Spotlight *on* Capital Resources:

New Markets Tax Credit Program Update

In 2012, Capital Link published ***Spotlight on Capital Resources: New Markets Tax Credit Program***, which described the basic program details and provided an example of how such a transaction could be used to finance a community health center capital project. This updated version provides you with new information on the following topics:

Targeted Populations Regulations–Since the New Markets Tax Credit (NMTC) program's inception in 2000, many health centers have utilized this powerful but complex financing tool to their advantage. This is due, in part, to the fact that the census tract-based qualifying criteria for NMTCs often compare favorably to the service areas established by the Health Resources and Services Administration (HRSA) for federally qualified health centers (FQHCs or health centers). As the FQHC industry grows and matures, health centers increasingly want to establish facilities in census tracts that do not meet the NMTC "high-distress" criteria under the standard rules even though there is a large population of uninsured and low-income patients in residence. This update will discuss how FQHCs may still be able to qualify for the NMTC program using the "Targeted Populations" rules.

Winding Up a NMTC Transaction–With many NMTC projects nearing the end of the seven-year tax credit period, FQHCs must take action in order to realize the equity benefits of the transaction on their balance sheets – this is referred to as "winding up." This document discusses the mechanics of how this can be accomplished.

NMTC Program Summary

In 2000, Congress passed legislation creating a new economic development tax credit program called New Markets Tax Credits (NMTC). This tax credit was designed to stimulate private investment in low-income communities. The program is administered by the Community Development Financial Institution (CDFI) Fund under the US Department of the Treasury.

Through a series of competitive application cycles, the CDFI Fund allocates tax credits to Community Development Entities (CDEs), which are organizations focused on providing financing in economically-distressed areas. CDEs work to attract investors, primarily banks and large corporations, to provide them with capital in exchange for federal tax credits. The CDEs, in turn, lend or invest this capital into businesses located in targeted census tracts to spur economic growth. Because the service areas of many FQHCs overlap these specific census tracts, health centers can often qualify to utilize NMTC investments as part of their capital financing.

Why would a Health Center Want to Use a NMTC?

Most NMTC transactions are structured so that all or a portion of the original investment amount can become equity for the health center after a period of seven years. NMTC transactions typically structure the investments as below-market, interest-only loans during the seven-year tax credit period; so in effect, ***a portion of the loan does not need to be repaid***. A health center project that qualifies for NMTC can often secure approximately 20-22% of total project costs through this type of financing, thereby reducing the amount of additional fundraising or borrowing. In some cases, the NMTC investment represents the 20% minimum equity frequently required by lenders to participate in a commercial real estate transaction.

Qualifying for New Markets Tax Credits

As mentioned, the NMTC program was designed to benefit low-income communities. Census tracts are tested for eligibility by certain poverty and unemployment statistics periodically published by the US Census Bureau. Initially a census tract was deemed either eligible or ineligible as noted in the table below. However, the program has proven to be very effective, and demand for a NMTC allocation by the ever-growing list of eligible CDEs has steadily grown over time. In order to differentiate themselves from the competition, an increasing number of CDEs are committed to placing their credits only in census tracts that are considered to be "highly distressed."

Census Tract Criteria	Eligible	Highly Distressed
Poverty Rate	>20% or	>30% or
Median Family Income	<80%	<60% or
Unemployment Rate	N/A	1.5x the national average

This evolution has resulted in projects located in merely "eligible" census tracts being unable to secure tax credits. One way to make an eligible census tract "highly distressed" is to test for compliance with the Targeted Populations regulations, as described in the next section. However, a highly-distressed census tract is tested only at closing and then deemed to be eligible for the seven-year tax credit period. Unfortunately this is not the case with Targeted Populations criteria, which are tested annually. This crucial distinction adds a substantial burden to the health center staff in compliance time and cost.

Targeted Populations Regulations

Note: The following section describes how a health center can demonstrate compliance under the Targeted Populations regulations. Please note that this description is not a substitute for the advice of legal counsel experienced in these transactions.

