nursing home and intermediate care facility shall include those facilities designated as skilled nursing facilities or intermediate care facilities by the Department of Health and Human Services”).

⁷⁴ *Id.* Medicare does not reimburse Intermediate Care Facility, *ergo* such entities are generally state based designations. Definitions vary from state to state, but in our experience a common definition is: “An Intermediate Care Facility is a facility with at least twenty beds, licensed and regulated by a governmental entity, providing minimum but continuous care but not continuous medical or nursing services.”

⁷⁵ This also is a state based designation. A commonly used definition is: “A Board and Care Home is a residential facility with at least five living units that provides room, board and continuous protective oversight, must offer three meals per day, and no more than twenty-five percent of units be independent living units.”

⁷⁶ “Assisted Living” is a state based designation, and there are over twenty-six designations that states use to refer to what is commonly known as ‘assisted living.’ There is no single uniform definition of assisted living. The following is the definition that Consumer Consortium on Assisted Living and a large number of national organizations support: “Assisted living is a state regulated and monitored residential long term care option. Assisted living provides or coordinates oversight and services to meet the residents’ individualized scheduled needs, based on the residents’ assessment and service plans and their unscheduled needs as they arise.” CCAL FAQ, *supra* note 57.

⁷⁷ U.S. Dep’t of Housing & Urban Dev., *Mortgage Insurance for Nursing Homes, Intermediate Care, Board & Care and Assisted-living Facilities: Section 232 and Section 232/223(f)*, <http://www.hud.gov/offices/hsg/mfh/progdsc/nursingalc232.cfm> (last visited Jan. 12, 2009).

⁷⁸ MAP GUIDE, *supra* note 46, ch. 3 § 9(A)(3)(b)(1).

be required to purchase additional services other than the rental of the unit and the project is not allowed to have a central institutional kitchen or provide meal services. The idea is that a facility, which provides additional services or meals should be considered under the programs for assisted living or board and care facilities. If the owner is a nonprofit entity, then the applicable program is under Section 221(d)(3) and there are additional requirements that must be met.⁷⁹

The apartment project must incorporate at least five residential units and the property must have been completed or renovated for at least three years before the application.⁸⁰ Once qualified for the program, loans under these sections will be the lesser of (i) eighty-five percent of HUD appraisal or (ii) eighty-five percent acquisition cost for new acquisition or the greater of cost to refinance or eighty percent of HUD appraisal for refinancing transactions.⁸¹ The term of the loan will be the lesser of thirty-five years or seventy-five percent of the remaining useful life of the property.⁸²

B. Eligible Borrower

Assuming that the project qualifies for one of the FHA programs, owners should then review their current ownership structure carefully and identify any structural issues that may cause difficulties under the HUD guidelines. In the authors' experiences, much heartache can be avoided if the borrower and its counsel examine the ownership structure at a very early stage so that any issues that have potential to arise can be addressed at the outset.

In order to qualify for any of the programs discussed in this article, the borrower must be a single asset, single purpose entity.⁸³ This means that the entity that signs the mortgage must have been formed for the sole purpose of owning that facility

⁷⁹ Other multi-family projects also are eligible, but are outside the scope of these materials.

⁸⁰ MAP GUIDE, *supra* note 46, ch. 3 § 5.

⁸¹ *Id.*

⁸² There are other requirements and provisions applicable to senior housing that are outside the scope of this article.

⁸³ MAP GUIDE, *supra* note 46, ch. 3 § 2(B). Note that the mortgaged property must be the only asset of the mortgager but it must also be single purpose—the charter's organizational requirements limit the corporate purpose to the project at hand.

and must not have any assets other than the assets necessary to operate that facility. If an entity owns more than one facility, then before it can become an eligible borrower for FHA financing, it will need to transfer the remaining assets to an affiliate and amend its charter to prohibit ownership of any other non-facility related assets.

Both “for profit” and “nonprofit” borrowers are eligible to apply for FHA insured loans. Nonprofit borrowers will execute a HUD 3433 form, which establishes their eligibility as a nonprofit. In general, a nonprofit borrower should have already obtained its confirmation of tax exempt status under Section 501(c)(3)⁸⁴ or have a pending application of nonprofit status at the time it submits its HUD application. No borrower or other participant (e.g., operator, lessee, manager, etc.) may have been involved in a bankruptcy proceeding within the last five years.⁸⁵

Practice Pointer: Consider a nonprofit owner that has two facilities that are owned by a single Section 501(c)(3) corporation. As discussed in these materials, in order to refinance under Sections 232/223(f), each facility must be owned by a separate single purpose bankruptcy remote entity with a legal existence more than ten years beyond the term of the loan. The problem is that the owner has already obtained its licenses in the name of the corporation, and changing ownership will mean that the facilities must be relicensed. Depending on the state and the licensing climate, relicensing may be very unattractive. Also, the corporation has a valid Section 501(c)(3) exemption, and if new owners must be organized, they would need to obtain new tax exemptions, which could be time consuming. One solution is to transfer the real estate to two new entities and have each of the new entities lease its facility back to the original owner. In most cases, the license may remain in the name of the original owner. If the original owner is a nonprofit with a Section 501(c)(3) exemption, and the new ownership entities are single member limited liability companies with the original owner as sole member, then the new entities will be “disregarded entities” by the IRS and should be given the tax treatment of the sole member, which is a Section 501(c)(3) corporation. The two new entities

⁸⁴ *Id.* ch. 3 § 6(A).

⁸⁵ *Id.* ch. 3 § 9(F).

will be mortgagors under two separate Section 232 loans, and the original corporation will now be an operating lessee and will execute the lessee form of the Regulatory Agreement.

C. *Eligible Uses of Proceeds*

The sole purpose of FHA financing is to allow owners to refinance eligible debt at lower interest rates, reduce debt service requirements, and/or make needed repairs. The borrower may use the loan proceeds to acquire, improve, renovate or upgrade the eligible project, including refinancing prior eligible debt of the eligible project. As part of the application process, the lender will obtain a Property Condition and Needs Assessment (PCNA), which will be prepared by a third party consultant. The PCNA will evaluate the condition of the property and will allow HUD and the lender to establish any “critical” repairs that the borrower must remedy before closing and any “non-critical” repairs that the borrower will remedy within the first twelve months after closing, using loan proceeds.

