August 9, 2013

Mr. Roger Miller
Deputy Assistant Secretary
Office of Healthcare Programs
U.S. Department of Housing and Urban Development
451 7th Street SW, Room 6264
Washington, DC 20410

Mr. Geoffrey G. Papsco
Director, Office of Hospital Facilities
U.S. Department of Housing and Urban Development
451 7th Street SW, Room 2247
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RE: Handbook 4615.1 REV 1
Section 242 Mortgage Insurance Program

Dear Mr. Miller and Mr. Papsco:

We are writing on behalf of the Committee on Healthcare Financing[1], to provide comments on the Department of Housing and Urban Development's ("**HUD**") new Section 242 handbook (Handbook 4615.1 REV 1), which was published in May 2013 (the "**New Handbook**"). First of all, we applaud the multi-year effort by HUD's Office of Hospital Facilities ("**OHF**") to update the Section 242 program by implementing the Section 242/223(f) program and updating the Section 242 handbook. Because the prior Section 242 handbook was issued in 1973, many of the provisions had become obsolete and inapplicable and therefore we believe that the New Handbook will provide much needed guidance to both lenders and hospitals seeking Section 242 mortgage insurance.

We understand that OHF is undertaking a significant internal effort to improve its process so as to make the application and loan process for Section 242 more efficient and effective. The New Handbook will certainly aid in that effort by clarifying many requirements. However, we do have serious concerns with several new requirements and changes contained in the New Handbook and this letter details those concerns.

[1] The Committee on Healthcare Financing is an association of national investment and mortgage bankers and financial advisors who participate in the Department's Sections 232 and 242 mortgage insurance programs.

As you know, many hospitals view the Section 242 program as a less than preferred financing option. That has caused many hospitals that are worthy candidates for the program to summarily dismiss Section 242, even when shown the interest rate savings of a Section 242 loan. That being said, the Section 242 Program does have some very attractive attributes that can, when added to the interest rate savings, encourage more creditworthy hospitals to consider a Section 242 loan. Our main concern is that several of the changes made in the New Handbook eliminate or significantly curtail the historically positive aspects of the Section 242 program while not going far enough to correct many of the negative aspects of the program. We are particularly concerned with the changes made to the Section 241 equity requirements (Section A.1 below), the timing of drawing on equity letters of credit during construction (Section B below), and the limitations on capitalizing HUD required and/or legitimate costs in the loan (Sections D.1(b) and D.1(c) below).

By taking away the historically positive aspects of the Section 242 program, OHF will continue to discourage more credit worthy hospitals from considering HUD, which will weaken and further marginalize the Section 242 program. While HUD's mission is to provide financing for urgently needed hospitals, particularly ones that are unable to otherwise secure affordable financing, we believe the program is better served if HUD is able to balance serving its mission with also attracting better hospital credits.

Because we were not permitted to review the New Handbook before it was published and implemented, we have very extensive comments. We have included in this letter the most serious changes that we feel are needed to the New Handbook. In the attached Exhibit A, we have included those comments that we feel are clean-up or clarification in nature.

A. SUBPART B – APPLICATION PROCEDURES AND COMMITMENTS

1. §242.23 – Item 4, Section 241 equity requirement

The New Handbook significantly changes current HUD rules by limiting a Section 241 supplemental loan to no greater than 90% of the costs of the new project to be constructed, without regard to the "value" of the entire project. OHF has always allowed the net property, plant, and equipment ("**Net PP&E**") to be included in the "value" of the improvements and thus sized a Section 241 loan in the same manner that it sized a Section 242 loan, i.e. 90% of HUD's "estimated replacement costs" of the entire project. Therefore, we believe this new rule conflicts with both the statute and HUD's longstanding interpretation of Section 241 based on our review of the following:

- The Section 241 statute itself and its relationship to Section 242;
- The Section 241 regulations;
- HUD's programmatic implementation as reflected in handbooks and various HUD memorandums; and
- Comparison to the Section 232/241 loan program.

If OHF retains this new rule, the Section 242 program will lose a longstanding attribute to the program, i.e. that borrowers can use their Net PP&E as equity to reinvest in their hospital and preserve their cash liquidity. We view this new rule as an attempt by HUD to artificially limit loan amounts without regard to the best interest of its hospitals. If OHF wishes to attach more credit-worthy hospitals, and also protect the liquidity of its existing portfolio, we believe this new Section 241 cash equity rule must be eliminated and OHF revert to is prior Section 241 interpretation. Additionally, the new Section 241 equity rule will curtail interest in HUD's Section 242/223(f) program. Because hospitals are not allowed to take cash out in a Section 242/223(f) loan, hospitals that come in to the HUD program through a refinance, will only be interested in HUD if they can use their Net PP&E as equity for future projects. If a hospital is forever locked out of using its Net PP&E for future capital projects, the Section 242/223(f) program becomes very limiting and unattractive to hospitals.

Therefore, we ask that you please review our analysis below and revise the New Handbook to not limit a Section 241 loan to 90% of the "new" costs of the project.

(a) Section 241 Statutory Language

Section 241(b) of the National Housing Act states that "a supplemental loan be limited to 90 per centum of the amount which the Secretary estimates will be the value of such improvements, additions, and equipment, except that such amount when added to the outstanding balance of the mortgage covering the project or facility, shall not exceed the maximum mortgage amount insurable under the section or subchapter pursuant to which

the mortgage covering such project or facility is insured or an amount acceptable to the Secretary."[2]

We believe Congress's use of the term "improvements" in Section 241 is not intended to be limited to just the new improvements but rather all the improvements of the project. Congress states in the statute that when added to the prior Section 242 (or 232 or d4) loan, the maximum insurable mortgage cannot exceed the maximum mortgage amount insurable under Section 242 (or 232 or d4, as applicable). As you know, a Section 242 loan may "not exceed 90 percent of the *estimated replacement cost* of the property or project,"[3] and HUD has long interpreted that limitation to allow a hospital to include its Net PP&E in its calculation of estimated replacement costs when determining the maximum insurable amount of a Section 242 loan. We believe it was not Congress's intent to narrowly define "improvements" to exclude all of the existing improvements of the hospital, particularly since those existing improvements will serve as collateral for the Section 241 loan. Instead, we believe that Congress's express cross reference to and tying of the sizing of a Section 241 loan to Section 242 was intentional; and therefore one must read those clauses together. Therefore, it would be impossible to take into consideration a combined Section 242 loan and a Section 241 loan when determining eligible loan sizing under Section 241(b) without concluding that the value of the improvements must include the value of both the Section 242 and the Section 241 improvements. As is well established already, the Section 242 improvements include the Net PP&E.

Because OHF will require that a hospital pledge all of its property (real and personal) to secure a Section 241 loan, then logic would say that in order to determine the "value" of the Section 241 improvements, one must certainly take into consideration the Net PP&E (real and personal) that a hospital will contribute to the transaction. It would be unfair to require a hospital to include all their improvements to satisfy HUD's Section 241 collateralization requirements but not allow that same hospital to include all its improvements to satisfy loan sizing, i.e., the Section 241 determination of "the value of such improvements."

We do not believe that the use of the phrase "such improvements, additions, and equipment" was intended by Congress to limit the maximum loan size to just the new work to be done because nowhere in the statute does Congress indicate that "such improvements" cannot include the existing improvements that will become part of the HUD loan collateral. In fact, the inclusion of the second clause in Section 241(b)(1) indicates that Congress intended the Section 241 loan to be combined with and sized in the same manner as the prior Section 242 loan. And, as discussed below, HUD has long agreed with that interpretation in its regulations.

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[2] *See* NHA Section 241(b)(1).
[3] *See* NHA Section 242(d)(2) (*emphasis added*).

(b) HUD's Implementation of Section 241

Attached to this letter as Exhibit B is a copy of 24 C.F.R. 241.70. (Please note that this regulation is not currently published in the CFR but is still considered an existing regulation pursuant to HUD's regulatory streamlining of the published regulations in 1996. Please see attached HUD memo for more background.)

