

Deborah C. Gordon

# squeezing the funding you need from today's capital sources

Healthcare providers facing difficulty in accessing capital in today's economic environment still have many options before them, and possibly brighter prospects in the future.

Starting in the third quarter of 2007, virtually every industry and type of company in the United States saw a severe decline in the ability to access capital. Lenders and sources of capital dramatically changed the terms of any extensions of funds, and many stopped making new loans or investments altogether. These developments have had a particularly severe impact within the healthcare industry, where demand and need for capital is as great as ever.

With an aging baby-boomer population and continuing advances in medicine, the industry faces

a rising demand for services against a backdrop of declining payment, intensifying competition, increasing lawsuits, proliferating bad debt, and growing capital needs.

Americans spent \$2.3 trillion on health care in 2008, representing 16.2 percent of the U.S. gross domestic product (GDP), according to a report published by the National Coalition on Health Care.<sup>a</sup> The amount spent on health care has increased more than 6 percent annually since 2001, far exceeding the rate of inflation. A recent government report forecasts that the amount Americans spend on health care will climb to \$4.4 trillion by 2018, which represents more than 20 percent of projected GDP.<sup>b</sup> From a demographic perspective, the aging of 78 million baby boomers is beginning to contribute to the rising healthcare needs of the U.S. population, and that trend will accelerate with each passing year. However, many healthcare facilities are aging and are in need of capital improvements to be able to meet this forecasted increase in demand.

In addition, healthcare facilities face increased competition from physicians, service companies,

a. CMS Report on 2008 National Health Care Expenditures, Jan. 5, 2010, [nchc.org/facts-resources/cms-report-2008-national-health-care-expenditures](http://nchc.org/facts-resources/cms-report-2008-national-health-care-expenditures).

b. [www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf](http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf).

## AT A GLANCE

- > Healthcare providers need to understand traditional and nontraditional financing options and other potential strategies for accessing capital.
- > Common financing options include bonds, commercial lending, acquisition financing, and financing through the Department of Housing and Urban Development's Section 232 program.
- > Alternative strategies for accessing capital include joint ventures, equity, sale of assets, fund-raising, capital leases, internal capital, public grants, and grants from foundations.

and for-profit companies. Accordingly, many hospitals are considering joint ventures and investments in more outpatient services.

And the list of challenges facing healthcare providers goes on. Others include the need to:

- > Meet demand for improvements in technology and equipment
- > Comply with ever-expanding safety and quality standards
- > Invest in electronic health record technology
- > Respond to increased litigation in areas such as wage-hour class actions, false claims, and malpractice
- > Implement pay-for-performance standards and meet other regulatory compliance requirements

Hospitals and other healthcare providers need capital not only to respond to these challenges, but also to meet obligations on existing debt. As such, demand for capital in the healthcare industry continues to grow.

At the same time, however, many healthcare providers are seeing an increased cost and diminishing availability of capital.<sup>c</sup> Despite the growing need, many lenders and sources of capital are reluctant to deploy such capital in the healthcare industry. Among the possible reasons for this widespread reluctance, three seem most plausible:

- > The healthcare industry often faces low margins and high costs.
- > Even during good economic times, the industry involves a host of regulatory complexities and uncertainty.
- > The industry is in a constant state of reform, giving lenders and investors cause to wait for the outcome of healthcare reform legislation before entering the market or deploying capital.

c. See *Report on the Capital Crisis: Impact on Hospitals*, American Hospital Association, January 2009.

The commercial lending market has slowly begun to open again. However, pricing is significantly higher, and the terms are significantly tougher.

However, despite this reluctance, healthcare providers still have many options available.

#### Financing Options

For tax-exempt entities, the most common financing option is in the form of tax-exempt bonds. For taxable entities, options can range from short-term or long-term commercial loans, taxable bonds, or government-insured loans. In particular, financing through the Department of Housing and Urban Development (HUD) is an attractive option for many healthcare providers in this environment of restricted access to capital.