Section 232 loan proceeds may also be used to finance new construction or substantial rehabilitation of qualifying facilities.⁸⁶ As a matter of nomenclature, Section 232 refers to a loan for acquisition, construction or substantial rehabilitation, while Section 232/223(f) refers to a Section 232 loan for the purpose of refinancing prior debt. There can be some rehabilitation and repair work included in a Section 232/223(f) project, as long as the work does not rise to the level of “Substantial Rehabilitation.” Substantial Rehabilitation means either (i) “the cost of repairs, replacements or improvements exceeds the greater of 15% of the estimated replacement cost” (after completion) or \$6,500 per unit, or (ii) “two or more major building components are being substantially replaced.”⁸⁷

This program distinction is important because a loan under Section 232 will have loan limits of up to ninety percent of appraised value (ninety-five percent for nonprofit borrowers)⁸⁸ and a term of forty years (or three-fourths of the remaining useful

⁸⁶ *Id.* ch. 3 § 10.

⁸⁷ *Id.* ch. 3 §§ 4(C)(1), (2).

⁸⁸ MAP GUIDE, *supra* note 46, ch. 3 § 10(C)(1).

life, whichever is less).⁸⁹ In contrast, a refinancing loan under Section 232/223(f) will have smaller loan limits of up to eighty-five percent of appraised value (ninety percent for nonprofit borrowers)⁹⁰ and a term of thirty-five years (or three-fourths of the remaining useful life, whichever is less).⁹¹ Another distinction relates to federal labor standards.

One common factor to all the programs is that equity take-out is prohibited. Thus, even if the project is worth significantly more than its current financing, the borrower is prohibited from closing a HUD loan in the maximum amount based on collateral value and taking home a check for the loan proceeds in excess of the payoff and closing costs.

“Eligible debt,” which may be refinanced with FHA financing, is secured or unsecured debt that is related to the project that was incurred for the purchase, construction, improvement or repair of the project, or for project operating deficits.⁹² It is important to note that debt to a party related to the mortgagor will not be deemed eligible for refinance, as that would violate the cash out prohibition.⁹³ An owner contemplating FHA financing should review its existing debt carefully with its underwriter, at an early stage of the process, to ensure that all the debt to be repaid will consist of eligible debt.⁹⁴ In certain circumstances, loans that were made within a particular period of time (two years) must be “seasoned” by the passage of time if such loans do not meet the definition of “eligible debt.”⁹⁵

Practice Pointer: When times are difficult, often an owner, particularly a nonprofit owner, will obtain short-term financial aid from an affiliate or a parent entity. This aid may take the form of a promissory note, as the parties will expect that when operations improve, the owner will repay the amount advanced back to its affiliate or parent. Beware of such an arrangement if

⁸⁹ *Id.* ch. 3 § 10(D).

⁹⁰ *Id.* ch. 3 § 11(G)(1)(a).

⁹¹ *Id.* ch. 3 § 11(G)(I).

⁹² U.S. Dep’t of Housing & Urban Dev., *HUD’s LEAN 232 Program Office of Insured Health Care Facilities (OIHCF): Update as of April 10th, 2009*, http://portal.hud.gov/portal/page/portal/HUD/federal_housing_administration/healthcare_facilities/section_232/lean_processing_page/underwriting_guidance_home_page/previous_e_newsletters/weekly_update_april_10_2009 (last visited Jan. 12, 2010).

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

FHA financing is on the horizon, as that sort of affiliate financing will not constitute “eligible debt” and may not be repaid with the proceeds of the FHA financing.⁹⁶ From the perspective of FHA financing, it would be far better to obtain the short-term assistance with a commercial loan from a local bank.

D. General Provisions Applicable to All Programs

There are some additional features of FHA financing that apply to all the loan programs—these are discussed in detail below.

i. Screening of Participants

All participants (i.e., borrowers, owners of borrowers, directors of borrowers, operators, managers, etc.) must be screened under the APPS program.⁹⁷ The APPS program is the online filing process that replaced the paper submission of 2530 forms for each participant.⁹⁸ Participants must furnish taxpayer ID numbers and disclose any other FHA insured financings in which they have participated in the past. HUD then runs an internal screening search to determine if that participant has been “flagged” for an event of default under such prior loans. For example, if a participant has been a participant in a loan project that failed its periodic physical inspection under REAC (discussed later in this article), then there will be a “flag,” which, if not resolved to the satisfaction of the HUD office processing the new loan, will bar that participant from the project.⁹⁹

ii. Prohibition on Bankruptcy

No borrower or other participant (operator, lessee, manager, etc.) may have been involved in a bankruptcy proceeding within the last five years.¹⁰⁰ While perhaps, in theory, this prohi-

⁹⁶ *Id.*

⁹⁷ MAP GUIDE, *supra* note 46, ch. 3 § 2(K).

⁹⁸ U.S. Dep’t of Housing & Urban Dev., Active Partners Performance System (APPS), <http://www.hud.gov/offices/hsg/mfh/apps/appsmfhm.cfm>. The HUD 2530 is a form executed by each “participant” (i.e., borrower, lessee, manager, and the officers of each entity, and principals owning ten percent or more of each entity). It requires disclosure of all other FHA insured debt for which each participant was a principal.

⁹⁹ See MAP GUIDE, *supra* note 46, ch. 10 §§ 4(A), (B).

¹⁰⁰ *Id.* ch. 3 § 9(F).

bition is capable of being waived by HUD, in practice, it is an absolute prohibition. If there has been a bankruptcy, the borrower must wait the full five-year period before seeking FHA financing.

iii. Regulatory Agreement

All borrowers must execute a Regulatory Agreement.¹⁰¹ The Regulatory Agreement is executed by the borrower and by HUD and is placed on record in the real estate recording office when the mortgage is recorded. There are specific forms of Regulatory Agreements for each program, and the specific requirements of the program will appear in each form. In general, the Regulatory Agreement will contain provisions such as the following: (i) requiring borrower to perform under the loan documents; (ii) requiring reserves for replacement; (iii) limiting the ability to transfer the project with HUD consent; (iv) limiting or prohibiting distributions to the owner of the borrower for certain programs; (v) prohibiting security deposits in excess of one month; (vi) prohibiting change of use of the facility; (vii) requiring maintenance of the project in good repair; (viii) not discriminating in the services offered at the project; (ix) providing for satisfactory management of the project; and (x) requiring record keeping and reports to HUD. The Regulatory Agreement provides that if the borrower violates the covenants therein, then HUD may, after notice and failure to cure, declare a default under the loan.

The Regulatory Agreement also will contain provisions that limit a borrower's ability to use operating profits for costs other than expenditures that preserve and improve the collateral. "Profit motivated" borrowers will execute HUD Form 92466, which allows surplus cash to be distributed to the owner once such surplus cash has been determined by a HUD compliant audit.¹⁰² "Nonprofit" borrowers will execute HUD Form 92466-E, which prohibits distribution of funds left after debt service and project costs, including repairs and improvements ("residual re-

¹⁰¹ *Id.* ch. 3 § 2(A).