You will note that 24 C.F.R. Section 241.70 uses the same language that the Section 241 statute uses regarding loan sizing. And again, we argue that nowhere does HUD (similar to Congress) indicate an intent to limit the definition of the term "improvements" to merely the new construction project and not include all the "improvements" that will serve as collateral for the Section 241 loan. In fact, the regulation goes further to provide another limitation on the Section 241 loan size. The regulation says that the Section 241 loan is the lesser of:

> *(a) Ninety percent of the Commissioner's estimate of the value of the improvements, additions, or equipment; or*
> *(b) An amount which, when added to any outstanding indebtedness relating to the property, does not exceed the maximum mortgage amount insurable under the section or title pursuant to which the mortgage covering such project or facility is insured.*[4]

In order to determine the amount provided in 24 C.F.R. Section 241.70(b), HUD must use the loan sizing method of Section 242, which includes Net PP&E to determine the hospital's estimated replacement costs. In other words HUD is allowing (in Section 241.70(b)) the mortgagor to borrow a loan amount that equals the following:

> Section 241 Loan + Unpaid Balance of Section 242 Loan = 90% of the estimated replacement costs of the entire project
>
> or
>
> Section 241 Loan = 90% of the estimated replacement costs of the entire project – Unpaid Balance of Section 242 Loan

The entire project as calculated per the instructions of Section 242.70(b) would include the costs of the new project plus Net PP&E per the Section 242 loan sizing. If, however, Section 241.70(a) is interpreted to mean that a Section 241 loan can never exceed 90% of the new costs, then a borrower would never be able to borrower an amount under Section 241.70(b) because that amount will always be lower than 90% of the estimated replacement costs of the project as sized pursuant Section 242. We do not believe Congress or HUD would ever draft a statute or regulation that provides two alternatives

[4] *See* 24 C.F.R. 242.70(a).

but intentionally draft one of those alternatives in such a manner that would render the other perpetually unavailable.

(c) HUD's Application of the Section 242/241 Program

HUD has a long history of insuring Section 241 loans, but we believe that there may be some confusion between HUD requirements and state law. As we said above, and as we will discuss more below, HUD has long limited Section 241 loans to no more than 90% of the estimated replacement costs of the improvements, which included Net PP&E, and calculated the loan amount by completing the HUD 2264 in the same manner that it completes such form for a Section 242 loan. In New York however, where most of the Section 241 loans have been made over the last 25+ years, a Section 241 loan is limited to 90% of new costs pursuant to New York State Department of Health requirements. Therefore, if OHF is looking for precedent in prior Section 241 loans, it may misinterpret actual loan sizing per New York State Department of Health requirements as HUD requirements. [5] If you would like to look at past deals for guidance on HUD's interpretation and implementation of Section 241 loan sizing, we ask that you review the HUD 2264's for the following sampling of projects:

1. Montefiore (012-10032) - initially endorsed Dec. 15, 2004;
2. Albany Med Center (014-10051) initially endorsed Dec. 2010; and
3. Hospital for Special Surgery (012-10039) initially endorsed Dec 2009.

You will see from those HUD 2264's that HUD approved the hospitals borrowing more than they actually borrowed. The hospitals, because of the New York Department of Health, had to limit the actual loan size.[6]

We also point out that the Section 241 preliminary review template in the New Handbook details how to size a Section 242/241 loan. Below is a portion of page 21 of Appendix 3-Section 241 Preliminary Review Template (*emphasis added*):

Loan-to-Value Requirement (LTV).

Hospitals must demonstrate no more than a 90 percent LTV ratio to be eligible.

Calculate LTV based on the proposed project costs from the HUD Form 92013. LTV is calculated using the formula below:

LTV = (Total Mortgage Amount(s) / (Total Estimated Replacement Cost)

[5] You may also find other projects outside of New York that limited the Section 241 loan amount to 90% of new costs, but that would have been because of other factors, such as the hospital's preferences, tax-exempt limitations on use of funds, or other local requirements.

[6] Because those projects involved various lenders, we have not attached the loan commitments to this letter. However, if you need us to send them separately, we are happy to do so.

> *Total Mortgage Amount – Includes the amount of the proposed mortgage (from Section D, Line 8 of Form 92013),* ***plus the unpaid principal balance of the hospital's existing Section 242 and 241 mortgages****.*
>
> *Total Estimated Replacement Cost – From Section C, Line 32 of Form 92013.*
>
> *Net PPE (used in the calculation of Total Estimated Replacement Cost) – From Section C, Line 30 of Form 92013 (****based upon the book value of the mortgagor's property, plant, and equipment in its latest financial audit****. Net PPE should not include equipment secured by leases nor real estate or other property that is excluded from the collateral). If the value of the hospital's Net PPE is projected to be written-down following construction, the Net PPE should be reduced by the total amount to be written-down. If portions of the facility will be demolished, please also subtract the approximate book value of that portion of the property from the calculation. OHF uses the residual value when calculating LTV.*
>
> *In addition to meeting the LTV requirement, applicants for Section 241 mortgage insurance must provide 10 percent of the Total Estimated Project Cost in cash as a minimum equity contribution.*

The Section 241 Preliminary Review Template conflicts with itself. First, it follows HUD's long standing practice of sizing Section 241 loans the same as Section 242 loans are sized, i.e., includes credit for Net PP&E. Then the New Handbook adds the new rule.

We have also reviewed HUD Handbook 4585.1 (supplemental loans) and do not find any indication that HUD has previously interpreted the Section 241 statute as being limited to 90% of the <u>new</u> costs. Therefore, we believe that OHF's Section 241 prior preliminary review template was prepared correctly (that is when it was issued without the new Section 241 mandatory cash equity rule) and provided lenders and hospitals with a methodology that was consistent with the intent of the statute and other HUD Section 241 programs in determining the size of a Section 241 loan.

(d) <u>HUD's Prior Guidance on Sizing Section 242/241 Loans</u>

Attached to this email as Exhibit C is a letter from James Hammernick, Director of the Office of Insured Multifamily Development to my firm dated March 28, 1986. In that memo, Mr. Hammernick clearly indicates that when sizing a Section 241 loan, a borrower is not limited to just the new costs, but that it may also include the other costs of the project, i.e. Net PP&E. In other words, it is calculated in the same manner as a Section 242 loan. This interpretation is restated again in a memo by Leonard Krystynak, Director of Division of Facilities Loans of HHS in a memo to Turabo Medical Center dated August 27, 1993. (See attached Exhibit D.) Mr. Krystynak confirms that

"throughout the history of the [Section 242/241] program, HHS [on behalf of HUD] has calculated replacement cost for a Section 241 project adding the net book value of the mortgage property to the Section 241 project costs." This interpretation is consistent with a plain reading of the statute, the regulations, and the Section 241 handbook, and it is consistent with HUD's longstanding Section 241/242 program.

(e) Section 232 Comparison

We think that a comparison of the Section 242 and Section 232 programs provides additional support for our position that a Section 242/241 loan is sized with the inclusion of Net PP&E. Section 232(d)(2) states that a loan under that program shall be sized "not to exceed 90 per centum of the estimated value of the property or project" (for a for profit borrower).[7] As in the Section 242 statute, the Section 232 statute states that a loan is sized based on the "property or project."[8]

When applying the Section 241 program to the Section 232 program, the Office of Healthcare Programs, via the Office of Residential Care Facilities, has published a Lender's Narrative for Section 232/241(a) the allows for the loan to be sized based on the "replacement cost of the improvements."[9] The Lender's Narrative Section 232/241(a) uses the Section 241 statutory term "improvements" but does not limit the sizing to just the "new" improvements. The "improvements" in a Section 232/241(a) loan include the entire project, i.e. Net PP&E. Therefore, we do not believe that OHP would require a limited interpretation of the term "improvements" for Section 242/241(a) loans but allow a broader interpretation of the term "improvements" for Section 232/241(a) loans when the underlying Section 232 and Section 242 statutes both use the same term "project or property." And, more importantly, the Section 232 Lender's Narrative just went through formal rule making by HUD and must be considered a valid interpretation of the Section 241 statute.

Therefore, based on the various analyses provided above, it is our position that a Section 242/241 is sized based on HUD's determination of the estimated replacement costs of the improvements, which includes all the improvements of the hospital project. Therefore, we ask OHF to conclude that a Section 241 loan may include credit for a hospital's Net PP&E and thus be sized in the same manner that HUD determines the maximum insurable mortgage for a Section 242 loan.

