Business Session

Health Care Issues

Hon. K. Rodney May, Moderator
U.S. Bankruptcy Court (M.D. Fla.); Tampa

Scott B. Davis
Grant Thornton LLP; Charlotte, N.C.

Suzanne Koenig
SAK Management Services, LLC; Northfield, Ill.

Robert A. Soriano
Greenberg Traurig, LLP; Tampa

Frank P. Terzo
GrayRobinson, PA; Fort Lauderdale

ISSUES IN HEALTH CARE BUSINESS CASES

Honorable K. Rodney May, Moderator
Suzanne Koenig, President SAK Management Services, LLC, Chicago
Scott Davis, Partner, Grant Thornton, LLC, Charlotte
Frank P. Terzo, Shareholder, Gray-Robinson, Miami
Robert Soriano, Partner, Greenburg Traurig, Tampa

I. Overview of the "Drivers" of Health Care Business Insolvency (Ms. Koenig, Mr. Davis)

- Case dynamics
  (secured creditors, providers, investors, regulators)

II. Patient Care Ombudsman (11 U.S.C. § 333) (Ms. Koenig, Mr. Terzo)

- When is appointment required or otherwise appropriate?
- What is the PCO supposed to do?
- How does a person get appointed PCO?
- How does the PCO get paid?
- Can a PCO hire professionals?
- What can a PCO do beyond filing reports?

III. Financial Issues in Health Care Insolvency (Mr. Davis, Ms. Koenig, Mr. Soriano)

- How do reimbursement reports get audited and adjusted?
- How can the government impact cash flow by recoupment?
- What are some other special needs in restructuring?
  - contingent liabilities
  - vendor management
  - potential closure and patient care issues
  - board/management desire to maintain independence or at least retain control
  - regulatory issues

IV. Asset Sales in Health Care Business Cases (Mr. Soriano, Mr. Terzo, Mr. Davis)

- How is the strategic decision made to use a § 363 sale or confirmation of a Chapter 11 plan?
- What will the regulators want and how do you deal with them?
- What must be done to sell special assets like CON's, provider contracts, medical equipment leases?
- Is "higher" or "better" the correct standard?
- What special buyer qualifications must be considered?
- How do strategies differ for for-profit buyers or sellers v. not-for-profit buyers or sellers?

- What additional legal hurdles must be considered?
    - Antitrust
    - Hart-Scott-Rodino Compliance
    - State regulators (e.g. Massachusetts)
- Are there any special bid procedures or conditions for a sale?
- How do buyers and sellers push the envelope (scope of releases for the buyer and for the seller's principals)?

V. Plan Confirmation Issues (Mr. Soriano, Mr. Terzo, Mr. Davis)

- How do you deal with objections by regulators?
- How do you resolve offsets or recoupment by payors?
- What special proof of feasibility is required?
- Are there any classifications/voting issues (e.g., patients' claims)?
- What lessons can be learned from the Bayou SNF case?

PCO's

In re Pediatrics at Whitlock, P.C., 507 B.R. 10 (Bankr. N.D. Ga. 2014)

In re Denali Family Services, 2013 WL 1755481 (Bankr. D. Alaska, April 24, 2013)

In re Alternate Family Care, 377 B.R. 754 (Bankr. S.D. Fla. 2007)

In re Beam Mgmt., LLC – PCO's Report (08/03/10)

In re Horizon Health Center, Inc., PCO's Letter to court regarding sufficient time to move patients (01/12/15)

In re Brotman Medical Center, Inc., PCO's response regarding cash collateral and DIP financing (04/08/08)

Recoupment

"Recoupment in Health Care Bankruptcies: A Shrinking Issue," Harold L. Kaplan and Timothy R. Casey, AM. BANK. INST. J., October 2007

Ravenwood Healthcare, Inc., v. State of Maryland (D. Md., June 5, 2007)

Section 363 Sales

In re Axcess Medical Imaging Corp., - Bid Procedures order (11/30/09)

In re Beam Mgt, LLC, - Bid Procedures Order (11/14/11)

In re Universal health Care Group, Inc., - Bid Procedures Order 02/22/13)

Plan Confirmation

In re Regional Care Services Corp., - Disclosure Statement (03/28/14)

In re Bayou Shores SNF LLC, – Debtor's emergency motion to enforce automatic stay (08/21/14)

In re Bayou Shores SNF LLC, – Order granting debtor's emergency motion (08/25/14)

In re Bayou Shores SNF, LLC, - Memorandum Opinion on Confirmation (12/31/14).