The statute creating the NMTC program recognized that not all worthwhile projects would be located in distressed census tracts. It was conceivable that substantial low-income populations might reside in census tracts with enough higher-income people to affect the demographic statistics and make the tract ineligible (Maui, Hawaii, for instance). Acknowledging that the intent of the legislation was to benefit people and not a designated piece of real estate, the regulations created a second means to qualify for the credits called Targeted Populations.

While this is generally good news for health centers looking to utilize NMTC, the 11-year delay between the passage of the initial NMTC regulations and the issuance of the final Targeted Populations regulations in 2011 presaged that compliance would no longer be as straightforward.

Before we dig into the details of how qualifying under the Targeted Populations regulations differs from qualifying under the standard criteria, it is important to point out that are only two reasons to use Targeted

Populations testing:

1. To make a project eligible even though it is located in a non-eligible census tract, or
2. To "upgrade" an eligible census tract to highly-distressed status.

This is a VERY significant distinction in that the likelihood of successfully completing a Targeted Populations transaction can vary dramatically depending on the goal.

Using Targeted Populations Testing for a Project Located in a Non-Eligible Census Tract

When utilizing Targeted Populations testing to achieve the first goal above, an investor would be very interested in the methodology and results because its legal right to obtain the tax credits each year depends on the outcome. If the testing fails at any point during the seven-year tax credit period, the investor faces tax credit recapture. The financial penalties of tax credit recapture are stiff and most investors would likely not risk those penalties for a deal in which the population being tested may become ineligible at some point during the seven-year period. As a result, the investor's counsel would determine whether the deal structure is acceptable, which would almost certainly result in long and drawn out negotiations surrounding the testing methodology. An investor would be more likely to request that the operating entity use the gross income test on patients or the employee test on all health center staff. These are more difficult and riskier tasks, and that is the primary reason that so few Targeted Populations transactions have been closed to date.

Using Targeted Populations Testing to Achieve Highly-Distressed Status

The second goal is much simpler to accomplish and the majority of Targeted Populations deals closed to date have been used for this purpose. In this case, the investor would be ambivalent about the outcome of the Targeted Populations testing. From the investor's perspective, there is no distinction between an eligible and highly-distressed project location or population because both pass Internal Revenue Service scrutiny for eligibility to receive tax credits. It is only the CDE(s) that would be concerned about the distress criteria as they want to be able to report to the CDFI Fund (the Treasury agency that controls the allocation of tax credits) that they have placed the highest possible percent of their allocation in the most distressed areas, which would have an impact on their future applications for additional credits.

As a final bit of background, it is important to recall that for NMTC transactions the entity that utilizes the tax credits to help finance its business or capital project is the Qualified Active Low-Income Community Business (QALICB). It is the QALICB's location (in the standard model) or its employees or customers/patients (in the Targeted Populations model) that are tested for income qualification. In many NMTC transactions, the health center itself is not the QALICB. Rather, a Special Purpose Entity (SPE) that the health center creates specifically for the financing transaction is the designated QALICB for the seven-year tax credit period. This entity owns the building and rents it to the health center, which is considered the "sponsor" of the QALICB. This is notable since the use of an SPE within the structure provides an opportunity to simplify the Targeted Populations qualification process, as will be discussed in more detail later in this document.

Identifying the Targeted Population

On its face, it would appear that few other industries could so easily qualify for a financing program that requires documenting the income levels of their customers as FQHCs. FQHCs already collect the type of income data from their patients that is required for compliance with the poverty criteria of the NMTC program. Patient income statistics are annually published in the Uniform Data System (UDS) reports and clearly demonstrate that most health centers provide the majority of their services to a NMTC-qualifying, low-income population.

It would be advantageous to health centers if the NMTC program would accept the UDS report as sufficient evidence of compliance, but that is not the case. Moreover, the final regulations specifically exclude using eligibility for other federal programs as a safe harbor for qualification under NMTC. ***As a result, even though the income limitations for Medicaid eligibility are very similar to those for NMTC eligibility, Medicaid enrollees do not automatically qualify under the Targeted Populations test.*** Unfortunately, the NMTC program requires much more comprehensive back-up documentation to prove continued compliance. As will be discussed further, the result of this requirement for detailed supporting documentation and the high minimum qualification percentages precludes using what should be the primary basis on which to determine eligibility – the specific health center's patient population.