[7] *See* 12 U.S.C. 1715w(d)(2).
[8] *See* 12 U.S.C. 1715z-7(d)(2).
[9] *See* page 81 of the attached Lenders Narrative Section 232/241(a).

B. SUBPART E - CONSTRUCTION

1. §242.46 Insured Advanced – building loan agreement

(a) Item 1 – New Rule on Equity Deposit Timing

OHF has implemented a new rule requiring borrowers not "later than ten days prior to the scheduled date of initial endorsement [to] provide evidence to HUD that equity held in cash is included in a restricted fund or account and/or a Letter of Credit to be used for equity is in place."

This is a new requirement and we ask HUD to please explain why this rule is needed. Has there ever been a problem with a lender collecting the required equity at closing? Also, please consider the additional burden that HUD is now adding to an already difficult application and closing process. Each additional burden OHF places on its hospitals further reduces the incentives of a hospital to pursue Section 242 financing.

First, we do not believe a Section 242 loan has ever failed to close because the borrower was unable to deliver their required equity at initial endorsement. Therefore, we believe this rule is attempting to fix a problem that has never existed. Second, many times the cash equity is invested or otherwise tied up such that it will cost to the hospital to move the cash to a restricted account or purchase a letter of credit ten days before closing. Additionally, closing dates get delayed for many reasons that are not in control of the borrower. So this ten days could easily expand to 30 days. Therefore, because collection of the cash equity is a lender responsibility, and failure to collect the cash equity is at the sole risk of the lender, and not HUD,[10] we request OHF amend this section to allow the lenders to continue determining what level of assurance each lender needs with regard to the cash equity component of the closing funds.

(b) Item 3 – New Rule on Equity Contribution Timing

The New Handbook is eliminating a long-standing, statutorily authorized, and very attractive aspect of the Section 242 program. HUD is now requiring that, during the final 25% of construction, all equity held in a letter of credit be spent before any remaining loan proceeds may be disbursed. This is a clear violation of the National Housing Act and should be eliminated.

[10] "Where the use of a letter of credit is acceptable to HUD in lieu of a deposit of cash or securities, the letter of credit shall be issued to the mortgagee by a banking institution acceptable to the lender. *The mortgagee shall be responsible to HUD for collection under the letter of credit*. In the event a demand for payment thereunder is not immediately met, *the mortgagee shall* forthwith provide a cash deposit equivalent to the undrawn balance of the letter of credit." *See* 24 C.F.R. Sec. 242.49(b) (emphasis added).

Congress has allowed nonprofit and public hospital to contribute their cash equity requirement with a letter of credit, "at the option of the mortgagee."[11] Further, and most importantly, if a nonprofit or public hospital did provide a letter of credit for their cash equity requirement, Congress instructed HUD that "mortgage proceeds may be advanced to the mortgagor ***prior to*** any demand being made on the letter of credit."[12]

In HUD's prior Section 242 handbook, HUD stated that "[b]ecause nonprofit hospitals traditionally receive gifts and donations during construction and, in the case of existing hospitals which are being rehabilitated, income during construction, in this program it is permissible, as set out in the HUD Regulations, for the mortgagee to accept an unconditional, irrevocable letter of credit in lieu of cash for over and above money."[13] HUD went on further to echo Congress's instruction by stating that "when the mortgagee accepts a letter of credit in lieu of a cash deposit for over and above money on a nonprofit project, all mortgage proceeds may be approved for advance prior to any demand being made under the letter of credit for additional funds necessary to complete the project."[14] We do not find any subsequent statutory language that gives HUD the right to override Congress's direct instruction or HUD's prior implementation of the statute.

Based on prior conversations we have had with OHF, we believe the basis for this rule is a perception, within HUD, that there is increased risk to HUD if the cash equity is not spent prior to the loan proceeds being disbursed. We've heard the comment that OHF wants the hospitals to have "skin" in the game. First, we can state unequivocally that the hospital is the only entity in a Section 242 loan that has all their skin in the game at initial endorsement. Besides foregoing other financing options and thus being left with just the HUD option on the closing date, a hospital must post with the lender an unconditional, irrevocable letter of credit in lieu of cash. That letter of credit will be collateralized. The HUD lender is able to draw on that entire letter of credit whenever the HUD lender desires and the letter of credit bank would then immediately take the collateral posted by the hospital.

Contrast that with HUD's limited liability. HUD insures only HUD-approved advances. Therefore, on day one, HUD's liability is limited to just the amount of the first advance. Additionally, as we discussed above, collecting on the letter of credit is solely the lender's responsibility- not HUD's. Therefore, if there is a default prior to completion of construction, HUD would be in no worse position if the letter of credit had been fully drawn or not.

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[11] *See* Section 242(d)(6) of the National Housing Act.
[12] *Id* (*emphasis added*).
[13] *See HUD H*andbook 4615.1, Chp. 3-3.d.
[14] *Id.*, Chp. 3-4.b(1)(a) (*emphasis added*).

For illustration, please consider the following two scenarios:

Scenario 1 – Mortgage Proceeds Disbursed First	**Scenario 2 – Mortgage Proceeds Disbursed Last**
Total Cost of Project = $100	Total Cost of Project = $100
Total Loan Amount = $90	Total Loan Amount = $90
Total Equity (LOC) = $10	Total Equity (Cash) = $10
If there is a default at 50% construction, the following occurs:	
Loan Proceeds Disbursed = $50	Loan Proceeds Disbursed = $40
Equity Proceeds Spent - $0	Equity Proceeds Spent - $10
HUD Receives Project with $50 already invested	HUD Receives Project with $50 already invested
HUD Receives Cash from Lender = $10	HUD Receives Cash from Lender = $0
HUD Pays Lender Insurance Claim = $50 (which is a net $40 payout because HUD previously received the cash equity from the lender) [15]	HUD Pays Lender Insurance Claim = $40 (which equals the total amount of the loan advanced)
HUD would have to invest the $50 to complete project	HUD would have to invest $50 to complete project

As you can see, if there is a default and loan assignment during the construction period, HUD is in the same position regardless of whether or not the equity is fully disbursed before loan proceeds or after. The lender retains all the risk of not spending equity before loan proceeds. Therefore, we believe that the decision to accept a letter of credit in lieu of equity, and when to spend that equity during the construction period, should be the lender's decisions, just as Congress stated.

[15] HUD could require the lender to convert the letter of credit to cash and deliver cash to HUD, or HUD could reduce the insurance claim by the amount of the letter of credit (i.e., $10) and assign to the lender HUD's rights to collect directly on the letter of credit. In either cash, HUD's out-of-pocket insurance payment is $40.

C. APPENDIX 3 - PRE APPLICATION GUIDE

1. Preliminary Review Report -Start-Up Hospital Supplement

Under "Initial Operating Capital," the handbook states that "letters of credit are usually not an option for for-profit hospitals." While this statement is correct as to the "over and above" cash requirements, i.e. equity, we don't believe it is accurate as to other escrow requirements. The 242 Regulations provide that "[i]n the case of a new hospital or a hospital expansion, HUD shall establish, on a case-by-case basis, the amount of initial operating capital, if any, that must be deposited in cash or a letter of credit (or combination) to be available to the new hospital upon commencement of operations."[16] HUD did not limit the letter of credit to nonprofit hospitals in the Regulations.

We do not believe there is sufficient justification to prohibit for-profit hospitals (but not nonprofit hospitals) from providing a letter of credit if the lender is willing to accept a letter of credit. As discussed above, the regulations puts the responsibility of realizing on a letter of credit squarely on the lender.[17] So if the lender is willing to accept a letter of credit, then HUD should allow that funding for for-profit borrowers as well.

[16] *See* 24 C.F.R. 242.24.
[17] *See* 24 C.F.R. 242.49(b) and Footnote 6.