**Bonds.** Bonds are a form of long-term financing for capital projects whereby the borrower or, in the case of tax-exempt bonds, a governmental issuer, for the benefit of the borrower, issues notes or other debt instruments. Bonds can be either taxable or tax-exempt. The bonds are then sold to investors in a private placement or a public offering. The proceeds of the sale of the bonds are used by the borrower to finance its project.

By issuing the bonds, the issuer agrees to make principal and interest payments on specific dates to the holders. If the bond is issued by a governmental issuer, the issuer will lend the proceeds from the sale of the bonds to the borrower and

the borrower will agree to repay the loan in the amounts and at the times necessary to retire the debt.

Interest paid on tax-exempt revenue bonds is generally not included in the adjusted gross income of the owner of the bond for federal income tax purposes. Because of the income tax exemption, the interest rates on a tax-exempt bond are significantly lower than with otherwise comparable taxable financing.

Tax-exempt financing for healthcare projects is available only to organizations that are exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code. Such 501(c)(3) organizations must be organized and operated solely for one or more religious, charitable, scientific, educational, or certain other limited purposes. Projects financed with tax-exempt bonds must be owned and used exclusively by a 501(c)(3) organization to further its exempt purpose, and not in an unrelated trade or business.

Taxable debt financing is an alternative to tax-exempt financing where a borrower or part or all of a project does not qualify for tax-exempt financing. For example, a 501(c)(3) organization may enter into a for-profit joint venture or other strategic initiative that does not meet its exempt purposes, making taxable debt the only financing option. Unlike tax-exempt financing, taxable financing does not limit a hospital or other healthcare provider in how it may use the proceeds.

Since the start of the economic downturn, many bond investors have sat on the sidelines and many hospitals have reported difficulty in accessing the bond market and increased interest rates. Similarly, the rating agencies have become significantly more conservative in rating debt. Hospitals with strong credit ratings and financial performance have been able to attract investors,

The current market for acquisition financing transactions continues to be weak. Many recent successful transactions have involved reduced valuations and seller financing.

but those with weaker credit ratings have, and will continue to have, a more difficult time with this type of financing. The market for fixed-rate debt is limited, and it is more difficult to access traditional credit enhancement sources.

**Commercial lending.** For single-purpose cash needs, ongoing working capital needs, or bridge loans, short-term loans or lines of credit may be available from commercial banks or finance companies. Typically, loans are secured and lenders generally impose various covenants and conditions to borrowing. For longer time horizons, borrowers often look to term loans. Mortgages are long-term loans secured with real estate. Because most healthcare facilities involve operating businesses with a combination of collateral (accounts receivable, hard assets, equipment, and real property), these facilities often have a variety of loan products available, such as cash flow, asset-based, working capital, and term loans.

The commercial lending market has slowly begun to open again. However, pricing is significantly higher, and the terms are significantly tougher. Many lenders have been sending out term sheets, but few deals have been closed. Borrowers should expect to see debt service reserve funds, additional collateral requirements, and tighter covenants.

**Acquisition financing.** All types of companies, in all industries, have faced difficulties recently in accessing financing for acquisitions. Accordingly, merger and acquisition activity is down significantly over the past two years. Purchasers have needed to look to existing credit lines or other sources of capital to finance purchases. The current market for acquisition financing transactions continues to be weak. Many recent successful transactions have involved reduced valuations and seller financing.

**HUD financing.** HUD provides mortgage insurance, including construction loans and long-term capital, to long-term care facilities through its Section 232 program. This program insures HUD approved lenders against loss for mortgage defaults. Interest rates on HUD loans are relatively low.