Structuring and Performing the Targeted Populations Test

There are three basic tests that a QALICB can utilize to demonstrate that the population it is serving or its employees qualify under the Targeted Populations criteria:

1. Gross Income
2. Employee
3. Ownership

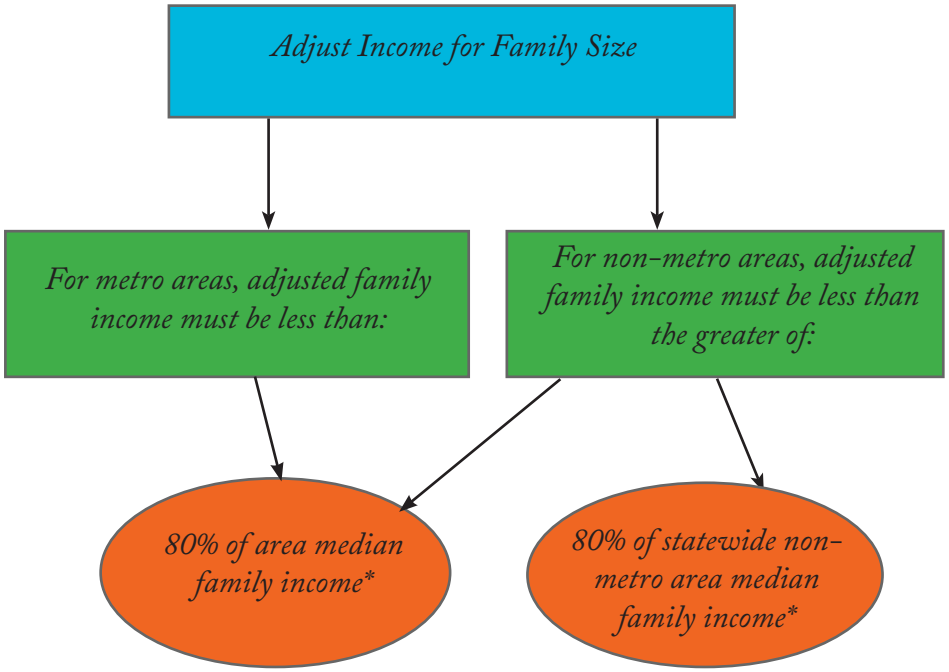
Since FQHCs are non-profit organizations, the third option (ownership) can be eliminated immediately since there are no owners whose income can be measured.

For the gross income and employee tests, there is an upper limit on the income of the census tract in which the project is located. Census tracts with incomes above 120% of the statewide median family income (or area median family income if the census tract is in a metro area) are disqualified from using NMTC regardless of the outcome of the individual patient or employee tests.

The gross income test requires that at least 50% of the gross income of the QALICB be generated through sales or services provided to low-income people and the employee test requires that at least 40% of employees of the QALICB are low-income persons. While this seems fairly straightforward, a problem arises in the definition of "income" and "low-income". The IRS insists on measuring family income when determining program eligibility (or household income as measured by the Census Bureau), not simply the individual patient's income.

Even if a FQHC decides to attempt to calculate whether its patient population is sufficiently low income to meet the test safely, the calculation itself is by no means simple. The test varies depending on where the project is located (urban/rural) as illustrated below:

Qualifying an Individual FQHC Patient or Employee



**Median family income is to be determined in a manner consistent with Section 8 of the Housing Act of 1937*

The Department of Housing and Urban Development (HUD) oversees many means-tested programs and the NMTC program chose to use its established system and set of definitions to determine the income thresholds of a particular geography. It is recommended that interested health centers go to: http://www.huduser.org/portal/datasets/il/il2014/select_Geography.odn to determine the relevant income statistics for their area.[1]

[1] The test is run on the family household income in the year prior to being hired by the SPE. Adjusted gross income under Section 62 of the Internal Revenue Code as reported on IRS Form 1040; provided that adjusted gross income must include the adjusted gross income of any member of the individual's family (defined to include brothers, sisters, spouse, ancestors, and lineal descendants) if the family member resides with the individual regardless of whether the family member files a separate return.