D. APPENDIX 4 - APPLICANT'S GUIDE & APPENDIX 5 – APPLICANT'S GUIDE CRITICAL ACCESS HOSPITAL

1. Supplement 2 – HUD-92013-OHP

(a) **Line C.12 – Limitation on Initial Advance for Purchase Price**- OHF has added another loan sizing limitation in item "l)" of the Estimated Initial Draw list. OHF says that the first draw may include "90% of the lesser of (i) HUD's estimate of the sum of the fair market value of the existing land and the replacement cost of existing improvements for land, property and equipment to be purchased or (ii) the purchase price of the land, property and equipment to be purchased. (C.31 and D.3)" In order to close on a purchase of real estate, the hospital will need to pay the full purchase price, so we do not see why HUD would want to limit the amount of the purchase price line item that can be disbursed at initial endorsement. When would the balance be disbursed? What purpose is served by delaying disbursement of the full line item? We request this formula be deleted because it conflicts with Lines C.31 and D.3.

(b) **Line C.15 – MIP** –

(I) The New Handbook imposes a new rule on capitalizing mortgage insurance premiums ("**MIP**") that is inconsistent with HUD's requirements and confusing cost certification rules with loan sizing rules. The new rule limits the amount of MIP that can be capitalized in the loan to "the cut-off date which may be up to 60 days past the date of substantial completion." This has never been HUD's requirement because it conflicts with HUD's rules for paying MIP.

At initial endorsement, and on each annual anniversary of initial endorsement during construction, the hospital must pay to HUD one year's worth of MIP based on the full loan amount, regardless of whether the project has reached substantial completion or if the loan is fully disbursed. If, on such anniversary, the project has not finally endorsed, the lender will requisition the full year MIP and pay it to HUD. After that payment, if substantial completion is reached prior to the end of the year, the amount of MIP requisitioned in excess of said 60 days post substantial completion would be deemed non-mortgageable by HUD during the cost certification process. If the borrower does not have sufficient other costs to justify the loan amount taking in to consideration all the disallowed costs, then the loan is reduced pursuant to HUD's normal, long-established cost certification/final endorsement process.

The new rule for MIP sizing is an attempt to undertake cost certification process before anyone knows the actual costs. Clearly, if HUD limits the capitalized MIP to the estimated substantial completion date plus 60 days, HUD will cause any hospitals that do not achieve substantial completion on time to pay MIP out

of its own pocket, prior to project completion. (We are confident that HUD is fully aware that virtually no hospital in the distant past has achieved substantial completion on time.)

The new rule both reverses the Section 242 program's history and conflicts with all of HUD's other programs. In this case, we do not believe there are sufficient differences in Section 232 and Section 221(d)(4) to justify treating a Section 242 deal differently.

Therefore, we request that HUD restate the MIP sizing requirements as follows:

> "The Mortgage Insurance Premium that may be capitalized in the loan may equal up to 1 year of MIP payments for each year or partial year of the construction period. However, at final endorsement of the loan, the amount of MIP that can actually be paid with loan proceeds will be limited to MIP actually owed as of the cost certification cutoff date, which may be up to 60 days past the substantial completion date of the project."

(II) Additionally, there is a statement that reads, "This amount is then tested for 223(a)(7) status and if so reduced for the lower rate in the first year." This sentence seems to be a non sequitur.

(III) For Section 242/223(a)(7) loans, we request that HUD follow the Section 223(a)(7) and Section 232/223(a)(7) programs and allow the first year of MIP to be capitalized in the loan. Again, we don't see a difference between a hospital borrower and a nursing home or housing borrower that would justify different treatment in the Section 242 program. We understand that OHF desires to limit the size of the HUD-insured loan, but we suggest that OHF should consider further the value of using debt rather than cash, particularly for a portfolio that tends to have liquidity issues. There are several other ways within the HUD process to reduce costs, and thus loan sizes, which we would be happy to discuss with you.

(c) **Line C-18 Permanent Placement Fee and Line C-19 Initial Service Charge** –

OHF has limited the financing and placement fees capitalized in a Section 242/223(a)(7) to 1.5%, which for all other HUD programs can be up to 3.5% of the loan amount. We understand that OHF believes that a Section 242/223(a)(7) should be less costly than a Section 242 loan and thus require lower fees. Unfortunately OHF has not fixed it processes for and barriers to a Section 242/223(a)(7) loan to make them less costly. The processing time for a Section 242/223(a)(7) loan greatly exceeds the time it takes to obtain a Section 223(a)(7) housing or Section 232/223(a)(7) loan. (Over the past two years, many Section 242/223(a)(7) took over

a year and significant work to even get HUD's approval.) Even though HUD's other loan programs are much more predictable and streamlined that a Section 242/223(a)(7), they allow borrowers to include the up to 3.5% for placement and financing fees.

Therefore, until OHF has a consistent and predictable Section 242/223(a)(7) loan program, the financing and placement fees will greatly exceed those on a housing or Section 232 loan. Those costs will not go away by OHF prohibiting their capitalization in the loan. HUD's hospitals will have to pay those expenses with their cash, once again being forced by a new HUD rule to stress their liquidity rather than using their Net PP&E to invest in the hospital.

(d) **Line 26 (AMPO)** – OHF has stated that AMPO may be used for "other purposes," but that those other purposes are not intended to include capital expenditures. This limitation penalizes a hospital that is able to complete a project on time and forces them to waste money. For each dollar borrowed, the hospital pays a cost in the form of interest expense and HUD and lender fees. If HUD requires a hospital to borrower money, e.g. for AMPO, but refuses to let the hospital spend that money, then HUD will force the hospital to pay for an asset that may not be used. HUD certainly would not make a hospital buy an MRI, but then not allow the hospital to use it. We believe HUD should have the same position with loan dollars that a hospital is required to "buy."

Again, if the desire is to reduce loan amounts, we ask that HUD first consider the benefits of using debt versus liquidity to invest in the project. Secondly, we would appreciate the opportunity to work with HUD to address the various HUD processing requirements that artificially inflate costs, none of which are addressed in the New Handbook.

E. APPENDIX 6 - SECTION 223(A)(7)

1. Construction Component – The handbooks states that if the construction work exceeds 20% of the mortgage amount, HUD will consider the construction component a Section 241 loan. First, neither the National Housing Act[18] nor the regulations[19] have such limitation. Under the statute, the outstanding principal balance of a loan may be increased to its original principal balance under a Section 223(a)(7) loan.[20] Therefore, Congress intended that in the later years of a loan, HUD could permit its mortgagors to borrower well in excess of 20% of the outstanding mortgage amount when doing a Section 223(a)(7) loan. By implementing the 20% limitation, OHF is limiting the program against the direct language of Congress and HUD's own Section 242 regulations, as well as putting its hospitals in a less favorable debt position.

   We think that forcing a borrower to fund a project under Section 241, rather than under Section 223(a)(7), may not provide the best economic benefit to both the hospital and HUD. When pricing a loan, a construction loan costs more than a permanent loan. Therefore, by forcing a hospital in its portfolio to do two loans (a Section 223a7 loan for the refinance component and a Section 241 for the construction component), HUD will prevent its mortgagors from obtaining the best possible interest rates. HUD should be working with its mortgagors to improve, rather than impair, their debt positions.

   If HUD would otherwise approve the Section 241 loan, then there is no real reason to not allow the work to be included in a Section 223(a)(7) loan. If HUD feels that the Section 241 underwriting and loan process allows for more oversight, then HUD can and should implement those Section 241 provisions in its review/processing of a Section 223(a)(7) loan.

[18] *See* 12 U.S.C. 1715n(a)(7).
[19] *See*24 C.F.R. 242.91(a).
[20] *See* 12 U.S.C. 1715n(a)(7).

F. APPENDIX 8 - CONSTRUCTION GUIDE

We appreciate that HUD has combined multiple handbooks into a single appendix. However, in doing so, certain redundancies remain that create confusion when reading Appendix 8. For instance, there are multiple sections covering retainage (Part I, Section 3(f); Part II, Section 5(h); and 11.5 in the sample contract), insurance (Part I, Section 2.e(4)(d); Part II, Section 3.j-o; and Section 2.7.2 of the sample contract) and labor standards (Part I, Section 2.e(2); Part I, Section 7; Part II, Section 3.d; and Part II, Section 4.e), many of which contain different and sometimes conflicting information. We also are aware of recent conflicts between hospitals and their construction managers ("**CMs**") that have arisen because of confusing or outdated language in the HUD form of construction management agreement. We believe that OHF should consider requesting industry comments on the CM Agreement and look to publish a new form, while further streamlining Appendix 8 to avoid inconsistencies.