¹⁰² U.S. DEP'T OF HOUSING & URBAN DEV., OFF. OF HOUSING, REGULATORY AGREEMENT MULTIFAMILY HOUSING PROJECTS 4 (2002), <http://www.hud.gov/offices/adm/hudclips/forms/files/92466.pdf> [hereinafter REGULATORY AGREEMENT].

ceipt”) without HUD approval.¹⁰³ Operating lessees will execute FHA Form 2466-nhl, which does not limit distributions, since the operating lessee is not a borrower and is not obligated on the loan.¹⁰⁴ The operating lessee signs the regulatory agreement in order to evidence its agreement to abide by the use restrictions that the owner has imposed in its regulatory agreement.¹⁰⁵

The reasons for restrictions on distribution are clear. Since these loans are nonrecourse loans to single asset borrowers, the project is the sole source of the funds that will repay the loan. If operating profits are used for anything other than the care and enhancement of the project and its operations, funds that might be potentially available to pay the debt service would be diverted from the project. Since underwriting under the nonprofit borrower guidelines allows a larger loan to value ratio, the underlying risk of the credit is, accordingly, higher and the limitation on distribution is stricter. Under “profit-motivated” underwriting, the loan limits are lower; thus, distribution is permitted but only after the borrower can establish with its audited financials that the distribution is truly surplus cash after payment of all debt service and operational costs. Some health care owners are entities that are part of a group of affiliates that operate a number of health care projects. Often, the group would like to use profits from one facility to cover losses from another facility in the group. For this reason, prospective borrowers and their counsel should carefully review the provisions of the Regulatory Agreement concerning distributions.

Practice Pointer: A nonprofit organization has a choice when it submits its application.¹⁰⁶ It can choose whether to seek the higher loan amounts allowable under nonprofit processing or elect to be processed under the “profit-motivated” processing and consequently accept a lower maximum loan amount. In general, a nonprofit will want to use the nonprofit processing. However, under nonprofit underwriting, there are stringent re-

¹⁰³ In return for the more restrictive distribution provision, the nonprofit borrower will have a larger maximum loan size. A nonprofit borrower may elect to be underwritten as a profit motivated entity, in which event it will have a lower maximum loan size but will use the more permissive form of regulatory agreement.

¹⁰⁴ REGULATORY AGREEMENT, *supra* note 102, at 1.

¹⁰⁵ *Id.* at 3-6.

¹⁰⁶ See MAP GUIDE, *supra* note 46, ch. 3 § 8.

strictions on the use of revenues generated from the project after payment of debt service and operating costs.¹⁰⁷ In particular, for a borrower that is part of a family of affiliated facilities, nonprofit processing will mean that it will not be able to use revenues from one facility (“residual receipts” in HUD terminology) for expenses not related to the operation and maintenance of that particular facility.¹⁰⁸ If the owner has had a single financing vehicle in the past (such as bond financing) secured by its multiple facilities, it has become accustomed to pooling the revenues and having the facilities support each other. Under nonprofit processing, that is generally not possible. Because of these restrictions, the authors have sometimes suggested that borrowers consider requesting that their loans be underwritten under the “profit-motivated” processing, particularly if the appraisal is expected to disclose value well in excess of the loan amount.

iv. Lease Structure

Leases are permitted so long as the lease complies with HUD regulations and lessee and lessor execute a Regulatory Agreement.¹⁰⁹ In general, leases must include provisions that (i) restrict assignment without HUD approval; (ii) provide for a rental amount that is large enough to pay the debt service and maintain the facility; (iii) require HUD approval for reduction of bed capacity; (iv) require submission of annual financial statements to HUD; and (v) require execution of and compliance with the regulatory agreement.¹¹⁰ Nonprofit mortgagors may lease only to another nonprofit entity.¹¹¹

Practice Pointer: Borrowers, particularly nonprofit borrowers, often use a “lessor-lessee” structure for nursing homes to be

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ See generally REGULATORY AGREEMENT, *supra* note 102. In fact, leases are very common in Section 232 financings. An operating lease to an affiliated operating lessee allows lessee profits to be distributed in circumstances that would limit the ability of the borrower to make distributions. While leases are permitted and quite common, for Section 232 loans, under the Section 242 program for hospitals, leases are prohibited (although there may be some ability to have the prohibition waived in certain circumstances).

¹¹⁰ U.S. DEP'T OF HOUSING & URBAN DEV., GUIDE TO MULTIFAMILY ACCELERATED PROCESSING (MAP), CH. 12: INSURANCE CLOSINGS §§ 1.2 (A) (7), 1.4 (2002), <http://www.hud.gov/offices/hsg/mfh/map/mapguide/chap12.pdf>.

¹¹¹ MAP GUIDE, *supra* note 46, ch. 3 § 9(G)(4).

financed under Section 232. Under the forms used for non-profit borrowers, residual receipts remaining after payment of the debt service and operating costs may not be used for purposes outside the operation of the facility, not even to support sister facilities that are operated under the same nonprofit parent organization.¹¹² Many nonprofit organizations rely on their ability to allow the facilities having good years to support sister facilities having poor years and, in that manner, ensure ongoing financial and operational viability. In order to preserve the ability to support sister facilities, a nonprofit could create a new nonprofit affiliate and have the project owner lease the land and building to the newly affiliated operating lessee. Under the form of regulatory agreement that the operating lessee would execute, the net operating cash remaining after payment of rent and operating costs is not restricted by HUD; therefore, the remaining net operating cash may be used for any purposes permitted under the lessee's nonprofit organizational documents, which may include financial support to a sister facility within the nonprofit organization.¹¹³

v. Insurance

All health care borrowers are required to maintain professional liability insurance.¹¹⁴ The basic coverage should be \$1,000,000 (single occurrence) and \$3,000,000 (aggregate) with a deductible of \$100,000 or less.¹¹⁵ There are special rules for certain state insurance providers and special rules for operators with more than fifty facilities. Insurance must be issued by an underwriter with a rating of "B++" or better from A.M. Best Company.¹¹⁶ Rating captives and risk retention groups will not be accepted without a rating. Self-insurance is accepted as long as it has a rated front. The facility must submit evidence of insurance for a time "period equal to the State's statute of limitations for

¹¹² REGULATORY AGREEMENT, *supra* note 102, at 4-5.

¹¹³ *Id.*

¹¹⁴ MAP GUIDE, *supra* note 46, ch. 3 § 9(D).