(Doc. No. 6). On January 13, 2013, Plaintiff filed a *Motion for Default Judgment* (Doc. No. 7) (the "Motion"). Plaintiff now seeks default judgment. For the reasons set forth below, the Motion will be ***granted***.

[1] Plaintiff's undisputed allegations show that Debtor's debt to Plaintiff—specifically, a $9,745.50 judgement entered in the Magistrate Court of DeKalb County, Georgia—arose from "malicious and willful theft by the defendant." Plaintiff asserts that Debtor stole an engagement ring from Plaintiff.

[2, 3] Under 11 U.S.C. § 523(a)(6), debts arising from "willful and malicious injury" are excepted from § 727 discharge. "A debtor is responsible for a 'willful' injury when he or she commits an intentional act ... which is substantially likely to cause injury." *Hope v. Walker*, 48 F.3d 1161, 1165 (11th Cir.1995). Loss of property is among the types of "injury" contemplated by § 523(a)(6). *Cf. In re Wolfson*, 56 F.3d 52, 54 (11th Cir.1995) ("Willful and malicious injury includes willful and malicious conversion[.]")

[4] Debtor also requests costs and fees associated with bringing this proceeding. Under the "American Rule" each party to a legal proceeding is generally responsible for his or her own fees and expenses. *Johnson v. Florida*, 348 F.3d 1334, 1350 (11th Cir.2003). Generally, statutory authority is required for departure from the American Rule. *Id.* Plaintiff has not pointed to any such authority excepting this proceeding from the American Rule. Accordingly, it is hereby

ORDERED that Plaintiffs motion for default judgment is ***granted:*** the $9,745.50 judgement entered in the Magistrate Court of DeKalb County, Georgia is non-dischargeable under § 523(a)(6). It is further

ORDERED that each party is responsible for its own fees and costs associated with this proceeding.

IT IS SO ORDERED.

In re PEDIATRICS AT WHITLOCK, P.C., Debtor.

No. 14–52367–MHM.

United States Bankruptcy Court,
N.D. Georgia,
Atlanta Division.

Signed March 4, 2014.

Filed March 5, 2014.

Background: Chapter 11 debtor, as operator of outpatient pediatric facility, moved for determination that appointment of patient care ombudsman was not necessary.

Holding: The Bankruptcy Court, Margaret H. Murphy, J., held that appointment of patient care ombudsman was not necessary under facts of case for protection of patients of bankrupt health care provider.

Motion granted.

1. Bankruptcy ⚿3029.1

In deciding whether appointment of patient care ombudsman is necessary for protection of patients of bankrupt health care provider, bankruptcy courts consider the following non-exclusive factors: (1) cause of debtor's bankruptcy filing, and whether it is something other than deficiencies, or alleged deficiencies, in patient care; (2) presence and role of licensing or supervising entities; (3) debtor's past history of patient care; (4) ability of patients to

protect their rights; (5) level of dependency of patients on debtor's facility; (6) likelihood of tension between interests of patients and debtor; (7) potential injury to patients if debtor drastically reduced its level of patient care; (8) presence and sufficiency of internal safeguards to ensure appropriate level of care; and (9) impact of cost of ombudsman on likelihood of successful reorganization. 11 U.S.C.A. § 333.