1. Part I, Section 3.d. Approval of Contracts. We believe that requiring the CM Agreement to be signed before HUD will issue its Commitment (in fact before it goes to credit committee) significantly increases costs to the hospital. HUD has seen many cases where this requirement has caused CM Agreements to be executed many months before closing. CM's of course will protect themselves and thus increase their guaranteed maximum price. Therefore, if HUD truly desires to reduce loan amounts, OHF should not require a signed CM Agreement or a guaranteed maximum price prior to issuing the HUD commitment. The HUD commitment instead should condition initial endorsement upon having the CM Agreement signed in the form previously approved by HUD, which includes a guaranteed maximum price that was previously approved by HUD. The failure to deliver those two items are risks that can and should be placed on the hospital.

   Also, in some states, execution of a construction contract starts the clock on mechanic's liens, so having a signed CM Agreement before closing will compromise HUD's lien position.

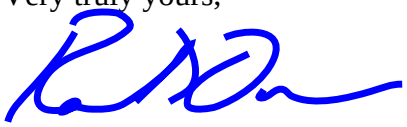
2. Part I, Section 9. Substantial Completion. We are confused by the second and third sentences of this section. When asking for a "revised application," is HUD requesting an updated 92013? That would be an inappropriate form and inaccurate to submit at this stage. First, the lender, not the mortgagor submits the HUD 92013. So the mortgagor could not, on its own submit the form. Second, the certifications/statements in the form would be completely false at this stage. After substantial completion, the correct requirement is for the borrower (not the lender) to submit is cost certification.

3. Part II, Section 3(i): Performance and Payment Bonds. The requirement that the CM post the P&P bond when Part B is entered into is a change in HUD's requirements. The delivery of the signed P&P bonds is and should remain a closing condition. Because of the costs of the bond premium, hospitals do not want to pay for the P&P bonds prior to closing at which time they are able to use loan dollars. Therefore this rule change is another example of OHF

stressing a hospital's liquidity to solve a problem that has never existed. This is also inconsistent with the requirement listed in Part I, Second Section 2.e(4)(c).

We thank you for your consideration of these comments and look forward, as always, to working with you and your team to improve the Section 242 program. Please do not hesitate to call us with any questions or comments.

Very truly yours,



Roderick D. Owens
Krooth & Altman LLP
Counsel to the Committee

CC: Philip DelVecchio
Susan Benz
Nicole Hoffpauir, Esq.
Anthony Luzzi
Steve Ervin
Paige Warren
Mark Beisler

Exhibits:

A. List of Clean-Up and Clarification Comments
B. 24 C.F.R. 241.70 and HUD Regulatory Streamlining Memo
C. March 28, 1986, letter from James Hammernick, Director of the Office of Insured Multifamily Development
D. August 27, 1993, memo from Leonard Krystynak, Director of Division of Facilities Loans of HHS to Turabo Medical Center

Roger Miller
Geoffrey Papsco
August 9, 2013

Exhibit A
LIST OF CLEAN-UP AND CLARIFICATION COMMENTS

A. SUBPART B – APPLICATION PROCEDURES AND COMMITMENTS

1. **§242.17 Commitments.**

(a) Deposit Account Control Agreements (Item 2)

HUD is requiring that the mortgagee obtain a control agreement on all deposit accounts. Because OHF periodically excludes certain deposit accounts from this requirement, we suggest that OHF add the following to the end of the first sentence in Item 1: "except for those deposit accounts that HUD excludes from the DACA requirement."

(b) Commencement of Amortization (Item 2)

OHF has retained the housing rule of commencing amortization of the note at 3 months after the substantial completion date, as estimated at initial endorsement. This rule is based on the following HUD housing theory:

- it takes 30 days from substantial completion for a borrower to complete and submit to HUD its cost certification;
- After submission of the cost certification, it will take HUD 30 days issue it HUD 92080; and
- Within 30 days of HUD issuing its 92080, the loan will be finally endorsed by HUD.

While this timeframe may work with HUD's housing program, it certainly has rarely worked in the Section 242 program. As HUD knows, virtually no project has been declared "substantial complete" at or prior to the date expected at initial endorsement. Further, virtually no project has either completed its cost certification within 30 days of the substantial completion date, as estimated at initial endorsement, or received a HUD 92080 within 60 days of such date. We don't expect merely adding this rule to the New Handbook will change 40+ years of actual experience. Therefore, nearly all Section 242 projects will continue to achieve final endorsement after commencement of amortization.

This accelerated commencement of amortization increases costs to borrowers because of other HUD requirements. Many loans are funded with mortgage-backed securities guaranteed by the Government National Mortgage Association ("**GNMA**"). The purchasers of the GNMA securities require a fee ("**GNMA Extension Fees**") if the loan is not finally endorsed by a date certain, which is determined at the time the loan is priced, i.e., prior to initial endorsement. If HUD allowed the commencement of amortization to be set beyond the three-month requirement, this would allow the HUD Lender/GNMA Issuer to set the required final endorsement date (for GNMA

extension fee purposes) at a later time. This in turn would reduce the chances that delays in construction or HUD's final endorsement process will cause hospitals to pay the GNMA Extension Fees.

We understand based on numerous conversations with OHF that HUD believes that the three month requirement will force lenders to get deals to final endorsement. Unfortunately this belief is not correct, and the facts, as we discussed above, bear that out. While we would be happy to continue working with OHF to improve the cost certification and final endorsement process, we believe allowing a greater period of time between estimated substantial completion and commencement of amortization will reduce costs to hospitals without causing any further delays in the final endorsement process.

B. SUBPART C – MORTGAGE REQUIREMENTS

1. §242.27 –Loan Maturity

The New Handbook states that HUD may limit the mortgage term to the useful life of the assets. While we believe this is a good policy to implement to ensure adequate collateral protection, we do suggest that HUD clarify how they will make that calculation. There are standards used pursuant to the tax code when financing tax-exempt bond transactions, but which may not be perfectly adaptable to the Section 242 program. Therefore, we would request an opportunity to work directly with OHF to develop a protocol for satisfying this requirement.

C. SUBPART H – MISCELLANEOUS REQUIREMENTS

1. 242.77 Liens

The New Handbook states that if secondary financing is provided by a governmental agency, it must be at a lower rate than the HUD loan. Does this requirement apply only to secondary financing in existence or to be entered into at the time of the Section 242 loan closing?

If the provision applies during the entire loan term, it could force borrowers to make bad financial decisions if interest rates rise after the Section 242 loan closes. At the time the secondary financing is needed, a Section 241 could loan carry a higher interest rate than the desired other governmental loan, and the interest rates on both loans could exceed the Section 242 loan interest rate. If read strictly, the New Handbook provision would require the hospital to finance a subsequent project with a Section 241 loan merely because the then interest rate on the other governmental loan exceeds the Section 242 interest rate, even if the interest rate on the other governmental loan is less than the current Section 241 loan. This will be particularly harmful for those 242 hospitals that were able to finance/refinance their loan during the recent period of historically low

interest rates. HUD will be forcing borrowers to the higher interest rate Section 241 loans or conventional financings.

2. 242.91(b) – Eligibility of Refinancing Transactions

The New Handbook states, that "[i]f the existing capital debt to be refinanced consists of more than one loan, the determination of debt service cost savings will take into account the weighted average of the monthly debt service payments of the loans to be refinanced." While this is understandable for multiple variable rate loans, if the loans to be refinanced are fixed rate, we believe that HUD should consider the actual debt service payments. Therefore, please clarify the weighted average of the monthly debt service payments is for variable rate loans.

D. APPENDIX 3 - PRE APPLICATION GUIDE

1. Required Documentation for a Preliminary Review Section 241 Mortgage Insurance

(a) The lettering sequence for he review template is off.

(b) Item C. Equity Contribution - Please see our prior comments on the 10% cash equity requirement.

(c) Section I First Lien – Please amend this section to clarify that the lien is a "supplemental" rather than "first" lien.