¹¹⁵ *Id.*

¹¹⁶ U.S. Dep't of Housing & Urban Dev., Professional Liability Insurance Notice H 04-15 (Aug. 3, 2004) at 2, available at <http://www.hud.gov/offices/adm/hudclips/notices/hsg/04hsgnotices.cfm> (click on the "Professional Liability Insurance for Section 232 Programs" hyperlink) (last visited Jan. 12, 2010) [hereinafter Professional Liability Insurance Notice].

filing claims of negligence, injuries, wrongful death and/or improper care.”¹¹⁷ If insurance was not in place for that period, there are provisions that allow a facility to establish “an estimate of the extent of unfunded insurance liability by occurrence.”¹¹⁸ HUD also requires a six-year loss history to be submitted with the application.¹¹⁹ In general, the loss history must disclose potential claims in excess of \$10,000.¹²⁰ In addition to the loss history, state licensing surveys must be provided for all unresolved deficiencies cited “G” or higher.¹²¹

Owners have expressed concerns about the requirement for insurance. Some owners may operate in states that have experienced very active tort litigation and, as a result, may be unable to obtain coverage at favorable rates, or they may believe that carrying such a large policy will invite lawsuits. HUD has a procedure by which a borrower may request a waiver of required liability insurance, under certain circumstances, if the owner can establish that liability insurance is not available at commercially available rates.¹²²

vi. Financial Statements

In general, the borrower and the operator, as well as any parent entity, will be required to submit audited financial statements for the past three years. Under certain circumstances, if audited statements are not available, operator certified financial statements may be submitted instead.¹²³

vii. Fees

All borrowers must pay certain HUD application and inspection fees, as well as HUD mortgage insurance premiums (MIP).¹²⁴ The amounts of MIP vary but the initial premium must be paid at closing.¹²⁵

¹¹⁷ *Id.* at 8.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 6.

¹²⁰ LEAN 232/223f Refresher Handout, 5th Annual Western HUD Lender’s Conference (December 2008) (on file with author).

¹²¹ Professional Liability Insurance Notice, *supra* note 116, at 10.

¹²² *Id.* at 11.

¹²³ REGULATORY AGREEMENT, *supra* note 102, at 5.

¹²⁴ MAP GUIDE, *supra* note 46, ch. 3 §§ 2(F)-(H).

¹²⁵ *Id.* ch. 3 § 2(H).

V. *Application Process—Love the Product, Hate the Process*

There seems to be some perverse human characteristic that likes to make easy things difficult. – Warren Buffett

A. *MAP Processing Versus Lean Processing*

HUD has been criticized, with some justice, for its slow and cumbersome processing. Many borrowers have been reluctant to use HUD financing due to the long timeframes and tiresome bureaucratic requirements. In an effort to become competitive with the time and scope of conventional financing, HUD revised the processing of Section 232 loans and promulgated the “*Lean*” Processing Program in 2008, with the roll-out in the first part of 2009. The announcement was made with great fanfare, and promised to reduce processing time by centralizing the process in an office that has been staffed by individuals with health care experience. William Lammers, HUD’s Health Systems Advisor, indicated that under *Lean* it will be possible to close a Section 232 loan within thirty days of the date the application is submitted to HUD.¹²⁶

Before the *Lean* program, all applications under Section 232 (and other multifamily programs) were processed under MAP Processing Guidelines, under the supervision of HUD’s Office of Multifamily Housing. Under the MAP system, Section 232 loans were processed by each separate HUD regional office (Hub Office), which sometimes led to inconsistent processing between offices. Each region in the country has its own HUD Hub Office—there are a total of eighteen Hubs nationwide.¹²⁷ The MAP system of processing in Hub offices is run by personnel who know and care about their local region. However, Section 232 health care projects are only one among many multifamily apartment projects; thus, personnel in any particular Hub may

¹²⁶ WILLIAM LAMMERS, HEALTH SYS. ADVISOR, OFF. OF INSURED HEALTH CARE FACILITIES, ELA MARCH 2007 CONFERENCE ON FINANCING AMERICAN HOSPITALS TODAY, SECTION 242: MORTGAGE INSURANCE FOR HOSPITALS OVERVIEW (2007), <http://portal.hud.gov/fha/healthcare/materials/ela.pdf> [hereinafter LAMMERS’ PRESENTATION].

¹²⁷ U.S. Dep’t of Housing & Urban Dev., *Multifamily Hubs and Program Centers*, http://www.hud.gov/offices/hsg/mfh/mfbroch/hubs_pcs.cfm (last visited Jan. 12, 2010).

not have extensive knowledge and experience about the nursing home or assisted living business.

Section 242 loans for hospitals have always been processed by a single office, the Office of Insured Health Care Facilities (OIHCF).¹²⁸ One of the strengths of the Section 242 program is that it is administered by an office that has extensive health care experience and knowledge. As HUD was considering improvements to Section 232, it heard from borrowers and brokers that one consistent frustration was dealing with HUD personnel who, while very experienced with apartment projects, simply did not understand the health care industry. Therefore, HUD decided to leverage its expertise in the OIHCF and allow that office to handle Section 232 loan processing, as well as the hospital programs under Section 242.

Under *Lean*, all health care loans are processed by designated HUD personnel in the HUD Seattle Multifamily Hub, under the jurisdiction of OIHCF.¹²⁹ OIHCF has, in the past, administered hospital lending programs, and one of the major advantages of the *Lean* program, cited by HUD, is the ability to leverage its hospital loan experience into the senior health care market. In fact, the OIHCF has used *Lean* for several years in the Section 242 program for hospital loans and has reduced the median processing time for those loans from 224 days to fifty-one days.¹³⁰

There is plenty of room for improvement in the Section 232 loan world. Before *Lean*, the average processing time for Section 232 refinancings¹³¹ was 211 days—this was just over seven months and significantly longer than conventional lenders.¹³² For new construction financed by Section 232 over the same period, the average processing time was 442 days—almost fifteen

¹²⁸ OFF. OF INSURED HEALTH CARE FACILITIES, 30-DAY PLANNING DOCUMENT 1 (2005), <http://afgocouncil222.tripod.com/B/5/stratwfkceplan04to08oihcf.pdf>.

¹²⁹ U.S. Dep't of Housing & Urban Dev., Off. of Housing, *232/223(f) LEAN Processing Training- for Lenders* (2008).

¹³⁰ U.S. Dep't of Housing & Urban Dev., Off. of Housing, *LEAN Training Program Materials* (2008) (on file with author) [hereinafter *LEAN*].

¹³¹ 24 C.F.R. pt. 200 (2009).