The primary issue for health centers with the gross income test is that the relevant statistical threshold is for family household income not solely patient income. This complicates the acquisition of this information tremendously. While 60% or more of a health center's patient base might in fact qualify under the family household income limits, it could be very risky to count on actually securing the supporting documentation from that high a percentage of all patients.

An easier alternative is the employee test. While it would appear that the employee test would face the same problems as the gross income test, such as getting large numbers of employees to provide total family income data, there is a methodology for simplifying the structuring and compliance process period. Under this structure, it is the QALICB's employees that are subject to the employee test and not all the employees of the health center, which will lease the building for the tax credit period.

Normally in a standard NMTC transaction, the SPE does not have any employees but under a Targeted Populations transaction, a number of facility-related full-time employees (FTEs) can be hired directly by the SPE and paid from additional lease payments made by the health center. Some of these positions might include functions such as maintenance, housekeeping, landscaping, security, and property management. For all but the largest of stand-alone health center projects, three such positions are probably all that is justifiable and necessary. Three FTEs is the minimum number that allows one position at any given time to be either in transition or above the income threshold and still have the requisite 66% of FTEs passing the test. It is also important to note that an employee need only submit these documents once for the length of the employment, however, if that employee quits, the new replacement employee must submit similar documentation. Annual compliance verification is not required for employees that remain employed from the previous tax credit year.

Winding Up a NMTC Transaction

The NMTC period extends for seven years from the date of closing. At the end of that period, it is imperative that the health center (usually on behalf of the QALICB SPE) take positive action to realize the equity benefits that were the primary reason for entering into the structure. These equity benefits are the conversion of the investor's original net investment in the project into the QALICB's – and ultimately the health center's – equity. This process is referred to as "winding up" the transaction. ***These benefits will not be realized without positive action***, so health centers need to be aware of the window of time that most NMTC transactions provide for the conversion of investor equity to project equity and act within that window. The actions required are not complex, but regardless, management would be wise to involve an attorney early on in the process to ensure that the events required occur at the proper time and in the proper sequence.

The details of the wind up process are specific to each deal, though the industry has evolved to use a fairly standard set of terms. Health center management should look to the "put/call agreement" to understand the process for initiating and completing the wind up.

As described in our first NMTC publication, a NMTC transaction requires the involvement of a for-profit entity as a means for creating the tax credits. Unlike the non-profit health center sponsor, this entity actually

has ownership interests (stock or LLC membership) that can be bought and sold. This entity is referred to as the investment fund in most transactions and is capitalized by a combination of the investment from the investor and borrowed funds (the "leveraged loan"). These two amounts combined represent the amount on which the tax credit allocation is based. The investment fund invests this combined amount, the Qualified Equity Investment (QEI), into an entity created by the CDE, called the Sub-CDE, in exchange for the tax credits over the seven-year tax credit period. As the owner of the Sub-CDE (which in turn is the lender to the health center's project through the QALICB), the investment fund owns the loan and whoever controls the investment fund controls the loan. Transfer of the ownership of the investment fund is the subject of the put/call agreement.

There are two ways for the ownership of the investment fund to be transferred from the investor to the QALICB, either:

1. the investor offers to sell its interest in the investment fund to the QALICB (the "Put"); or
2. the QALICB requires the investor to sell its interest (the "Call").