E. APPENDIX 4 - APPLICANT'S GUIDE & APPENDIX 5 – APPLICANT'S GUIDE CRITICAL ACCESS HOSPITAL

1. Supplement 2 – HUD-92013-OHP

(a) **Line C.11 (Total Hard Costs)** – For Section 242/223(a)(7) loans, the handbook tracks the regulatory language that allows "required" repairs. We would ask that HUD provide more clarity on how it will determine what it considers a "required" repair. In this analysis, we request that OHF use a broad interpretation so that owner-elected repairs needed to maintain the proper, while they may be put off, can be eligible.

Using the Section 242/223(a)(7) program as a way to upgrade a facility could be an enhancement to HUD's portfolio. If, however, a hospital is unable to include owner-elected repairs that OHF does not deem "required" in a Section 242/223(a)(7) loan, then the hospital will be forced to choose among: (1) not doing the repairs, (2) paying for the owner elected repairs with cash, and (3) using non-HUD financing to fund the repairs. Each of these options could be less beneficial to the hospital than including the owner-elected repairs in a Section 242/223(a)(7) loan. For example:

- Not doing the repairs – continued neglect of any facility will increase its depreciation over time, thus leaving the community with a lower quality facility and HUD with collateral that has depreciated more than it should- because of a HUD rule.

- Paying for the owner elected repairs with cash – HUD should not make the assumption that borrowing is bad. When a hospital, or any institution or individual, borrows, they must determine that the costs to borrower are less than the costs to use its own cash. Rather than forcing borrowers to use their cash merely in an attempt to limit HUD's perceived risk of doing a Section 223(a)(7) loan, HUD should be working with their hospitals to determine what is the best option, i.e., cash or debt, to accomplish the hospital's needs. In other words, HUD should not automatically consider each additional dollar of increased HUD loan amount as a risk to HUD without also considering the benefits those additional dollars of debt bring to the hospitals in HUD's portfolio.

- Using non-HUD financing – If non-HUD financing were available and cheaper than a Section 242/223(a)(7) loan, the hospital most likely would have obtained it. By forcing a hospital to use non-HUD financing when the Section 242/223(a)(7) loan is cheaper, HUD will be putting its hospitals in a less favorable economic position, which is certainly more risky than HUD increasing its insurance obligations under a Section 242/223(a)(7) loan with owner-elected repairs. Also, to use a conventional loan would most likely require the hospital to refinance all existing HUD debt. While we understand some in Congress may prefer rules that force hospitals out of the program, we don't believe HUD is servicing its mission by do so.

(b) **Line C.12 (Interest)** – **Estimated Initial Draw** -- OHF has provided a formula to determine the Estimated Initial Draw. However, OHF should not promulgate a formula because this will eventually be interpreted by HUD as the only items that may be included in the first draw. This could result in confusion if OHF requires certain line items to be fully disbursed at initial endorsement when there are not enough costs at initial endorsement to support the disbursement, e.g., title and recording, or does not allow monies to be drawn to cover expenses that are not on the list, e.g., construction costs for pre-commitment work that is included in Line C.1.

The program has operated successfully without a promulgated formula for the first draw and we request removal of the new formula. The first draw should include all the costs to be paid or reimbursed to the hospital on the initial endorsement date. For those items with specific disbursement limitations, e.g., organizational expense, HUD should state those.

(c) **Line D.3**- The purchase price of property to be acquired is already included in Line C.31. Therefore, adding it to Line D.3 would be double counting that cost item.

(d) **Line E** – In the notes section on how to complete the years of a lease, the HUD-92013 instructions state, in part, "99 if the lease will be for a minimum term of (i) 99 years following initial endorsement or (ii) 50 years with an option for the Mortgagor to renew the lease for an additional 49 years following initial endorsement." This language does not accurately follow the National Housing Act and thus changes the lease requirements. Therefore, to be consistent with the statutory language, we suggest the following new language:

> "99 if the property is held under a lease (i) having a period for not less than 99 years which is renewable or (ii) having a period of not less than 50 years to run from the date the mortgage is executed with an option for the Mortgagor to renew the lease for an additional 49 years following its initial 50 year term."

F. APPENDIX 8 - CONSTRUCTION GUIDE

1. The term Lender, Mortgage Banker, and Mortgagee are used interchangeably throughout Appendix 8. These should all be combined into a single term.

2. Part I, Section 1.b: Typical Steps in OAE Review.

   (a) Specific Requirements for Refinance Loans - Many of these requirements are not required or are modified for refinancing loans. We suggest that OHF's Office of Architecture and Engineering ("**OAE**") clarify that this is for a Section 242 construction project, or identify those that may be inapplicable for a Section 223(a)(7), 241, or Section 223(f) loan, i.e., survey, zoning, utility letters.

   (b) Survey Requirements - OAE's requirement to have a current certified survey of the mortgaged site with legal description and legal opinion in order to approve proceeding to initial endorsement is problematic from both a timing and delivery standpoint. The final, signed, and sealed surveys have always been a closing requirement, and thus delivered at closing. This is because such a survey cannot be delivered to HUD until all of HUD's comments have been addressed. For most loans, mortgagors are receiving HUD's comments up to and on the closing date. Therefore, this new requirement will create significant delays to getting to closing and thus increase costs to hospitals.

   Therefore, we ask that the requirement be that OAE approve a draft survey for purposes of recommending a project proceed to initial endorsement. The delivery of the final, signed, and sealed survey at closing is already a standard HUD closing requirement and does not need to be altered.

   We also recommend that OAE remove the requirement for a legal opinion stating that the legal description submitted and the current land survey reflect the property included in the HUD-242 project. At closing, the lender and HUD receive a title policy that insures that the property on the survey is the same as the property being

insured. And it also insures the type of title the hospital owns, i.e., fee simple or leasehold.

Furthermore, HUD's Section 242 application already has a requirement for a legal opinion as to the ownership interest that the borrower has in the property.

3. Part I, Section 2.b: Construction Standards: HUD notes that HUD Form 92442 is required to be utilized for lump sum construction contracts. We note that the 92442 cannot be used without modification to meet the requirements of the 242 Program (i.e., retainage requirements). In order to manage contractor expectations, we suggest revising this section to state, "HUD Form 92442 is required to be utilized for lump sum construction contracts, as modified for Section 242 requirements." A similar change would need to be made in Part 1, Section 2.e(3).

4. Part I, Section 2(d)(1): First Stage: Schematics. HUD requires that the Hospital "Owner's Representative" submit his/her contract with the hospital for OAE review and approval. This makes it appear as if the Owner's Representative must be an independently contracted party. HUD routinely has approved a current hospital employee to serve in this role (as noted in Appendix 8, Part I, Section 5) and we would not imagine that HUD reviews their employment contract. This requirement should be qualified to require a contract only for contracted independent "Owner's Representatives."

5. There are 2 Section 2.e)s.

6. Part I, First Section 2.e(3). This section refers to Construction Manager Agreement in "OAE Handbook 2.4." This reference should be instead to the sample form in Appendix 8.

7. Part I, Second Section 2.e(3)(b): Wage Determination Applicability. We suggest incorporating this requirement into the CM Agreement form.

8. Part I, Second Section 2.e.4)(b): General Conditions. Please add the Lender as a party that shall have access to the work site.

9. Part I, Section 8. Change Orders. Please add the Lender to the change order approval requirement. This will be consistent with HUD's Building Loan Agreement.

10. Part I, Section 13.a- Final Constriction Closeout by OAE.

    (a) OAE Final Report for Construction (Item 13.a)- This is a form prepared by HUD so we recommend that this be removed from the list and added above, so that the sentence prior to the list reads "As part of the closeout process, OAE will need to complete its OAE Final Report on Construction, requiring HUD to receive and process the following documents from the contractor and Owner";

(b) CPA Final Cost Certification with opinion relating to overall costs (Item 13.g)— Because this item is delivered with the HUD 2330, by listing it separately, hospitals may interpret this as a separate and distinct document. We recommend that you delete the current Item 13.g. and change 13.i and 13.j) as follows:

> i. HUD Form 9330- Mortgagor's Certification of Final Costs with CPA audit opinion attached.
>
> j. Either HUD Form 92330-A, Contractor's Certification of Final Costs, with CPA audit opinion attached, (CM project or lump sum where identity of interest exists), or Contractor's letter certifying as to final costs (for design build and lump sum projects).

