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# InfoSeries

## Financing Rural Facilities

For years, smaller healthcare organizations, particularly in rural areas, have struggled for access to the tax-exempt capital markets. The past few years have seen a marked improvement in such access, in part because of the “critical access” designation for rural hospitals, with its attendant improved reimbursement under the Medicare program and in part because of an increased willingness on the part of both the federal government and the private sector to extend or create financing programs for such organizations. The purpose of this article is to highlight these opportunities for smaller healthcare organizations.

### 242 Mortgage Insurance Programs

This program exists for both critical access and non-critical access hospitals. It was created as a successor to the Hill Burton program responsible for much of the hospital construction from post WWII into the early ‘70’s. FHA Section 242 mortgage insurance can be used for a variety of hospital purposes including construction, re-financings, acquisitions, equipment purchases, renovations and expansions.

The FHA mortgage insurance provides an automatic AA rating on any tax-exempt bonds issued for the project. The term of the bonds can be up to 25 years, depending on the lives of the assets financed, the bonds will bear interest at a fixed rate and a two year mortgage reserve fund is required to be funded monthly over a ten-year period. The maximum loan to cost ratio is 80-90% (and costs include both project costs and certain financing costs, including the cost of any feasibility study required

for the funding). The FHA in turn will insure 99% of the loan. The borrower under the program grants to the FHA-insured lender either a first mortgage on or its leasehold interest in the entire hospital. Finally, the federal Davis Bacon Act provisions apply to construction under this program, which does increase construction costs.

While the federal government is working to streamline the process, the chief complaint among users of the 242 program continues to be the length of time necessary to complete the financing and receive the mortgage insurance. This is somewhat critical these days given the escalating costs of concrete, steel and transportation. Further, while the interest rates on the loans are very attractive when compared to the options in the private sector, the costs are higher too.

### USDA Community Facilities Loan Program

The USDA also has a program of growing importance for the rural healthcare community: its Community Facilities Loan Program. Under this program, the USDA is able to either loan money directly or guarantee loans made by lenders such as banks, savings and loan associations, mortgage companies and Farm System Credit Banks. Such loans can be used to fulfill Community Reinvestment Act requirements as well.

The USDA makes loans to develop essential community facilities in rural areas of less than 20,000 people for such projects as hospitals, healthcare clinics, nursing homes and

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ambulatory care centers. Eligible borrowers include public bodies and nonprofit organizations which are unable to obtain commercial credit.

Loan funds may be used to construct, enlarge or improve community facilities and can include the costs of acquiring land, purchasing equipment and paying professional fees. The maximum term of the USDA loan is 40 years, and the interest rate is fixed (or possibly variable in the case of a guaranteed loan). The USDA can guarantee up to 90% of the loan though 80% is typical. The security for these loans consists of taxes, assessments or revenues, or a mortgage on the title or leasehold interest in the facilities.

Tax-exempt bonds can be issued to secure direct loans but cannot be used for guaranteed loans. There is legislation introduced in Congress (Section 157 and H.R. 2378) which proposes to permit federally guaranteed essential community facilities loans to be tax-exempt.

These loans are not subject to Davis Bacon Act requirements. As with the 242 program, these loans can be time consuming to accomplish.

## Private Programs

With the improved creditworthiness of rural healthcare borrowers and the ongoing frustration with the time line for federal program financing, the private sector has begun to provide financing to rural and/or smaller borrowers.

One of these is the \$2.5 billion loan program developed by Pine Creek Healthcare Capital LLC and Citigroup Global Markets, Inc. These funds will be loaned to small and rural nonprofit hospitals for new or replacement hospitals, renovations, expansions, equipment, acquisitions and refinancings.

Pine Creek manages the credit evaluations, financing and servicing of the loan and will, through Citigroup, purchase the tax-exempt bonds issued for each hospital as a private placement.

The program provides loans of \$3 million and higher, with terms of up to 25 years with a tax-exempt fixed interest rate. A debt service reserve fund equal to twelve months principal and interest is required at closing and can be funded with loan proceeds. The security is a pledge of revenues and assets but no mortgage is required.

The program is structured to provided funding within six months of receipt by Pine Creek of a hospital's letter of intent.

Merrill Lynch and Capital Express LLC are also developing a private loan program with loans of \$3 million and up and terms of up to 30 years. Both refinancings and financings (including new construction) are permissible.

While the interest rates on the private sector loans are not as low as under the federal government programs, the fees are lower and more importantly, the funding can occur at a much faster rate.

## Bank Qualified Bonds

Finally, the National Council is working with Congress to amend the tax laws to provide that a nonprofit borrower can issue up to \$10 million in bank-qualified bonds, making them more attractive to local banks and thus less expensive for borrowers. This is because banks can deduct their carrying costs when purchasing "bank qualified" paper. (Currently, tax law has a \$10 million limit and imposes it at the issuer, not the borrower, level, thereby curtailing the benefit for most small borrowers).

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