



# Lending to

# Senior Care Facilities

••As the population ages, the demand for facilities that provide care to older adults is increasing. Accordingly, financial institutions are seeing more loan applications from providers of senior care services. Lending to this industry can be profitable, but banks need to perform due diligence.

Jack Dwyer, owner of CFG Community Bank, Baltimore, has considerable experience in this area. He was interviewed recently by Mary Jo Taylor, a member of *The RMA Journal* Editorial Advisory Board.

**Taylor: Senior housing is a growth industry. Why haven't the credit markets been receptive to this industry in recent years?**

**Dwyer:** Many banks have put their toe in the water with respect to independent living and assisted living because those industries are funded privately. There is more reluctance to fund the nursing home segment because Medicare or Medicaid reimbursements pay for about 70% of the cost of caring for the patients. Each state has its own Medicaid system that gets partially funded—about 50%—by the federal government. The states are responsible for the rest of it.

Lenders view those reimbursements as riskier because of state budgetary issues. But government reimbursements are a sure form of payment. Clients receiving Medicare and Medicaid represent a guarantee that the operator will be repaid. These facilities represent a much more certain

## Segments of Senior Housing

- Independent Living: The individual lives in a housing community for seniors, but needs no assistance with daily living activities.
- Assisted Living: The individual resides in a facility where he or she needs assistance with two or more activities of daily living, such as bathing, dressing, ambulating, taking medications, or preparing meals.
- Nursing Homes: Residents in these facilities need 24-hour care.
- Continuing-care Communities: Independent living, assisted living, and nursing care are provided within a single community.

form of payment than a non-age-restricted apartment building, where occupancy rates can be determined by market conditions.

**Taylor: Historically, the issue with government receivables is that it's extremely difficult to ensure that the payment comes through to the bank.**

**Dwyer:** Payments may lag, but you're ultimately going to get paid. It's just a matter of time until the provider of the service at the facility gets paid by Medicare and Medicaid. There are different aspects and different asset classes of risk in an apartment building versus a nursing home. I'm much more comfortable with senior facilities than with the market risk attached to apartment buildings.

**Taylor: Are there permanent financing sources?**

**Dwyer:** Yes. Even though they're government controlled now, Fannie Mae and Freddie Mac are probably the leaders in the assisted living and independent living space. They don't finance nursing homes, unless it's a small aspect of the project. But HUD [Department of Housing and Urban Development] has a great program for long-term financing for nursing homes, which is predominantly made up of

**Taylor: We have clients who come directly into the bank for nursing home financing.**

**Dwyer:** Yes, they can go directly to banks. The difference is that banks typically do only five- to seven-year loans. Most providers or owners of the real estate on nursing homes or assisted living are looking for long-term fixed-rate loans. Some are comfortable with a five- to seven-year loan, similar to those for an apartment building or office building. Either is a good financing mechanism; it's just not as broad for apartments or office buildings, and banks haven't gotten completely comfortable with it yet.

**Taylor: We've heard that the market is saturated with certain facility types. Is this true? And which ones would they be?**

**Dwyer:** First, no one should finance a project without first doing a market study. It's crucial and even more important than the environmental report or the appraisal. Even if it's an existing building, it's important to know what competition may be entering the market. Most states create barriers of entry to the nursing home industry with a certificate-of-need process to determine the counties where a need exists. Even in those states, I would still recommend doing

a market study because the state isn't flawless. But at least in the nursing home space, the competition is limited. Only a handful of states, including Texas and California, have no certificate-of-need process.

In the assisted living and independent living spaces,

without a doubt, the most important element is the market study because you want to make sure that that market is not saturated. There are some great groups that specialize in performing these market studies.

A market study might cost between \$10,000 and \$20,000. But it's money well spent, even from the potential customers' perspective, to get a yes or no up-front. If the market study looks strong, you can order the appraisal and the property inspection report.

**Taylor: Specifically, what information should banks look for in the market study other than demographics?**

**Dwyer:** Besides demographics, you want to know how many projects already exist in this market, and the occupancy of all the buildings in the market as well as its population. That information is all readily available.

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nonrecourse loans with terms of up to 40 years at a fixed interest rate. The interest rate is a function of the GNMA mortgage-backed security market, and today it's probably in the low 4% range.

As an FHA-approved lender, I can request that HUD insure my loan. I can then issue GNMA mortgage-backed securities to ultimately fund the loan. The current 4% interest rate, coupled with the HUD annual mortgage insurance premium of 50 basis points, equates to a rate of approximately 4.5%, which is a great fixed rate. The ultimate goal would be to get most providers on long-term fixed-rate financing because that's what has worked best in the nursing home space. Frequently, though, we provide bridge loans for acquisitions, with the understanding that our ultimate goal is to put the provider, or the owner of the real estate, on a fixed-rate mortgage.