2. Bankruptcy ⚿3029.1

No patient care ombudsman would be appointed for protection of patients of bankrupt health care provider, where nothing in record indicated that debtor's bankruptcy was precipitated by deficiencies in patient care, and there was nothing in record to show that any claims had been made against debtor's malpractice insurance, where debtor operated an outpatient pediatric facility, and nothing in record suggested that debtor's patients or their guardians were unable to protect their own interests, and where it appeared that costs of ombudsman would likely outweigh the benefits of appointing ombudsman. 11 U.S.C.A. § 333.

Paul Reece Marr, Paul Reece Marr, P.C., Atlanta, GA, for Debtor.

Lindsay N.P. Swift, Office of the U.S. Trustee, Atlanta, GA, for U.S. Trustee.

ORDER

MARGARET H. MURPHY, Bankruptcy Judge.

[1] Debtor filed a Chapter 11 petition initiating this case February 3, 2014. On the petition, Debtor indicated that it is a "Health Care Business" for which a patient care ombudsman might be appointed under 11 U.S.C. § 333. On February 27, 2014, Debtor filed a *Motion for Order Finding and Ordering that Appointment of Patient Care Ombudsman is not Necessary* (Doc. No. 34) (the "Motion"). In determining whether an ombudsman is needed, courts have weighed nine non-exclusive factors:

(1) the cause of the bankruptcy;

(2) the presence and role of licensing or supervising entities;

(3) the debtor's past history of patient care;

(4) the ability of the patients to protect their rights;

(5) the level of dependency of the patients on the facility;

(6) the likelihood of tension between the interests of the patient and the debtor;

(7) the potential injury to the patients if the debtor drastically reduced its level of patient care;

(8) the presence and sufficiency of internal safeguards to ensure the appropriate level of care; and

(9) the impact of the cost of the ombudsman on the likelihood of a successful reorganization.

In re Alternate Family Care, 377 B.R., 754, 758 (Bankr.S.D.Fla.2007); *In re Flagship Franchises of Minnesota, LLC,* 484 B.R. 759 (Bankr.D.Minn.2013) (quoting *Alternate Family Care* and collecting cases).

[2] Generally, the first factor weighs against the appointment of an ombudsman when the cause of Debtor's bankruptcy is something other than deficiencies, or allegations of deficiencies, in patient care. *See, Alternate Family Care,* 377 B.R. at 759 (that the bankruptcy was precipitated by a fire at Debtor's facility, rather than patient care or privacy matters, weighed against appointment of an ombudsman); *In re The Total Woman Healthcare Center P.C.,* 2006 WL 3708164 (Bankr.M.D.Ga.,

December 14, 2006) (J. Hershner) (declining to appoint an ombudsman because the debtor's liabilities arose from taxes rather than deficient patient care). Nothing in the record indicates that Debtor's bankruptcy was predicated by deficiencies in patient care, and the Motion asserts that "No claims have been made against Debtor's malpractice insurance" and "Debtor is unaware of any professional malpractice claims, or incidents that could result in claims, against anyone associated with Debtor." For the same reasons, the third factor appears to weigh in favor of granting Debtor's Motion.

Factors four and five also weigh against the appointment of an ombudsman. *Alternate Family Care* involved a foster care and placement agency which provided psychiatric, residential treatment services to emotionally disturbed children. The court in that case concluded that children are generally presumed to be unable to preserve and protect their own interests, and that presumption is particularly appropriate in the case of children with emotional and psychological issues; thus, in that case, the fourth factor weighed in favor of appointing an ombudsman. *Alternate Family Care,* 377 B.R. at 760; *see, also, Flagship Franchises of Minnesota,* 484 B.R. 759 (debtor's patients could not protect their own interests where debtor specialized in care of chronically ill and vulnerable adults, such as those with Alzheimer's, Parkinson's, and brain injuries). Similarly, the fifth factor, as applied to the facts of *Alternate Family Care* and *Flagship Franchises,* weighed in favor of a patient care ombudsman because the patients are unable to protect their own interests. Though Debtor appears to be a pediatric care facility, it is an outpatient facility; nothing in this case suggests that Debtor's patients or their guardians are unable to protect their own interests.