Under Section 242 of the National Housing Act, HUD, through the Federal Housing Administration (FHA), provides certain qualified lenders with insurance against loss on defaults under loans to for-profit, not-for-profit, and government-owned hospitals. Through the Section 242 program, hospitals can obtain better access to long-term, low-interest, fixed-rate, and nonrecourse loans for a mortgage term of no more than 25 years. The Section 242 program supports the financing of new hospitals or capital improvements of facilities. The FHA has approved certain mortgage lenders for these loans.

On July 1, 2009, HUD issued a notice announcing the expansion of its hospital mortgage insurance program.<sup>d</sup> HUD will now permit refinancing of hospital mortgage debt with federally guaranteed loans under Sections 242 and 223(f) of the National Housing Act, without requiring such

refinancing to take place only in conjunction with construction or renovation. On Jan. 29, 2010, HUD published a proposed rule for implementation of this expansion.<sup>e</sup>

Pursuant to Section 223(f)(1) of the National Housing Act, the FHA is authorized to insure refinancing and acquisition loans for existing hospitals (as well as existing nursing homes, assisted-living facilities, or other types of healthcare facilities). However, to date, HUD has not exercised this authority with respect to the refinance of debt for existing hospitals. Previously, HUD believed that private capital was sufficiently available to assist hospitals in refinancing their debt, and that demand was not as great as was the need for new construction, renovation and rehabilitation, and equipment purchases. However, recognizing the current difficulty hospitals face because of the economic downturn in obtaining financing, HUD is expanding its hospital mortgage insurance program to allow for refinancing of existing debt without conditioning such refinancing on new construction or renovation.

To be eligible under the proposed regulations, a hospital must have maintained an aggregate operating margin of at least 0 percent and an average debt service coverage ratio of at least 1.4 for the past three years. The hospital also must demonstrate that its financial health depends upon refinancing its existing capital debt and that it provides an essential service to the community in which it operates. A hospital can meet this requirement by showing that if it were no longer in operation, its community would suffer inadequate access to an essential service; that few affordable financing alternatives are available; and that it meets three of seven listed criteria.

d. [www.hud.gov/offices/adm/hudclips/notices/hsg/files/09-05hsgn.doc](http://www.hud.gov/offices/adm/hudclips/notices/hsg/files/09-05hsgn.doc).

e. See the *Federal Register*, Jan. 29, 2010, [www.access.gpo.gov/su\\_docs/fedreg/a100129c.html](http://www.access.gpo.gov/su_docs/fedreg/a100129c.html).

These criteria are as follows:

- > The proposed refinancing would reduce the hospital's total operating expenses by at least 0.25 percent.
- > The interest rate of the proposed refinancing would be at least 0.5 percent less than the interest rate on the debt to be refinanced.
- > The interest rate on the debt to be refinanced has increased by at least 1 percent since Jan. 1, 2008, or is very likely to increase by at least 1 percent within a year.
- > The hospital's annual total debt service is in excess of 3.4 percent of its total operating revenues.
- > The hospital has experienced a withdrawal or expiration of its credit enhancement facility or the lender has been downgraded.
- > The hospital is a party to overly restrictive or onerous bond covenants.
- > There are other circumstances that demonstrate that the hospital's financial health depends upon refinancing its existing capital debt.

The maximum mortgage loan amount permitted under the new Section 242/223(f) program cannot exceed the cost to refinance the existing indebtedness, which includes the payoff amount, reasonable and customary legal fees, title and recording expenses, costs of any repairs totaling less than 20 percent of the new mortgage amount, fees paid to the HUD-approved lender, and inspection fees. Notwithstanding the limitation that the maximum loan amount must not exceed the cost to refinance, the new proposed amendments to the regulations also contemplate that an insured loan may be used to finance the costs of acquiring a hospital.

The market for HUD-insured loans and bridge-to-HUD loans has been a rare bright spot in the current lending market. Although many of these deals involve long-term care facilities, the market for hospitals appears to be improving.