¹³² *LEAN*, *supra* note 130, at 26; U.S. Dep't of Housing & Urban Dev., General Overview of FHA Insurance and LEAN Section 232, http://portal.hud.gov/portal/page/portal/HUD/federal_housing_administration/healthcare_facilities/section_232/lean_processing_page/general_overview_of_fha_insurance (last visited Feb. 10, 2010).

months.¹³³ It is no wonder there has been a high level of frustration among everyone in the industry. If, in fact, the processing time for Section 232 loans were to reach the thirty days suggested by Mr. Lammers, it would be a significant positive change. However, there is some skepticism in the community of HUD borrowers, as the program is still in its nascent stages. Indeed, the MAP program was rolled out in 2000 to similar fanfare, with the goal of simplifying the process of obtaining FHA insured multifamily financing.

The transition from traditional processing to *Lean* varies from program to program, and the schedule for deployment has been extended several times; however, since July 1, 2008, all new Section 232 applications are required to use *Lean* processing.

B. Underwriting of Section 232 Loans under *Lean*

A lender approved by HUD must underwrite the loan application. The underwriting process includes evaluation of the financial strength of the borrower and the project operations, as well as an analysis of the value of the project. The lender will assemble the application for HUD insurance of the mortgage loan and will prepare a detailed narrative explaining the project and its financial characteristics. The *Lean* program continues this responsibility; in fact, *Lean* requires even more detailed information in the lender's narrative. Under *Lean*, HUD has indicated that there will be more emphasis on the operator's strength as opposed to the strength of the project alone.¹³⁴ This may include heightened review of any parent entity. To some extent, this change of focus reflects the reality that a health care facility is a residential facility, but is also a service provider. The value and credit of a residential facility such as an apartment project depends, primarily, upon its location and physical attributes. The value and credit of a service provider, by contrast, depends primarily on the quality of the services that are provided by its operator.

¹³³ *LEAN*, *supra* note 130, at 26.

¹³⁴ *See generally id.* at 25, 45-46.

i. Third Party Reports

Third party reports have always been required as part of the underwriting for FHA financing. These reports are ordered by the lender, typically with funds provided by the borrower when the lender is engaged, and will consist of an appraisal, an environmental report, and a PCNA.

The primary changes under the *Lean* program involve the appraisal. As discussed earlier, the appraisal is used to size the loan and uses the traditional cost, income and comparable sales approaches. The maximum loan amount will be the lesser of (i) ninety percent (for a nonprofit) or eighty-five percent (for profit) of the appraised value and (ii) the total required to repay eligible debt, construct HUD-approved improvements and pay approved closing costs.¹³⁵ Borrowers are not permitted to receive a return of equity in a HUD insured financing.¹³⁶ Thus, even if the valuation is well in excess of the current financing, the maximum loan amount will be limited to the funds needed to satisfy the current financing, pay for approved facility improvements, and pay approved costs of closing.

In the past, HUD required a particular form and appraisal methodology.¹³⁷ Rather than the arcane HUD form of appraisal, *Lean* purports to use standard “market” appraisal.¹³⁸ For example, there was a deduction of “proprietary earnings” under the prior HUD methodology— this will not be required under *Lean*.¹³⁹ Instead there will be an allowance for a management fee, which is a more typical treatment in market appraisals.¹⁴⁰ Many appraisers believe the changes are beneficial because they remove some of the unique and problematic HUD issues, such as proprietary earnings, and allow the appraisal to be based upon more realistic market assumptions. Under prior rules, there were limits set on the percentage of Medicare census that could be used in the revenue calculation—the new rules are expected to relax some of those limits. However, the early experi-

¹³⁵ *Id.*

¹³⁶ MAP GUIDE, *supra* note 46, ch. 3 § 11(J).

¹³⁷ *Id.*

¹³⁸ U.S. Dep’t of Housing & Urban Dev., *Applicant Requirement Checklist* (2003) [hereinafter *Applicant Requirement Checklist*].

¹³⁹ See generally MAP GUIDE, *supra* note 46.

¹⁴⁰ *Applicant Requirement Checklist*, *supra* note 138.

ence has been that the appraisals are resulting in lower values for *Lean* loans. This may be due to appraisers with typical multi-family experience appraising health care facilities without a deeper understanding of health care projects. Standard advice is to select an appraiser who has extensive experience appraising HUD insured health care projects.

The loan size depends on the valuation of the project based upon the appraisal. In general, the appraisal is very dependent upon the income approach, which values a facility by applying a cap rate to its income. Based on materials presented in HUD's recent training materials, HUD is unlikely to approve cap rates that vary significantly from the national insurance contributions (NIC) cap rates and will not permit using net operating income (NOI) or profitability adjustments to increase the value upward.¹⁴¹ In particular, older facilities or facilities with three-bed wards will be expected to use higher cap rates.¹⁴²

In addition to the appraisal, there is a Phase I Environmental Report, which is a traditional environmental audit.¹⁴³ If matters of concern are noted, health facility owners will then need a Phase II report.¹⁴⁴ If the report discloses the presence of asbestos containing materials, an owner will be required to adopt an Operations & Maintenance Plan (O&M Plan).¹⁴⁵ The facility's environmental engineer can assist in preparing the O&M Plan.¹⁴⁶

Finally, there will be a PCNA, which is a report from a third party assessor that determines the immediate and long-term capital needs. The assessor will physically inspect the property and identify immediate critical and non-critical repair needs, as well as project future replacement and major maintenance needs. The PCNA will also be used to establish the replacement reserve account.

¹⁴¹ *LEAN*, *supra* note 130, at 13-15, 80-81.

¹⁴² *Id.*

¹⁴³ *Id.* at 32.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *LEAN*, *supra* note 130, at 32-33.

ii. *Organization of Borrower*

The organizational documents—consisting of articles of incorporation and bylaws (for a corporation), or the articles of organization and operating agreement (for a limited liability company), or the certificate of partnership and partnership agreement (for a partnership)—must be submitted to HUD.¹⁴⁷ HUD has strict requirements pertaining to what must be included in these documents. In general, HUD requires: (i) the organizational documents must expressly indicate that the duration of the ownership entity is at least ten years longer than the term of the FHA-insured mortgage; (ii) the terms of the Regulatory Agreement take precedence in the event of any conflict with the terms of the organizational documents; (iii) the ownership entity has authority to enter into the transaction and to comply with the requirements of the insurance program; and (iv) unless approved otherwise by HUD, the mortgagor is a single asset entity.¹⁴⁸ The requirements are very specific, and experience suggests that a borrower is well-advised to insert a word-for-word recitation of the requirements as a separate section in each organizational document, so that the HUD reviewer can determine compliance with ease.