The Put Mechanism

Most of the wind ups completed to date have been done through the put mechanism. The put/call agreement should establish a price (often set at $1,000) that the investor agrees up-front to accept in exchange for its interest in the investment fund (that interest could take the form of stock or LLC membership). This option to exercise its right to sell is time constrained – it usually begins on the last day of the tax credit period (seven years from the day of closing) and extends for some limited period afterward (usually 90 days). Because the documentation and decision-making can take time, the QALICB is advised to begin inquiries as to the investor's intent and schedule for completing the put at least six months prior to the seven-year anniversary date. Management should ensure that going forward the center's audit specifically describes the transaction in the notes and specifies the wind up date so that the management team at that time (which could be different than the team at the time of closing) is aware that action is required well before the wind up date. In addition, while the put process for investors is getting more streamlined as they gain more experience, health centers should seek the assistance of counsel experienced in NMTC transactions to be sure they understand the schedule of events and their role in the process. This should not be an expensive legal engagement, but is a prudent step to take to protect the health center's interests. The most logical counsel to choose is the firm that represented the health center/QALICB in the original transaction. That firm can also assist in ensuring that preparations for the wind up begin at an appropriate time.

Health centers need to be aware, however, that nothing in the NMTC documentation compels the investor to put the shares of the investment fund to the QALICB. This is only an option, but one which is almost universally pursued. There are no compelling technical or accounting reasons for investors to exercise the put – it is market-driven decision. Large banks buy most of the NMTC credits and if they ever decided not to put the shares back to the QALICB, that would quickly become known across the industry and no CDEs or sponsors would ever want to offer credits to that bank again. This would extend to other tax credit programs as well, such as Low Income Housing Tax Credits and energy-related credits. The financial impact of being shut out of the tax credit market would dwarf any gain that bank might envision by trying to recover its investment in one or more NMTC transactions.

The Call Mechanism

In the unlikely event that an investor chooses not to offer to put its interest in the investment fund to the QALICB, the QALICB has a right through the call mechanism to compel the investor to sell those interests to them. It is important to understand, however, that the share transfer process and price under the call provisions are much different than for the put. Most put/call agreements provide for the rights of the QALICB to call for the purchase of the investor's shares to be activated upon the expiration of the put option period noted above and extend for only a limited time (again, usually 90 days). The price for which the QALICB can purchase the shares is dependent on the results of a fair market value analysis of the value of the ownership interests to be performed by an independent appraiser. The mechanism for choosing this appraiser is usually spelled out in the put/call agreement. There is no published history of NMTC call pricing, but the mechanism suggests it will be substantially higher than the put price.