#### ***Special lending issues with healthcare receivables.***

Lenders typically require a security interest in a borrower's accounts receivable (A/R) in connection with a typical financing. Revised Article 9 of the Uniform Commercial Code (UCC) includes healthcare insurance receivables as a subset of "Accounts." Under the UCC, a healthcare provider can grant a lender a security interest in healthcare insurance receivables, and the lender can then perfect such security interest by filing a financing statement. Lenders generally also enter into deposit account control agreements with the banks and other financial institutions that receive the cash generated by such "Accounts."

Federal law, however, prohibits the assignment of Medicare or Medicaid A/R. To avoid the anti-assignment prohibition, the lender and provider enter into a lockbox arrangement, whereby payments from the government are made first to an account controlled by the healthcare provider. Amounts are then automatically and routinely swept out of that account into another account controlled by the lender. Because payments are first made to an account controlled by the healthcare provider, the government is not making payments to a third party, thereby circumventing any violation of the anti-assignment provisions.

#### **Alternative Strategies**

With traditional sources of financing unavailable, alternative strategies for financing have been popular among hospitals and health systems. Alternative financing can come from many sources, including joint ventures, equity, and sale-leaseback arrangements.

***Joint ventures.*** Hospitals and other healthcare providers are increasingly contemplating joint ventures to share risk and resources. Joint ventures often occur between hospitals and physicians, large and small hospitals, and hospitals and other types of healthcare providers or service

## Recognizing the current difficulty hospitals face in obtaining financing, HUD is expanding its hospital mortgage insurance program to allow for refinancing of existing debt without conditioning such refinancing on new construction or renovation.

companies. Similarly, many hospitals and health systems have looked to strategic alliances, affiliations, and consolidation as a means to improve access to capital and to reduce costs.

Joint ventures require careful structuring from a regulatory perspective and can be a source of legal scrutiny. However, this trend is not a repeat of the widespread efforts to create independent practice associations, physician-hospital organizations, and integrated delivery systems of the 1990s. Healthcare providers have become more sophisticated, capable, and insightful in assembling joint ventures that are more strategic and focused.

Many also see accountable care organizations (i.e., provider groups charged with managing the cost and quality of health care for a given patient population) as playing a key role in healthcare reform and see the consolidation of healthcare providers as being an important element. Further, many physicians have looked to specialty hospitals and outpatient facilities for investment opportunities, and many hospitals and healthcare facilities have looked to participate in these types of investments, as well.

**Equity.** For-profit entities can look to the equity market for capital, such as venture capital or private equity. Since the beginning of 2009,

financial sponsors have invested more than \$27 billion in the healthcare sector according to research conducted by investment banking firm Lincoln International LLC. In addition, many private equity investors have expressed intentions to allocate a greater percentage of their funds to healthcare transactions over the next three to five years.

**Sale of assets.** In seeking additional sources for capital, many hospitals and health systems have contemplated sale of or investment in medical office buildings (MOBs) and other sale-leaseback of real estate. Many real estate investment trusts, insurance companies, and other investors also have expressed an interest in medical facilities and MOBs as attractive investments. By selling assets, hospitals and health systems look to improve their balance sheets and improve their financial performance.

**Fund-raising.** A decrease in charitable giving due to the economic downturn has made it more difficult for many not-for-profit healthcare providers to rely on philanthropy as a source of capital, with those that are most dependent on fund-raising being most adversely affected. This effect has been compounded in many instances by the recent negative press stemming from allegations that many not-for-profit hospitals have failed to provide sufficient levels of charitable care, which has led to increased scrutiny of not-for-profits' justification for tax exemption and a corresponding negative impact on their fund-raising efforts. Many not-for-profit hospitals have attempted to counter this negative press through their own public relations campaigns, highlighting their charitable mission and community activities. However, with reduced amounts raised through fund-raising, many healthcare facilities have scaled back projects or put major projects on hold.