Under prior MAP processing, organizational documents were submitted to the HUD legal counsel during the preparation for closing. This had an unfortunate result—borrowers were hit with a requirement to amend organizational documents quickly, as a condition to the closing. Depending on the borrower's situation—that is, its number of shareholders or members, etc.—this requirement could create consternation and delay. Now, under *Lean*, the organizational documents are to be submitted with the application.¹⁴⁹ A borrower may move forward and amend its organizational documents to add in the required HUD provisions prior to the application, or it may

¹⁴⁷ U.S. Dep't of Housing & Urban Dev., 232/223f *Legal Punch-List Draft Schedule 11* (2008); see also U.S. Dep't of Housing & Urban Dev., *Accounts Receivable Financing Punch-List Draft* (Jan. 2, 2009), http://portal.hud.gov/portal/page/portal/FHA_Home/lenders/232_lean_processing_page/underwriting_guidance_home_page/accounts_receivable_financing_documents/accounts_receivable_hud_legal_counsel_tools/Accounts%20Receivable%20Punch%20List%205Jan2009.doc (last visited Jan. 10, 2010).

¹⁴⁸ *Id.*

¹⁴⁹ *Applicant Requirement Checklist*, *supra* note 138.

choose to obtain board and member/shareholder approval to the changes but not actually file the amendment until the loan commitment is issued.

iii. Other Real Estate and Facility Information

Survey and title (title report and proforma policy) must be complete with the *Lean* application.¹⁵⁰ In the past, a borrower could submit its application with copies of the prior title and survey and wait to incur update costs¹⁵¹ until it had received the loan commitment. In general, the survey may be dated no earlier than 120 days prior to the closing.¹⁵² Now, unless the *Lean* program is really successful in its speed, the borrower will need to have a new survey and title prepared for the application and then expect to pay for an update prior to the closing.

If there is going to be an operating lease, it must be submitted with the application.¹⁵³ Also, the application will need to include organizational documents and other information about the operating lessee.

Under *Lean*, the borrower must submit evidence of zoning compliance and compliance with building codes with the application, not at closing.¹⁵⁴ This means that borrowers and their counsel will need to order zoning letters early in the process. In particular, if the rehabilitation work that borrower plans to do with the proceeds of the loan will require any sort of permit or zoning variance, the borrower needs to move forward with the permit or variance so that it will be in hand for the application. The expectation is that the *Lean* processing is so speedy that the closing will happen quickly and any time limits on the permit or variance would not expire before the closing. However, current experience shows that the process, while faster than before, may still require substantial time. If a permit or a variance is granted upon condition that the work be completed within a particular time frame, the borrower should be prepared to request an extension if the application and commitment process drags out.

¹⁵⁰ *Id.*

¹⁵¹ Update costs can be considerable for a survey.

¹⁵² U.S. DEP'T OF HOUSING & URBAN DEV., 232/223(F) LEGAL PUNCH-LIST 4 (2009).

¹⁵³ *Applicant Requirement Checklist*, *supra* note 138.

¹⁵⁴ *LEAN*, *supra* note 130, at 32-36, 56-57.

iv. Accounts Receivable Financing

The largest source of payments received by nursing homes are governmental payments from Medicare and Medicaid programs.¹⁵⁵ A survey conducted shows that Medicare and Medicaid accounted for sixty-two percent of long-term care financing.¹⁵⁶ Due to complications of the enrollment and certification process, it may be months before a nursing home begins to receive reimbursement from Medicare and/or Medicaid—payment times can vary. Meanwhile, operations continue, employees must be paid, and the residents fed. Given this unpleasant reality, many if not most skilled nursing facilities require some sort of working capital. Commonly, an owner obtains a line of credit from a commercial lender and secures the line of credit with a first priority lien on the facility's accounts receivable (AR). Current lending practice is to lockbox the receivables. In other words, the payors are instructed to send payments to an account owned by the borrower but with contractual provisions that allow the line of credit lender to sweep the contents of such account daily into a second account controlled by the lender, from which the lender then repays the current line of credit borrowings and remits the remaining funds to the owner.

It has been cumbersome to obtain HUD consent to AR financings in the past, in part because loans were processed by Hub offices that were unfamiliar with the health care industry and thus, unfamiliar with the structures used for line of credit or AR financing. Multifamily apartment owners, in general, do not need working capital financing because almost all of their tenants pay rent in advance, while health care facilities typically bill for their services only after the services have been rendered. One of the changes under *Lean* is a recognition that AR financing is a common financing method and, in general, should be permitted.¹⁵⁷ Thus, the program requires that documents must be included in the initial application.¹⁵⁸

¹⁵⁵ THE HENRY J. KAISER FAM. FOUND., KAISER COMM'N ON MEDICAID FACTS, MEDICAID AND LONG-TERM CARE SERVICES 1 (2006), <http://www.kff.org/medicaid/upload/Medicaid-and-Long-Term-Care-Services-PDF.pdf>.

¹⁵⁶ *Id.*

¹⁵⁷ See generally LAMMERS' PRESENTATION, *supra* note 126.

¹⁵⁸ *LEAN*, *supra* note 130, at 32-36, 56-57.

In the new HUD training materials for the *Lean* program, HUD clearly understands that many health care borrowers require AR financing in order to keep their doors open¹⁵⁹ and contain detailed information about AR financing. This seems to be a welcome change from the past, when an AR loan could present practical issues in closing a loan. One important point about AR loans: HUD permits cross collateralization of AR loans across multiple facilities *only* if all the facilities are financed under Section 232.¹⁶⁰

Practice Pointer: Because the Section 232 application will require many details about the AR financing, as a practical matter, it is difficult to obtain new AR financing concurrently with the Section 232 loan closing. Particularly in an acquisition, the AR lender will not be able to underwrite the accounts receivable from the project to be acquired without extensive due diligence. Such due diligence is not likely to be complete by the time the Section 232 application is filed. Thus, a purchaser may want to consider internal financing of working capital for the first few weeks after the acquisition and seek AR financing once the HUD loan has closed.

Some AR lenders are familiar with the HUD program and can assist the borrower through the process of obtaining the necessary HUD approval and intercreditor agreement. Clearly, selecting a lender that is familiar with HUD will aid in the expediency and efficiency of the process. For existing facilities, the authors suggest the owner obtain AR financing *before* submitting the application for HUD financing. This sequence ensures that the complete details of the AR financing can be provided to HUD in the application. It is important to note that the owner should always discuss the future HUD Section 232/223(f) refinancing with any potential AR lenders and seek an AR lender that has experience with HUD insured projects.