## Assigning Rights to Payment

Lending to health-care providers must be done by those having sufficient expertise in both documenting and managing the credit. The anti-assignment provisions of the Medicare and Medicaid statutes prohibit providers from making a direct assignment of their claims for reimbursement to a third-party financier. Put another way, unlike other federal government contractors who are allowed to assign their rights to payment under the Assignment of Claims Act, health-care providers are prohibited from assigning their rights to payment. However, since enactment of the anti-assignment provisions, courts have held that providers may grant a security interest in their receivables in order to obtain working capital financing.

The generally accepted way to do this is through a "double lockbox." In a double lockbox situation, the provider is required to open two deposit accounts: one that receives only its Medicare and Medicaid (governmental) receivables, and one that receives all other receivables. The provider then enters into an agreement with its bank and its lender wherein the bank recognizes the lender's security interest in the receivables in the government account, and the provider establishes a standing sweep instruction so that the bank is required to sweep all deposits in the government account into the account where all the other (commercial and private pay) receivables are deposited.

The provider and the bank will enter into a control agreement over that account wherein the provider grants the lender absolute control over the account and agrees the bank will not honor instructions given by the provider, based on the lender's security interest. That account then sweeps to an account held in the lender's name, which then sweeps to the bank and pays down the provider's loan.

It should be noted that the anti-assignment provisions do allow assignment of claims upon entry of a court order. Therefore, all banks taking health-care receivables as collateral should be prepared to move for a court order upon default and acceleration of their loans, which can then be presented to Medicare and Medicaid, directing them to make payments to the lender.

### Physician Practice Groups

Lending to physician practice groups can add a layer of complexity to these arrangements based on a few factors. One of these is state law, which will dictate whether physicians can technically form a corporate practice entity. Virginia, for example, does not permit the corporate practice of medicine, and therefore a lender must take a security interest in each physician's receivables and be willing to monitor each physician's receivables and foreclose on same. This can complicate underwriting and documenting of the loans.

In other states, physicians are allowed to form corporate entities to which they may assign their claims, and which in turn submit claims for reimbursement to their payors. These entities are obviously much easier to finance.

There don't appear to be any moves on the horizon that would loosen the anti-assignment provisions. These were created during the early days of the Medicare and Medicaid programs, when providers often used traditional factors to obtain cash flow financing. The factors were often found to have abused the billing and payment systems, submitting multiple, fraudulent claims. Recent amendments to the federal whistleblower statutes and requirements of states' participation in Medicaid, including requirements for fraud-detection task forces, underscore the federal government's heightened concern about fraud and abuse in the medical delivery system. Therefore, it is highly unlikely that the anti-assignment provisions will be repealed or pared back. ❖

### Taylor: Which segments are the most susceptible to federal or state budget cuts?

Dwyer: Most states have budgetary woes right now. Typically, though, they've been good to the nursing home industry. Independent living and assisted living are private-pay arrangements, so they would not be impacted.

No state has ever made a cut so dramatic that it crushed a good operator. From a political perspective, they know that they don't want to cut it back too much for the elderly. Make sure you're lending to those who are recognized as great managers of nursing homes. Check their track record,

their history, and their compliance with state regulations with respect to inspections. With a good manager, reimbursement issues will never be a problem.

### Taylor: As state governments try to decrease their deficits, the focus on home care is increasing. How will nursing homes respond to that challenge?

Dwyer: Well, I'm a business owner in both industries. I own nursing homes and assisted living facilities, and I also own home health agencies. I think the government is learning that home care is more expensive than nursing home

## Red Flags for Fraud

Initial due diligence will turn up fraud. Clues can be found in a review of the litigation searches:

- Do plaintiffs' complaints often include statements from current or former employees?
- Has the provider been subject to several recoupments?
- Have there been civil money penalties? Are there corporate integrity agreements, civil investigative demands, and so on? Is there a high level of employment litigation?

Frequent employment litigation could be a sign of disgruntled employees, a source of whistleblower lawsuits.

Frequent, unexplained spikes in the use of revolving lines of credit can indicate fraud if the usage is not tied to payrolls, taxes, rent, and other traditional uses.