**Capital leases.** Capital leases can be used to finance large equipment acquisitions, thus allowing healthcare providers to invest in new technologies and improved diagnostic equipment. Vendor financing for expensive projects has increased.

**Internal capital.** Failing the ability to obtain external sources of capital, healthcare providers can look to internal sources of capital, such as operating and nonoperating cash flow and proceeds from the sale of assets. However, ROIs and profit margins have fallen, leaving healthcare providers to rely more heavily on cost cutting and strong management to generate any internal sources of cash.

**Public grants.** Hospitals and health systems have also looked to public grants as a source of capital. Many states have used tobacco settlement recoveries as sources for additional grants in the healthcare industry. However, as both the federal and state governments are facing budget deficits, public grant monies are often an early casualty in cost cutting.

**Grants from foundations.** Many hospitals and health systems rely heavily on grants from public or private foundations or from governmental bodies. Grants often have specific restrictions on use and involve strict accountability standards. Increased competition for available grants and a decline in the number of grants offered due to recent economic conditions have caused this to become a less reliable source for many organizations.

### **Working with Lenders and Sources of Capital**

Due to the difficulty in completing new capital-raising transactions—largely in the area of traditional financing—deal activity has mainly come from existing, performing relationships.

Lenders, for example, have focused more on “add on” deals and amendments to existing transactions and relationships. However, these deals are focused on strong-performing existing loans. Even so, many lenders are requiring additional credit enhancement in the form of letters of credit, insurance, interest rate protection, or guarantees, as well as additional financial disclosures and transparency.

Many healthcare lenders have left the market or closed their doors. New loan volume is down, and acquisition finance and leveraged finance activity is significantly down. At the same time, many healthcare providers have encountered upcoming maturity dates, financial covenant defaults, and increased pricing. Leverage ratios are tougher, pricing has increased, and transaction structure is significantly more conservative. As a result, capital projects, acquisitions, and refinancings have been delayed or canceled.

As a general matter, smaller deals are easier for lenders to execute. It is significantly more difficult to close a widely syndicated deal or a large bond issue. As a result of the recent economic crisis, lenders have become significantly more conservative and risk adverse. Accordingly, they are focused on the reputation and background of the borrower, evaluating a healthcare provider on financial performance, valuation, and character. They will look not only at the provider’s financials, but also at its market, leadership, strategic goals, and business plan.

Lenders also have become more sophisticated in understanding trends in payment, payer mix, collection history, receivables aging, service mix, utilization, operating margins, and efficiency. And in addition to subjecting providers to heightened scrutiny and due diligence, lenders have reduced their loan to value, have required stronger financial performance, and have adjusted capitalization rates.

During today's difficult economic times then, in particular, borrowers should keep a few key principles in mind in working with their existing lenders.

**Communicate.** During a difficult economy, lenders are under pressure for their own business and portfolio, and portfolio managers are held more accountable for performance.

Accordingly, at such a time, borrowers will be well-served to work more collaboratively with lenders. A lender will tend to be less accommodating with a borrower if the lender feels that the borrower is not responsive, trustworthy, or forthcoming with information.

**Comply.** To the extent feasible, borrowers need to comply with their loan documents. Although this advice may seem self-evident, borrowers need to avoid simple slip-ups, such as failure to deliver financial statements on time, failure to seek lender approval for certain actions, and failure to inform the lender of certain events.

**Manage performance.** In general, absent a major event, financial performance does not deteriorate quickly. Problems generally persist for an extended period. A strong leadership team and management are crucial during difficult economic times. Hospitals may lose focus on the core business or may not have adequate financial information to monitor performance. Many troubled healthcare providers have, voluntarily or at the bidding of their lenders, looked to turnaround managers or financial advisers to manage cash, improve performance, and reduce costs.

An effective improvement plan should focus on financial performance, operations, strategic needs, and clinical matters. Many healthcare providers are also turning toward process improvement such as Six Sigma or Lean to improve efficiency and performance.