The sixth factor—whether the interests of Debtor and its patients are likely to be in tension—can be evaluated by asking whether a decline in patient care would help Debtor's reorganization. In *Alternate Family Care,* no such tension existed because a decline in patient care would injure the facility's reputation and, consequently, would reduce Debtor's referrals and revenue. 377 B.R. at 760. Similarly, in *Flagship Franchises of Minnesota,* the Court found no tension because, "Without the high standard of care, clients would not use the services and Debtor would lose its licenses." 484 B.R. at 764. For the same reasons, Debtor's incentives in this case appear to align with the interests of Debtor's patients.

As noted by the court in *In re Denali Family Services,* 2013 WL 1755481 at *3 (Bankr.D.Alaska, April 24, 2013), the seventh factor "will almost always support the appointment of an ombudsman." In *Denali,* the court noted that the potential for harm resulting from a drastically reduced level of care is mitigated where other options for treatment are available. Nothing on the record suggests Debtor provides a different type of service than any of the many other pediatric care services in the area. Moreover, the Motion indicates that Debtor maintains comprehensive malpractice insurance.

Neither the Motion nor Debtor's Schedules speak directly to factor two—the presence and role of supervising entities—or factor eight—whether internal safeguards exist to ensure the appropriate level of care. Factor nine—whether the costs associated with the appointment of an ombudsman impacts the likelihood of Debtor's reorganization—is difficult to weigh so early in the case. While Debtor has not presented any evidence of the potential cost of an ombudsman or Debtor's ability

to pay for an ombudsman, this factor typically weighs against an appointment under § 333. *In re Denali Family Services,* 2013 WL 1755481 at *4. Rather than looking at factor nine in isolation, cost of an ombudsman should be weighed against the value of an ombudsman. *Id.* (Finding the cost outweighed the value where other safeguards made an ombudsman redundant). Considering the other factors weigh against appointment of an ombudsman, it appears the costs would likely outweigh the benefits of an ombudsman. Accordingly, it is hereby

ORDERED that the Motion is ***granted;*** subject to subsequent motion by the United States Trustee or other party in interest under Fed. R. Bankr.P.2007.2(b), no patient care ombudsman will be appointed at this time.

IT IS SO ORDERED.

In the matter of CHATHAM PARKWAY SELF STORAGE, LLC, Debtor.

No. 12–42153.

United States Bankruptcy Court,
S.D. Georgia,
Savannah Division.

Signed March 3, 2014.

Background: Chapter 11 debtor filed motion to compel execution of loan documents, as contemplated in its confirmed plan of reorganization. Hearings were held.

Holdings: The Bankruptcy Court, Lamar W. Davis, Jr., J., held that:

(1) the court had authority to direct the parties to execute the loan documents in order to protect the confirmation order and aid in the plan's execution;

(2) the court had authority to supply commercially reasonable terms and conditions to the loan documents where the plan was silent and such terms and conditions would not alter any provision of the plan;

(3) note would be amended as specified by the court;

(4) financial stress experienced by debtor's owner did not constitute legal duress under Georgia law; and

(5) debtor did not establish a claim for economic duress under Georgia law.

So ordered.

1. Bankruptcy ⚿3570

Post-confirmation jurisdiction pursuant to the section of the Bankruptcy Code governing implementation of Chapter 11 plans is generally restricted to protecting the confirmation order, and aiding in the plan's execution. 11 U.S.C.A. § 1142(b).

2. Bankruptcy ⚿3570

On post-confirmation motion of Chapter 11 debtor to compel execution of loan documents, bankruptcy court had authority to direct the parties to execute the loan documents in order to protect confirmation order and aid in plan's execution; addendum expressly stated that debtor would execute the loan documents in favor of bank based on terms of repayment set forth in plan, debtor had drafted four iterations of plan and addendum before terms of repayment were sufficiently detailed and acceptable to both parties, final terms and conditions of plan and addendum were direct result of mediated settlement between the parties, and plan and addendum set forth material terms of loan repayment, including such items as secured

Westlaw.