VI. *After the Closing—Life under FHA Financing*

There's no such thing as a free lunch. – Milton Friedman

¹⁵⁹ *Id.* at 71.

¹⁶⁰ *Id.*

Once the FHA financing has closed, there are a few points to remember. First, an owner must submit audited financial statements to HUD annually.¹⁶¹ The owner should identify an auditor who has experience providing the financial statements in the HUD approved format. In general, HUD expects the financial statements to be submitted electronically.

HUD will schedule physical property inspections, which will be performed by independent contractors under the REAC system.¹⁶² In the authors' experiences, the first such inspection occurs approximately one year after the closing. The score is assembled by the results of a standard set of property inspection criteria, which are weighted in accordance with HUD guidelines.¹⁶³ The inspector will visit the property with a laptop computer into which he or she will enter the inspection results as the property is being inspected—the computer will calculate the final score. The process is fairly mechanical and has little room for subjective judgments by the inspector.¹⁶⁴

The final score consists of a number (between 1 and 100) and a letter (a, b, or c)¹⁶⁵—the letter “a” indicates no health and safety deficiencies (other than smoke detectors); the letter “b” indicates one or more non-life-threatening health and safety de-

¹⁶¹ REGULATORY AGREEMENT, *supra* note 102, at 5. More specifically, Within sixty (60) days following the end of each fiscal year the Secretary shall be furnished with a complete annual financial report based upon an examination of the books and records of mortgagor prepared in accordance with the requirements of the Secretary, prepared and certified to by an officer or responsible Owner. . . . If the mortgage is insured under Section 232 . . . [t]he Owners shall execute a Security Agreement and Financing Statement . . . upon all items of equipment. . . which are not incorporated as security for the insured mortgage. The Security Agreement and Financing Statement shall constitute a first lien upon such equipment and shall run in favor of the mortgagee as additional security for the insured mortgage.

Id.

¹⁶² 24 C.F.R. pts. 5, 200 (2009). The regulations require annual inspection unless the program regulations governing the housing provides otherwise or HUD has provided otherwise by notice. See 24 CFR § 5.705 (2009).

¹⁶³ U.S. Dep't of Housing & Urban Dev., Real Estate Assessment Ctr., *Physical Inspection Summary Report (Ver 2.3)*, http://www.hud.gov/offices/reac/products/pass/pass_isrpt.cfm (last visited Jan. 13, 2010) [hereinafter *Physical Inspection Summary Report*]. The score is “calculated by subtracting the sum of deductions for H&S deficiencies from the sum of the individual ‘area points.’” *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*; see also Public Housing Assessment System Physical Condition Scoring Process, 65 Fed. Reg. 39,988, 39,988-89 (Dep't of Housing & Urban Dev. Jun. 28, 2000) (notice), available at http://www.hud.gov/offices/reac/products/phas/PDFs/pass_scoring62800.pdf.

iciencies, but no exigent/fire health and safety deficiencies; and the letter “c” indicates that there were one or more exigent/fire safety deficiencies.¹⁶⁶ Exigent/fire safety deficiencies require immediate remediation.¹⁶⁷ Numeric scores of sixty or above are considered passing.¹⁶⁸ Scores below sixty are considered failing scores and the owner must remedy the deficiencies and the property must be re-inspected or else the owner will be referred to the Departmental Enforcement Center¹⁶⁹ and may risk an enforcement action under the Regulatory Agreement and Mortgage.¹⁷⁰ The score will receive an asterisk if there are deficiencies in connection with smoke detectors.¹⁷¹ The numeric score will indicate the frequency of future inspections.¹⁷² Scores between sixty and seventy will be re-inspected annually.¹⁷³ Scores between seventy and eighty will be re-inspected every two years, and scores above eighty will be re-inspected every three years.¹⁷⁴ For example, a score of 92b* means that the facility passed with flying colors and will not be re-inspected for three more years.¹⁷⁵ However, while the number of its deficiencies was low, the deficiencies included at least one health and safety deficiency (that was non life-threatening, based on the “b” letter) and at least one smoke detector deficiency.

Practice Pointer: Do not assume that a facility will pass its REAC inspection just because it has passed all its state health department inspections with flying colors! The inspection pro-

¹⁶⁶ *Physical Inspection Summary Report*, *supra* note 163.

¹⁶⁷ See 24 C.F.R. pts. 5, 200 (2009). In our experience, immediate attention translates to three business days.

¹⁶⁸ Memorandum from the U.S. Dep’t of Housing & Urban Dev. to all Owners, Agents and Contract Administrators, Performance Based Contract Administrators, Rural Housing Service 1 (Jan. 16, 2003) [hereinafter Memo to all Owners].

¹⁶⁹ *Id.* at 1.

¹⁷⁰ *Id.* at 3.

¹⁷¹ *Physical Inspection Summary Report*, *supra* note 163.

¹⁷² See generally Memo to all Owners, *supra* note 168.

¹⁷³ See generally 24 C.F.R. pt. 902 (2009) and U.S. DEP’T OF HOUSING & URBAN DEV., OVERVIEW OF PHAS AND NASS, PHAS MADE SIMPLE IN 0 TO 2.6 SECONDS, 7-8 (2005), http://www.hud.gov/offices/reac/products/PDFs/PHAS_NASS.pdf; see also E-mail from Leslie King, Junior Underwriter, Greystone Financial Group (Oct. 12, 2009, 1:19 CST) (on file with author) (notice regarding December 2009 updates to HUD’s LEAN 232 Program).

¹⁷⁴ *Public Housing Evaluation and Oversight: Changes to the Public Housing Assessment System (PHAS) and Determining and Remedying Substantial Default*, 73 Fed. Reg. 49,544, 49,556 (Dep’t of Housing & Urban Dev. Aug. 21, 2008) (proposed rule), available at <http://www.hud.gov/offices/reac/products/phas/phasprule.pdf>.

¹⁷⁵ *Id.*

protocols are quite different. The REAC protocols focus on physical conditions alone.¹⁷⁶ In certain instances, the requirements (for openable windows that could be an alternative fire escape, for example) are inconsistent with nursing home operations (requirements to prevent elopement of memory-impaired residents). Thus, an owner should review the results of the REAC inspection right away and pursue its right to appeal and/or schedule re-inspection as soon as possible if the score is low.