Healthcare providers have become more sophisticated, capable, and insightful in assembling joint ventures that are more strategic and focused.

#### **Defaults, Workouts, and Bankruptcy**

Many borrowers have faced financial covenant defaults or other operating defaults due to the recession or other changes in the market. As a result, lenders have increasingly called defaults, reserved their rights, or imposed default interest rates. For many borrowers, the current default interest rates may be lower than current market rates for refinancing. Some lenders have worked with borrowers to reset financial covenants or require additional credit enhancement, such as guarantees or additional collateral. Other lenders have entered into forbearance agreements or other workouts with borrowers.

As a last resort, lenders have exercised their remedies upon an event of default. Such remedies may include appointing a receiver, seizing collateral, accelerating indebtedness, or instituting foreclosure proceedings or a public sale of collateral. A creditor may force a borrower into bankruptcy, or the borrower itself may file bankruptcy.

A bankruptcy filing presents challenges for creditors. To exercise remedies against the borrower, such as commencing a foreclosure action or effecting a setoff, the lender must first obtain relief from the automatic stay. Similarly, disputes can arise in bankruptcy regarding whether the

debtor can use the lender's cash collateral for operations. However, over the past few years, debtor-in-possession financing has been difficult to come by and many distressed companies have found it too expensive to file bankruptcy, electing instead to just shut their doors.

Bankruptcy issues become particularly complicated when healthcare providers are involved. The various regulatory requirements, licenses, provider numbers, certificates of need, and other permits need to be evaluated in any Chapter 11 plan. In any sale as part of a Chapter 11 plan, any assumption of an existing Medicaid or Medicare provider number or provider agreement requires careful analysis and coordination among governmental agencies. Healthcare facilities also maintain patient lists and medical records, which must be handled in accordance with the applicable privacy protections. The Bankruptcy Reform Act of 2005 (the Bankruptcy Act) recognized that health care is an important national industry with unique needs.

One significant amendment under the Bankruptcy Act was the addition of Bankruptcy Code Section 333. Section 333 directs a bankruptcy court to appoint an ombudsman where a healthcare provider is in bankruptcy. The ombudsman is tasked with monitoring the quality of patient care during the bankruptcy proceeding and reporting back to the bankruptcy court. If patient care declines, the ombudsman is to inform the court so that appropriate corrective action may be taken. The Bankruptcy Act also permits the federal government to unilaterally terminate a healthcare debtor's participation in federal healthcare programs, such as Medicare, without having to seek relief from the automatic stay.

### Bidding Time

It is widely recognized that many healthcare providers have encountered difficulties in accessing

Given that health care is almost certain to continue for a long time to grow as a percentage of GDP, there is good reason to believe that the industry will only become more attractive to lenders and other capital sources.

capital at a time when their needs for capital are at all-time highs. But in relative terms, the worst may, at least, be over. Results of a survey released on Feb. 1, 2010, by the Federal Reserve indicate that banks do not seem to be making it tougher to borrow—although they do not seem to be making it any easier either.<sup>f</sup> In such circumstances, healthcare providers may need to manage their existing lending relationships for the near term until improved financing and refinancing options emerge. Indeed, given that health care is almost certain to continue for a long time to grow as a percentage of GDP, there is good reason to believe that the industry will only become more attractive to lenders and other capital sources that will want to participate in that growth going forward. ●

f. See *The January 2010 Senior Loan Officer Opinion Survey on Bank Lending Practices*, The Federal Reserve Board, [www.federalreserve.gov/boarddocs/snloansurvey/201002](http://www.federalreserve.gov/boarddocs/snloansurvey/201002).

### About the author



**Deborah C. Gordon, JD,** is a partner, Seyfarth Shaw LLP, Chicago ([dgordon@seyfarth.com](mailto:dgordon@seyfarth.com)).

Copyright of hfm (Healthcare Financial Management) is the property of Healthcare Financial Management Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.