Slip Copy, 2013 WL 1755481 (Bkrtcy.D.Alaska), 57 Bankr.Ct.Dec. 262
(Cite as: 2013 WL 1755481 (Bkrtcy.D.Alaska))

H

United States Bankruptcy Court,
D. Alaska.
In re DENALI FAMILY SERVICES, Debtor.

No. A13–00114–GS.
April 24, 2013.

MEMORANDUM ON DEBTOR'S MOTION FOR AN ORDER DETERMINING THAT THE APPOINTMENT OF A PATIENT CARE OMBUDSMAN IS NOT NECESSARY

GARY SPRAKER, United States Bankruptcy Judge.

***1** On April 12, 2013, the court held a hearing on debtor in possession Denali Family Services's ("DFS") *Motion Pursuant to 11 U.S.C. § 333(a)(1) for an Order Determining that the Appointment of a **Patient Care Ombudsmen** is not Necessary ("Motion")*. DFS provides services for troubled children, and qualifies as a health care business under the Bankruptcy Code. As a result, 11 U.S.C. § 333(a)(1) requires that an ombudsman be appointed to monitor patient care and represent their interests within the bankruptcy unless the court finds that an ombudsman is not necessary.[FN1] DFS argues that its reorganization does not threaten its level of care, and that existing internal safeguards and governmental supervision render appointment of an ombudsmen unnecessary in this case. DFS' interim chief executive officer, Allen Blair, testified in support of the *Motion*, which is unopposed.[FN2] Based upon Mr. Blair's testimony, and the statements of counsel at the hearing, I agree that the appointment of an ombudsman is not necessary at this time.

FN1. 11 U.S.C. § 333(a)(1).

FN2. Mr. Blair has worked for DFS since 1999, and has served as its clinical director since 2004. He became the interim CEO in February 2013 when the discovery of substantial tax issues forced DFS's prior CEO to resign. *Declaration of Allen Blair in Support of Chapter 11 Petition and Debtor's First Day Motion* (Docket No. 2), at 1.

DFS provides a wide range of behavioral health services to severely emotionally disturbed children, including psychiatric assessments and counseling, placement in foster homes, case management, skills teaching, after school programs, and a therapeutic preschool. It has roughly 171 employees and works with about 50 foster care families. It employs one psychiatrist for psychiatric assessments, and a number of clinical staff who provide therapy treatment under the supervision of Mr. Blair and another individual. DFS serves roughly 500 children, ranging anywhere from 3 to 24 years of age, annually.

DFS is a grantee of the State of Alaska, subject to a number of municipal, state, and federal statutes and regulations. Its operations are closely supervised by the Alaska Department of Health and Social Services, Division of Behavioral Health, which conducts a periodic audit of its operations.[FN3] All staff are required to undergo structured training, and must document all patient treatments and encounters for review and auditing. DFS has a detailed internal grievance policy, including an online component that allows complaints to be made without direct confrontation. Complaints are administered by a designated Quality Assurance Person responsible for reviewing grievances, conducting periodic audits, and compiling client data for review.

FN3. Mr. Blair testified that periodic audits were conducted, but could not remember if they were performed annually or biannually.

Recognizing that patients of a health care business in bankruptcy may have greatly different interests from a debtor's creditors, § 333(a)(1) of the Bankruptcy Code mandates that the court appoint a **patient care ombudsmen** to advocate for, and rep-

resent, the patients' interests.[FN4] The ombudsman is charged with monitoring the quality of patient care, filing reports with the court every 60 days regarding the quality of patient care, and if the quality of care declines significantly, filing a motion with the bankruptcy court so that the issue can be addressed.[FN5] Section **333**(a)(1) authorizes courts to forego appointment of an ombudsman, but only where the debtor proves that "the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case."[FN6] Such a determination necessarily requires a careful examination of the totality of circumstances surrounding the debtor's bankruptcy and operations.[FN7] Courts have applied a nine factor analysis to evaluate the need for appointment of an ombudsman:

FN4. 3 *Collier on Bankruptcy* ¶ **333**.01 at **333**–3(Alan N. Resnick & Henry J. Sommers eds. 16th ed.).