Similarly, a sudden increase in the acuity levels at a skilled-nursing facility, if off-trend for either the borrower's performance history or the market, could be a red flag that residents are not being properly assessed at intake. ❖

care. People often prefer to stay in their own homes, but it's often not economical. Providing care in a home setting means that services and supplies must be delivered, often costing more than nursing home care. The jury is still out with respect to savings.

**Taylor: In terms of bank financing of these care facilities, which phase is the most appropriate for banks to finance? Would it be the construction phase? The rehab phase?**

**Dwyer:** From a safety perspective, we focus on the refinancing of existing, established projects that have a great EBITDA [earnings before interest, taxes, depreciation, and amortization]. Those are the easiest and safest to finance.

That's not to say that you should shy away from construction, depending upon the market study. Amazing growth is predicted over the next 20 years for the 75-plus and 80-plus age groups. Statistics show we're all living longer. And then the baby boom generation, unfortunately, is aging. Fortunately, many of the baby boomers bought long-term care insurance, and this trend is continuing, easing the government burden.

There are two different types of continuing-care facilities, one in which the residents pay a large monthly fee, and

another where they pay a much smaller fee but are required to make a large down payment to enter the community. The down payment, which could be around \$250,000, is reimbursed to the resident or to his or her estate when the resident leaves the community.

I'm a fan of the strictly rental-type of community where pensions and Social Security provide the means to pay rent. Both concepts are great, but the recession is taking a toll on those that require a down payment because many people can't sell their homes and consequently they can't make the down payment.

**Taylor: These various facilities focus on quality of care, but some also develop a specialization.**

**Dwyer:** Yes. Putting my development hat on, I would say specialization is good. Our specialty is assisted living with a memory care aspect. It's what we like, and it works well for us.

**Taylor: Which segments are the riskiest regarding the assisted living, the independents, and the skilled nursing?**

**Dwyer:** Least risky are nursing homes and then assisted living. Independent living is the riskiest. Unlike most people in the industry, I think nursing homes are least risky because the residents need to be there based on their health situation and finances. Those considering independent and assisted living arrangements have other options, and many are reluctant to leave their homes. Nursing homes also need to be marketed, but not to the extent that independent and assisted living communities do.

**Taylor: When you're looking at the financing of a facility, what do you consider a good mix of payment types?**

**Dwyer:** A good manager will always focus on a quality mix, which would be insurance, private pay, and Medicare. Because the margins are so thin, the least desirable patient, from a profitability perspective, is the Medicaid patient. Typically, Medicaid patients make up a high percentage of residents in a nursing home. Owners need to push for the more profitable Medicare and private-pay patients to make up for that lack of profit margin on Medicaid patients. The private-pay/Medicare mix should be in the vicinity of 15-30%.

Medicare requires that patients have a hospital stay before entering a nursing home, and hospitals are incented to discharge patients as soon as possible because of the reimbursement structure at a hospital. The nursing home industry really took off about 15 years ago, when Medicare began incenting hospitals to release patients to nursing homes as a result of it being cheaper to provide proper care at the nursing home. The profile of a patient in a nursing home changed from one needing custodial care to one where people were rehabilitated so they could return to

their homes in 30 or 90 days. The nursing home industry has as many as 48 different classifications of patient types, so the key is to efficiently provide that care and capture the profit margin.

**Taylor: What is the most complicated issue with the underwriting of a nursing home?**

**Dwyer:** The staffing levels. Various states have different mandatory staffing levels for the number of registered nurses, licensed practical nurses, and aides. On the revenue side, estimating the patient mix is complicated. If it's new construction, be conservative in estimating the number of Medicare and private-pay residents so you don't overstate your margins.

When refinancing an existing building, underwrite it using the patient mix it experienced over the past three years and the expense ratio it experienced over the past 12 months, reviewing also its expenses over the

past three years. Also consider the census, which is the overall occupancy of the building. If it's 90-95%, it'll make money. Staffing levels should correspond to occupancy. If occupancy drops, staffing levels must decrease as well.

**Taylor: What type of reporting should the banker obtain in the underwriting process? And what type of ongoing monitoring?**

**Dwyer:** Reimbursements are based on the Medicare and Medicaid cost reports. They're detailed and sometimes a little hard to understand, but bankers should require them. Typically, we require three years of financial statements and a year-to-date financial on the operator's facility. Bankers also should ask for the state health survey reports, which include information regarding the upkeep of the building and the care level. That's extremely important. From a multi-facility operator, you will also want consolidated financial statements.

You also need to know the manager and its history. Hopefully, it's been in business for many years and has a long track record.