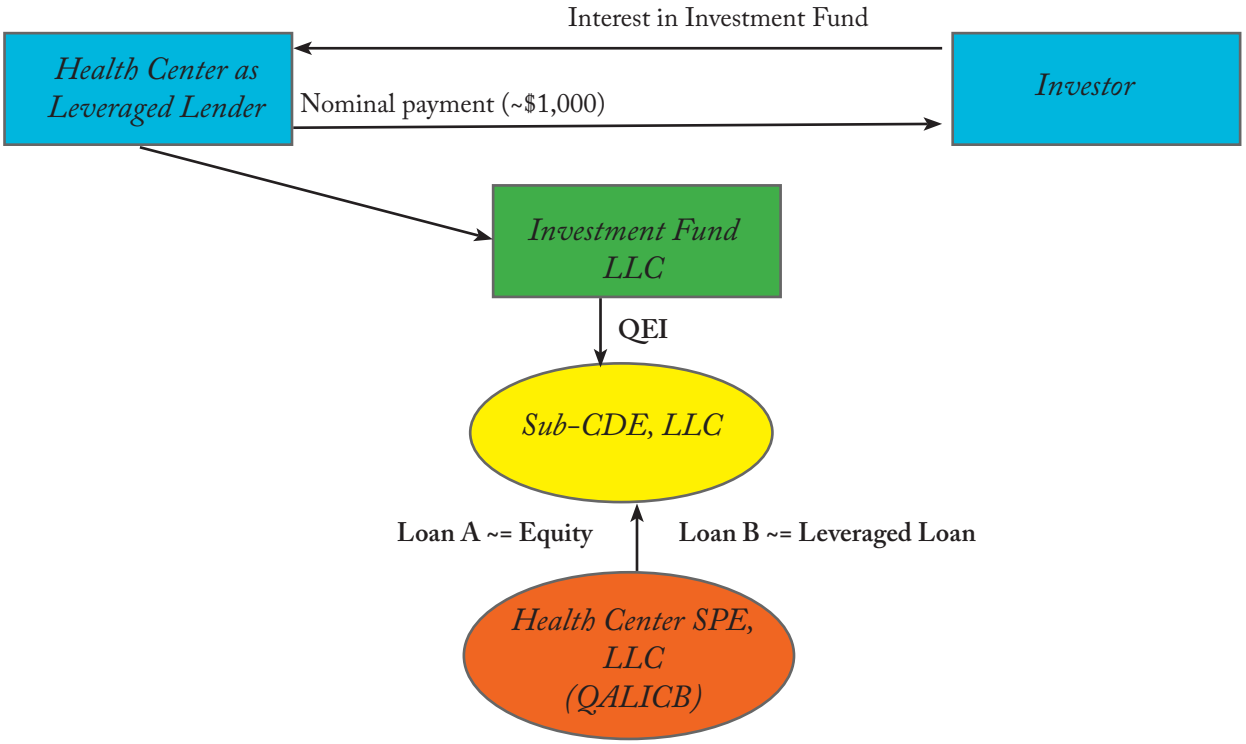
Obligation to Repay the Leveraged Loan

It is essential for the health center and QALICB to understand that with the acquisition of the ownership of the investment fund, the QALICB is also acquiring the obligation to repay the leveraged loan. If, as in many health center transactions, the health center is the leveraged lender, this is not a problem. Effectively, this amounts to an accounting transaction in which the health center owes money to itself and cancels the debt. If the leveraged lender was a third party (such as a bank) the terms of the leveraged loan will have made it due and payable on the day the tax credit period expires. In this case, it is imperative that the health center arrange for a take-out loan or the agreement of the leveraged lender to renew the loan, well in advance of the end of the tax credit period. Also, management should be aware that if the land and building are owned by a separate SPE distinct from the health center itself, there could be excise or transfer tax liability as a result of the transfer or sale of the project back to the health center.

The steps below and chart on the next page outline the basic wind up process utilizing the usual NMTC structuring format.

1. Before wind up, the investment fund's only asset is the QEI in the sub-CDE and its primary liability is a note to the leveraged lender (LL).
2. At the end of the seven-year tax credit period, Notes A and B to the sub-CDE are due in full.
3. The put period begins immediately upon expiration of the seven-year tax credit period. Investor offers to put interest in investment fund to leveraged lender for nominal price.
4. The LL now owns the investment fund and its primary asset, the QEI to the sub-CDE and its primary liability, the leveraged loan. The LL now owes the balance of Note B to itself and simply cancels it. The LL then consolidates and dissolves the investment fund and takes the value of Note A to equity.

Steps in the Wind Up of a Typical NMTC Transaction



In summary, while the NMTC industry continues to evolve toward a more standardized structure, older transactions that are now approaching their wind up date may have idiosyncrasies that could materially affect the wind up process. In preparation, health center management should:

- If there is true hard debt in the transaction that comes due at the end of the tax credit period, begin talking to potential take-out lenders early (one year in advance is not too soon);
- Re-read all the pertinent documents including the put/call agreement, loan agreement, and any amendments to those documents to fully understand the wind up process and the order of required actions;
- Consult and engage counsel to assist in the wind up process especially if there were unusual aspects to the original deal structuring;
- Talk to the CDE to understand their approach to the wind up and especially to discuss any timing issues with loan payments that may come due during the put option period;
- Consult with the health center's auditor to be sure they understand the implications of the wind up on the health center's statements (and any tax implications);
- Work with the board of the QALICB/SPE to ensure that all understand what will happen during the wind up process and what actions/votes may be required of them.

While management may not fondly recall how long and complicated the NMTC closing process was, they must remember the old adage "It's not over 'til it's over." None of the benefits promised will be realized until and unless the wind up process is completed on time and as stipulated in the original transaction documentation.

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About Capital Link

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