11. Part II, Section 3.a- Sample forms. Will HUD accept contracts that other than the sample forms?

12. Part II, Section 3.f): Retainage. Please clarify that release of the retainage should be approved by the Mortgagee as well.

13. Part II, Section 3(g) Liquidated Damages. This section is inconsistent with Section 2.e(7), as it permits the Mortgagee to determine the amount of liquidated damages, but HUD has historically set that requirement with a formula. Please insert HUD's required formula for liquidated damages.

14. Part II, Section 3, (j)-(n)- Insurance Requirements. The term Builder's Risk Insurance is defined in the Addendum and evidence of which has historically been delivered at the initial endorsement. However, Builder's Risk Insurance is not referenced in the insurance sections of Appendix 8. Please clarify that, as it is unclear to us what would be delivered at closing.

Roger Miller
Geoffrey Papsco
August 9, 2013

Exhibit B
24 C.F.R. 241.70 and HUD Regulatory Streamlining Memo

the components in the name of the mortgagor while in transit and storage; and (2) delivering or contracting for the delivery of the components to the storage area and to the construction site, including payment of freight.

(d) *Advances.* (1) Before an advance for a building component stored off-site is insured: (i) The mortgagor shall (A) obtain a bill of sale for the component, (B) give the mortgagee a security agreement, and (C) file a financing statement in accordance with the Uniform Commercial Code, and (ii) the mortgagee shall warrant to the Commissioner that the security instruments are a first lien on the building components covered by the instruments except for such other liens or encumbrances as may be approved by the Commissioner.

(2) Before each advance for building components stored off-site is insured, the mortgagor's architect shall certify to the Commissioner that the components, in their intended use, comply with HUD-approved contract plans and specifications. Under those circumstances permitted by the Commissioner in which there is no architect, compliance with the HUD-approved contract plans and specifications shall be determined by the Commissioner.

(3) Advances may be made only for components stored off-site in a quantity required to permit uninterrupted installation at the site.

(4) At no time shall the invoice value of building components being stored off-site, for which advances have been insured, represent more than 25 percent of the total estimated construction costs for the insured mortgaged project as specified in the construction contract. Notwithstanding the preceding sentence and other regulatory requirements that set bonding requirements, the percentage of total estimated construction costs insured by advances under this section may exceed 25 percent but not 50 percent if the mortgagor furnishes assurance of completion in the form of a corporate surety bond for the payment and performance each in the amount of 100 percent of the amount of the construction contract. In no event will insurance of components stored off-site be made in the absence of a payment and performance bond.

(5) No single advance which is to be insured shall be in an amount less than ten thousand ($10,000) dollars.

[44 FR 8197, Feb. 8, 1979, as amended at 48 FR 15898, Apr. 13, 1983]

§ 241.45 Note and security form.

The lender shall present for insurance a note and security instrument on forms approved by the Commissioner for use in the jurisdiction in which the property to be improved is located.

§ 241.55 Method of loan payment.

The loan shall provide for monthly payments on the first day of each month on account of interest and principal and shall provide for payments in accordance with the amortization plan as agreed upon by the borrower, the lender, and the Commissioner.

§ 241.60 Date of first payment to principal.

The Commissioner shall estimate the time necessary to complete the improvements to the project and shall establish the date of the first payment to principal.

§ 241.65 Maturity.

The loan shall have a maturity satisfactory to the Commissioner.

[46 FR 51383, Oct. 20, 1981]

§ 241.70 Maximum loan amount.

(a) Where the project is covered by an insured mortgage, the principal amount of the loan shall not exceed the lesser of the following:

(1) Ninety percent of the Commissioner's estimate of the value of the improvements, additions, or equipment.

(2) An amount which, when added to any outstanding indebtedness relating to the property, does not exceed the maximum mortgage amount insurable under the section or title pursuant to which the mortgage covering such project or facility is insured.

(b) Where the project is covered by a mortgage held by the Secretary, the principal amount of the loan shall be in an amount acceptable to the Secretary.

§ 241.75 Agreed interest rate.

The mortgage shall bear interest at the rate agreed upon by the mortgagee and the mortgagor.

[49 FR 19459, May 8, 1984]

§ 241.80 Eligibility of title.

In order for the mortgaged property to be eligible for insurance, the Commissioner shall determine that the title to the property is vested in the borrower as of the date the security instrument is filed for record. The title evidence will be examined by the Commissioner and the endorsement of the credit instrument for insurance shall be evidence of its acceptability.

§ 241.85 Title evidence.

(a) Upon insurance of the loan, the lender shall furnish to the Commissioner a survey, satisfactory to the Commissioner, and a policy of title insurance as provided in paragraph (a)(1) of this section. If the lender is unable to furnish such policy for reasons satisfactory to the Commissioner, the lender shall furnish such evidence of title as provided in paragraph (a) (2), (3), or (4) of this section as the Commissioner may require. Any survey, policy of title insurance, or evidence of title required under this section shall be furnished without expense to the Commissioner. The acceptable types of title evidence are:

(1) A policy of title insurance issued by a company and in a form satisfactory to the Commissioner. The policy shall name the lender and the Secretary of Housing and Urban Development, as their respective interests may appear, as the insured. The policy shall provide that upon acquisition of title by the lender or the Secretary, it will continue to provide the same coverage as the original policy, and will run to the lender upon its acquisition of the property in extinguishment of the debt, and to the Secretary upon acquisition of the property pursuant to the loan insurance contract.

(2) An abstract of title satisfactory to the Commissioner, prepared by an abstract company or individual engaged in the business of preparing abstracts of title, accompanied by a legal opinion satisfactory to the Commis-

Roger Miller
Geoffrey Papsco
August 9, 2013

Exhibit C
March 28, 1986, letter from James Hammernick, Director of the Office of Insured Multifamily Development

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, D.C. 20410-8000

OFFICE OF THE ASSISTANT SECRETARY FOR
HOUSING-FEDERAL HOUSING COMMISSIONER

MAR 28 1986

Mr. Michael E. Mazer
Krooth and Altman
2101 L Street, NW
Washington, DC 20037

Dear Mr. Mazer:

This is in response to your letter of February 10, 1986 concerning St. Joseph's Hospital and Medical Center, Patterson, New Jersey, Project No. 031-13009.

You have indicated that a proposed Section 241 loan will be used to refinance a Hill-Burton loan and a New Jersey Health Care Facilities Financing Authority loan (NJ loan) and to provide additions and improvements to the subject hospital. Legal approval to include the refinancing of existing secured debt was provided by letter from Mr. John A. Maxim, Jr. of October 21, 1985. While refinancing of the Hill-Burton and the NJ loans is acceptable, it should not be assumed that we will grant approval for future cases where improvements are completed before applying under Section 241. In any case, clear evidence must be provided to HHS that the second mortgagees for the Hill-Burton and NJ loans refused to permit a third lien.

In calculating the proposed Section 241 Loan, the following procedures should be used in the determination of value. The "Memorandum for Section 241 Regarding Value of Improvements" should be completed, per instructions set forth in HUD Handbook 4480.1, Reports and Forms Catalog, page 2264-58, except that the Estimated Cost of Improvements, item 1A, should be arrived at by totaling the following:

1. Estimated cost of new improvements including carrying charges, financing and legal expenses.

2. Replacement cost associated with original Hill-Burton loan with typical reasonable refinancing costs.

3. Replacement cost associated with the NJ loan with typical reasonable refinancing costs.

Value of Improvement by Capitalization, item 1b(1), should be based on the annual net income from the total property after completion of the Section 241 improvements. (The calculation will consider the new improvements, the original Section 242 loan, the original Hill-Burton loan and the NJ loan.) This estimate will have to be determined by the Department of Health and Human Services.

Item 1b(2) of page 2264-58 will reflect the debt service of the present Section 242 loan divided by 90 percent to reflect the net income needed to service that loan. The net income remaining after subtraction of the net income needed for the Section 242 mortgage will be the basis for determining the maximum amount of the Section 241 Loan.

Since interest rates have dropped dramatically since our first discussion of this case, perhaps it would be just as cost saving to incorporate the debts in a new Section 242 loan.