**Taylor: What are the most realistic secondary sources of repayment? Is it the real estate or is it the guarantors?**

**Dwyer:** A combination thereof. We try to get personal guarantees, but people are reluctant to provide those. Real estate is the main collateral, but try to get both if you can.

**Taylor: Does the bank have any liability or obligation if it forecloses on a facility?**

**Dwyer:** No, but reputational risk is an issue. Since I've been in the industry for a long time, I have relationships with nursing home operators and managers throughout the country, which is really important. If your borrower gets into trouble, you need to be able to install a manager or receiver almost immediately. It's complicated to do that because of state licensing requirements.

I recommend that lenders establish a relationship with the state department of health and tell them that, as the lender on this property, you want to be made aware of any issues that may arise. You want to make sure that you can

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keep that license or relicense that facility as quickly as you possibly can should the facility be shut down. You want to make sure you could step in and have a manager in your back pocket that can take over right away.

**Taylor: And the licensing would transfer?**

**Dwyer:** It could. Regardless of whether there's a real estate borrower and an operator, you always want the license as collateral on your loan because you want it to stay with your building. Even though it could be an arm's length lease, you still want that license to be assigned from the lessee to the lessor, and your borrower, the lessor, pledging it to you.

**Taylor: On the receivables again, how does the bank address the challenges to timely payment?**

**Dwyer:** Most borrowers should have an accounts receivable line of credit because the bank could go 30 days or longer without getting paid by Medicaid. Medicare pays a little quicker, sometimes biweekly. As the lender on the accounts receivable line, the way to protect yourself is to always put all of the cash, including the private-pay payments, the Medicare, and the Medicaid, into a designated lockbox that you control. (You can take assignment, but you can't perfect the actual assignment; see the sidebar "Assigning Rights to Payment.")

The first thing that comes out of that lockbox is the



## Jack Dwyer

Owner and Chairman of the Board  
CFG Community Bank

Jack Dwyer began his career in the early 1980s as a CPA at a community bank. In 1993, he formed Capital Funding Group with his own money. His plan was to focus on obtaining HUD-insured financing for nursing homes and assisted living facilities. Capital Funding Group's work accounted for 10% of HUD's portfolio, an estimated \$2 billion in lending to more than 400 nursing homes and assisted living facilities.

Dwyer learned that securing HUD funds can take up to two years, so he created Capital Lending and Mortgage Group to provide bridge loans to facility operators while they waited on their HUD applications.

Realizing that most facilities rely on Medicare and Medicaid for the bulk of their income, he created Capital Finance to secure working capital programs that would meet those facilities' particular needs.

In August 2009, Dwyer obtained bank regulators' approval to purchase the \$120 million asset AmericasBank in Baltimore. He injected more than \$34 million in new capital into the bank, renaming it CFG Community Bank. He also transferred over some highly profitable loans previously held by Capital Funding Group. In less than a year, the bank's total assets climbed to \$400 million.

For more information about CFG Community Bank, visit [www.cfgcommunitybank.com](http://www.cfgcommunitybank.com).

payment on your accounts receivable loan. If you're the real estate lender, the second thing that comes out is the mortgage payment. And then the balance of the cash can be given to the operator to fund payroll and the other operating expenses.

Accounts receivable lending is a big part of our business, which I deem even less risky than on the real estate side because all of the accounts receivable money in the lockbox is for services that have already been rendered. So you know you're going to collect the payment. The only way to really get buried would be if the borrower defrauded you by falsifying receivables. Third-party audits can protect you from fraud by auditing the receivables quarterly.

### **Taylor: What keeps you up at night with this type of lending?**

**Dwyer:** The riskiest aspect of nursing home lending is the wildcard of the states' surveys. The state surveys the physical plant, kitchen, quality of care, everything. If an operator receives a bad survey, it can't be closed immediately. But if it's not in compliance on a follow-up survey, it can be shut down.

Surveys are supposed to be done annually, and you want to have a provision in your loan agreement that requires the operator to provide you with the survey within three days after receiving it. While the surveys are available publicly, you want to receive them in a timely fashion so that you are aware of any problem that may develop and make sure it is corrected. Use a lawyer when closing your loan because all of these covenants should be in the loan documents.

In our loan documents, we assert the right to hire consultants, at the operator's cost, if the regulators give the facility a rating that falls below a certain grade. The consultant or another manager would make sure that the operator brings the facility back into compliance.

Certainly, you have to have a lender on staff that understands this market and its idiosyncrasies so that he or she can underwrite projects. But everybody doesn't have to be in the shop, as long as you have competent third-party people. And they're easy to come by. ❖



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