VII. *Heard from the Hill—Health Care Reform*

Salus populi suprema est lex. The welfare of the people is the ultimate law. – Cicero

President Obama has made health care reform one of his top priorities and, as a result, he initiated the sweeping health care reform debate currently taking place in America. Congressional Committees were tasked with producing Health Care Reform bills, three in the House and two in the Senate.¹⁷⁷ To date the House of Representatives and the Senate have passed bills—H.R. 3972, the Affordable Health Care for America Act and H.R. 3590, the Patient Protection and Affordable Care Act, respectively.¹⁷⁸ However, on January 19, 2010, Republican Scott Brown won a special election in Massachusetts for the late Ted Kennedy's senate seat, thus reducing the Democrats' numbers from sixty to fifty-nine, one seat short of being able to overcome a filibuster.¹⁷⁹ At this time, it is unclear how this shift will affect

¹⁷⁶ U.S. Dep't of Housing & Urban Dev., Real Estate Assessment Ctr., *About REAC*, <http://www.hud.gov/offices/reac/aboutreac.cfm> (last visited Feb. 10, 2010).

¹⁷⁷ See generally THE HENRY J. KAISER FAM. FOUND., SIDE-BY-SIDE COMPARISON OF MAJOR HEALTH CARE REFORM PROPOSALS 1 (2010), http://www.kff.org/healthreform/upload/housesenatebill_final.pdf [hereinafter REFORM PROPOSALS]. The five Congressional Committees are (1) Energy and Commerce (H); (2) Ways and Means (H); (3) Education and Labor (H); (4) Finance (S); and (5) Health, Education, Labor & Pensions (S).

¹⁷⁸ See Cynthia Conner, *Keeping Up with Healthcare Reform Legislation; Member Forum: Top Ten Issues for Health Lawyers in 2010*, 14(2) AHLA CONNECTIONS 1, 24 (2010), available at http://www.healthlawyers.org/News/Connections/CurrentIssue/Documents/2010%20Member%20Forum/MbrForum_mar2010.pdf [hereinafter *Keeping up with Healthcare Reform*]; see also American Health Lawyers Ass'n, Long Term Care and the Law Conference, *National Healthcare Reform: Implications for Long Term Care* (Feb. 2010) (discussing the current health care reforms).

¹⁷⁹ *Keeping up with Healthcare Reform*, supra note 178, at 24.

the current health care reform.¹⁸⁰ This could pose a significant impediment to the Democratic health care reform efforts if the Republicans remain united.

The overarching goal of health care reform is to expand access to affordable health insurance to all American citizens.¹⁸¹ Many ideas on how to enact such reform have been introduced by various individuals and Congressional committees.¹⁸² Although any form of health care reform, when finally passed (if at all), will significantly impact all individuals and employers in America, especially those individuals or entities in the health care field, very little discussion has focused on HUD financing or possible effects on real property transactions or holdings. The effect on the real property financing and transactions may take months or even years to be realized.

VIII. *Views of the Future—The Road Ahead*

The only function of economic forecasting is to make astrology look respectable. — John Kenneth Galbraith

The new *Lean* program has been very popular so far and due to the large number of applications, HUD has instituted a queue for filed applications that await assignment to an underwriter at HUD. For the fiscal year 2009 and thereafter through December 10, 2009, there have been 271 applications for Section 232 financing received by HUD, and from those, 132 firm commitments have been issued and eighty-eight closings have occurred. As of December 10, 2009, there were sixty-five applications in the underwriting process and 135 applications in the queue awaiting assignment to an underwriter.¹⁸³ Of those, 109 commitments have been issued and seventy-six transactions have actually closed.¹⁸⁴ We can expect the number of applications

¹⁸⁰ *Id.*

¹⁸¹ Off. of Mgmt. and Budget, *President Obama's Fiscal 2010 Budget: Transforming and Modernizing America's Health Care System*, http://www.whitehouse.gov/omb/fy2010_key_healthcare/ (last visited Feb. 10, 2010).

¹⁸² See generally REFORM PROPOSALS, *supra* note 177.

¹⁸³ Memorandum from Off. of Insured Health Care Facilities on Sept. Update (Dec. 18, 2009) (on file with author).

¹⁸⁴ Memorandum from Off. of Insured Health Care Facilities on Sept. Update (Sept. 18, 2009) (on file with author).

that ripen into actual closings to increase as borrowers and lenders become more familiar with the details of *Lean* processing.

So far, it is clear that the process revisions under *Lean* have shortened some of the long time periods. By requiring more information to be submitted at the application stage, rather than the closing stage, the *Lean* program has transferred some of the time-consuming tasks to the borrower at an earlier point in the process, thus reducing the time period between the commitment and closing. However, this means that the borrower must expend substantial time and money before the borrower has confidence that the loan commitment will, in fact, be issued. For example, under *Lean*, proof of zoning must be submitted with the application. Suppose that the loan will be used to rehabilitate and add to a therapy area on a nursing home, and as a result of the renovation, a few parking spaces will need to be eliminated. If a zoning variance is needed for the parking area reduction, the borrower will need to go through the time consuming local process of applying for the variance before it knows whether the loan commitment will eventually issue.

Also, as discussed in this article, there are time limitations on the age of various required third party submissions, such as property surveys, environmental reports, and the like. If processing takes more time than expected, the borrower will have to pay the consultants to update these reports.

Practice Pointer: Be sure to select surveyors, title companies, environmental engineers and appraisers who have extensive experience with HUD loan requirements. Let them know at the point of engagement that the transaction is FHA financed and that you expect there will be an update required prior to closing. Let the title agent know that it needs to provide a representative, in person, at the closing, who can sign the proforma and issue the policy “on the spot” once the documents have been filed. The closing will be much easier if the title agent understands its role ahead of time.

IX. Conclusion

*If you don't know where you are going, any road will get you there. –
Lewis Carroll*

Given current market realities, one can expect a steady increase in the numbers of health care facilities obtaining FHA financing. The terms are extremely attractive, and in many cases FHA financing will be the only viable option for many borrowers. As operating margins tighten for many health care providers, FHA financing offers a way for owners to control costs and maintain a predictable level of debt service. Thus, despite the somewhat frustrating process and Byzantine labyrinth of regulations, it behooves health care facility owners to consider FHA financing when seeking to finance or refinance their facilities.

HUD has rolled out its new *Lean* processing system, which should make financing under its programs more attractive by reducing processing time and the amount of bureaucratic red tape. The *Lean* program is so new that it is impossible to determine if it will fulfill its promises to create a more user-friendly, market-based approach to financing. Regardless, health care facilities present their own unique challenges when obtaining financing. The main points for owners to remember are (i) there are programs available to fulfill almost any individual and organizational health care initiatives and (ii) the success of acquiring funds depends on the selection of a lender with expertise in health care financing under HUD.