Very truly yours,

James L. Hamernick
Director
Office of Insured Multifamily
Housing Development

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, D.C. 20410-0500

OFFICE OF THE GENERAL COUNSEL

EXHIBIT "B"

OCT 21 1985

Michael E. Mazer, Esquire
Krooth & Altman
2101 L Street, N.W.
Washington, D.C. 20037

Dear Mr. Mazer:

This responds to the two inquiries in your letter of July 24, 1985, as discussed at your subsequent meeting on September 5, 1985, with members of my staff and Mr. Charles Storrs of Housing, concerning use of a supplemental loan insured under Section 241 of the National Housing Act to finance improvements and additions to St. Joseph's Hospital and Medical Center, which is currently subject to a HUD-insured first mortgage and a HHS-guaranteed second mortgage.

Your first inquiry is whether HUD will permit a Section 241 supplemental loan to be secured on a third lien basis, assuming consent of the existing mortgagees. A third lien would be less expensive for the mortgagor than alternative approaches since it would avoid the need to refinance one or both of the existing mortgages which carry a 8.95% interest rate. There is no legal requirement that a supplemental loan be secured by a second lien, although that is ordinarily the case. We have referred your letter to James L. Hamernick, Director, Office of Insured Multifamily Housing Development, since an administrative determination would be needed as to whether a third lien would be acceptable under the circumstances described in your letter.

You also ask whether prepayment of the current second mortgage can be an eligible cost under the Section 241 supplemental loan if the second mortgagee does not consent to the supplemental loan, thereby requiring such prepayment. We have found no clear indication of Congressional intent on the issue. It is clear that Congress did not intend a § 241 supplemental loan to be a vehicle for refinancing FHA-insured first mortgages; instead, it is a means through which the cost of additions and improvements which are necessary to keep a project competitive and extend its economic life can be financed through insured financing without disturbing an existing first mortgage.

We do not think the statute or legislative history suggests any Congressional consideration of refinancing second mortgages through § 241. When § 241 was extended to cover hospitals in 1976, we presume Congress was aware that second mortgages on FHA-insured hospitals were common. If § 241 supplemental loans were required to be secured by second mortgages, it could be inferred that Congress intended to permit refinancing of existing second mortgages through § 241 since otherwise § 241 would only be potentially available for a fraction of the FHA-insured hospitals. However, since § 241 loans do not need to be

secured by second mortgages, we may not infer a Congressional intent to provide for refinancing of second mortgages on hospitals through § 241. The ability to use third liens as security for a § 241 supplemental loan is of course subject to the consent of the second mortgagee, in addition to the consent of the first mortgagee which is always a prerequisite for a § 241 supplemental loan. The fact that the second mortgagee may object to use of § 241 is not persuasive evidence that refinancing of the second mortgage through § 241 was intended by Congress, since § 241 clearly cannot be used to refinance the first mortgage in the case of a nonconsenting first mortgagee. The 1968 Housing Report on the original version of § 241 stated that § 241 financing would supplement an existing insured mortgage and be available without refinancing such mortgage. On the other hand, there is no clear evidence that Congress intended that § 241 never be used for refinancing a junior mortgage. As discussed below, we believe that the availability of § 241 supplemental loan proceeds for refinancing will depend in the final analysis on the maximum insurable loan amount, which is limited by a number of considerations including the concept of "value" as used in § 241.

The loan proceeds may be used only to finance improvements, additions or equipment, according to § 241.125 of the Regulations. Certain "soft" costs (i.e., architect's fees, organizational legal costs, and "other items of expense approved by the Commissioner") are payable from loan proceeds in accordance with § 241.160(d) of the Regulations. In our opinion, the prepayment of some existing secured debt through refinancing is not necessarily precluded by the Act and the Regulations from being a certifiable cost if: 1) the debt to be refinanced is not the first mortgage, 2) the refinancing is necessary to permit the new lien, and 3) the Commissioner can reasonably determine that refinancing is not a principal purpose of the new § 241 supplemental loan and that the refinancing is incidental to the principal purposes of the loan. Regarding the second test, clear evidence that the second mortgagee refused to permit a third lien would be required to demonstrate that refinancing is necessary.

Despite our opinion that the Commissioner has the legal discretion to treat some refinancing as part of the financing of improvements, additions or equipment, the refinancing may be accomplished through use of § 241 supplemental loan proceeds only to the extent that sufficient loan proceeds are available within the maximum insurable loan amount. The maximum insurable loan amount is limited to ninety percent of the value of the improvements, additions or equipment by § 241(b)(1) of the Act and § 241.70(a)(1) of the Regulations. It can also be limited by other administrative criteria. Questions concerning calculation of value or other applicable administrative criteria should be addressed to Mr. Hamernick's office.

We hope this response will assist St. Joseph's Hospital and Medical Center in making its determination of how to finance the contemplated additions and improvements.

Sincerely,

John A. Maxim, Jr.
Associate General Counsel
Insured Housing and Finance

Roger Miller
Geoffrey Papsco
August 9, 2013

EXHIBIT D
August 27, 1993, memo from Leonard Krystynak, Director of Division of Facilities Loans of HHS to Turabo Medical Center

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Bureau of Health Resources Development

Health Resources and
Services Administration
Rockville MD 20857

AUG 27 1993

Administrator
Turabo Medical Center
P.O. Box 1744
Caguas, Puerto Rico 00626

Dear Administrator:

Your hospital currently has a mortgage insured by the Department of Housing and Urban Development (HUD) under its Section 242 program. In the future you may wish to borrow additional funds using HUD's supplemental mortgage insurance program, under Section 241. This is to inform you of a technical adjustment that we have made that may affect the maximum amount of HUD insurance allowed for such a supplemental mortgage.

Estimated replacement cost is used to determine the maximum insurable loan amount. The Department of Health and Human Services (HHS) is responsible for determining estimated replacement cost pursuant to an interagency agreement with HUD and as spelled out in HUD's program instructions. Throughout the history of the program, HHS has calculated replacement cost for a Section 241 project by adding the net book value of the mortgaged property to the Section 241 project costs. Net book value was considered to be a fair indication of the value of existing assets since it represents the source of future funds from depreciation that would be available to pay debt service.

After recent discussions with representatives of the hospital industry, we have refined our method for calculating replacement cost for Section 241 applications as follows:

1. **The balance in the trustee-held HUD Depreciation Reserve Fund (DRF) will be added to the net book value of the mortgaged assets.** We believe that this methodology is appropriate because in the early years of a loan, part of the depreciation expense reimbursement is used to pay principal on debt service. Much of the remainder (often referred to as "excess" depreciation expense reimbursement) goes to fund the DRF. In the latter years of the loan, when annual principal requirements exceed depreciation expense reimbursement, funds from the DRF are then used to pay this shortfall. Thus, the DRF, like net book value, represents a source of future cash flow for debt service.

2. **Unamortized deferred financing costs associated with existing Section 242 mortgages will be added to the net book value of the mortgaged assets.** Deferred financing costs are loosely defined as debt issuance costs other than capitalized interest, and may include financing expenses, placement fees, FHA fees, legal, consulting, etc. Instead of being allocated to property, plant and equipment, they are separately capitalized and usually appear on the balance sheet in the long-term assets section under the title "Deferred Financing Costs." These costs are amortized over the life of the debt.

   In the past, when calculating the maximum insurable loan for Section 242 and Section 241 mortgages, all of the budgeted financing costs for the proposed debt have always been included in the valuation of replacement cost. However, deferred financing costs associated with existing debt have not been included in the schedule of property, plant and equipment that is provided in an application package and, therefore, were not included in our calculation of replacement value.

In conclusion, the determination of Estimated Replacement Cost and the maximum allowable Section 241 mortgage insurance amount will now be calculated as follows:

Section 241 project cost (from line C.8 of HUD 92013-HOSP)
+ Net Book Value of Mortgaged Property
+ Amount in Trustee-Held DRF
+ Unamortized Deferred Financing Expenses from Sec. 242 Mortgage
= Total Estimated Replacement Cost of Project
x .90
= Maximum Allowable HUD Mortgage Insurance
- Outstanding Balance of Section 242 Mortgage Insurance
= Maximum Allowable Section 241 Mortgage Insurance

If you have any questions concerning this matter, please call Mr. Timothy Miller at 301 443-5317.

Sincerely yours,

Leonard F. Krystynak, Ph.D.
Director
Division of Facilities Loans