FN5. 11 U.S.C. § **333**(b)(1)-(3).

FN6. 11 U.S.C. § **333**(a)(1).

FN7. *In re Alternate Family Care*, 377 B.R. 754, 758 (Bankr.S.D.Fla.2007).

***2** (1) the cause of the bankruptcy;

(2) the presence and role of licensing or supervising entities;

(3) debtor's past history of patient care;

(4) the ability of the patients to protect their rights;

(5) the level of dependency of the patients on the facility;

(6) the likelihood of tension between the interests of the patients and the debtor;

(7) the potential injury to the patients if the debtor drastically reduced its level of patient care;

(8) the presence and sufficiency of internal safeguards to ensure the appropriate level of care;

(9) the impact of the cost of the ombudsman on the likelihood of a successful reorganization.[FN8]

FN8. *Id*. at 758; *see also In re Flagship Franchises of Minnesota, LLC*, 484 BR 759, 762 (Bankr.D.Minn.2913)(collecting cases).

No single factor is determinative, and the weight to be given individual factors depends upon the circumstances of the case.[FN9]

FN9. *Flagship Franchises*, 484 B.R. at 762 .

In the case of DFS, four of the above factors weigh in favor of the appointment of an ombudsman to varying degrees. The third factor—the debtor's history of patient care—tips slightly in favor of the appointment of an ombudsman. DFS has operated for 18 years, and no regulatory actions or restrictions have been taken against it. The State of Alaska was given notice of DFS's *Motion,* and has filed no response. Although the State has not opposed the *Motion,* and has not had to take any corrective action against DFS, there was evidence that issues have arisen with regard to DFS's patient care. Mr. Blair testified that DFS occasionally receives contact from parents asking it to change counselors or complaining about the timeliness of staff responses to questions. However, it appears DFS is responsive to these complaints. According to Mr. Blair, DFS consistently works to match counselors to the children, and makes changes if an issue arises. He is also aware that at least one individual has received more than one complaint that calls were not timely returned, and DFS has addressed that matter internally.

More troubling was a prepetition incident involving two teenagers who, while waiting for a counseling session, made plans to have sex on DFS premises. This incident has been listed as a poten-

tial claim in DFS' schedules. Although this situation did not arise directly out of DFS' services or patient care, it could suggest a lack of supervision. For this reason, I find that this factor weighs in favor of appointing an ombudsman, although the isolated nature of the incident and the absence of any regulatory complaints or action limit the weight placed upon it. Moreover, Mr. Blair's testimony established that DFS is aware of the issues involved in its patient care and promptly addresses them as they arise. The overwhelming majority of issues relating to patient care relate to the compatibility of counselors and patients, and are accommodated as a matter of policy. The appointment of an ombudsman would not prevent these issues from arising, nor does it appear that an ombudsman would facilitate their resolution.

The fourth factor—the ability of the patients to protect their rights—also weighs in favor of the appointment of an ombudsman. It is unlikely that minors, particularly those with emotional or psychological issues, would be able to protect their rights as health care patients.[FN10] DFS' clients are children, most of whom have behavioral issues. DFS admits that they are not well equipped to protect their own interests.[FN11] However, most of these children have parents or guardian ad litems who are involved in their care. Presumably, they are able to protect their children's rights, particularly because DFS' services are provided on an outpatient basis, giving them the ability to monitor the care given.[FN12] Moreover, Mr. Blair testified that the bankruptcy has not affected DFS' services to its patients. The bankruptcy has not increased the risk to the patients, or otherwise altered whatever ability they had to protect themselves prior to the bankruptcy.[FN13] While the fourth factor supports the appointment of an ombudsman, the circumstances of this case limit its weight.

FN10. *Alternate Family Care*, 377 BR at 760.

FN11. *Id*. at 760 ("By presumption children are generally unable to protect and preserve their interests.")

FN12. *In re Genesis Hospice Care, LLC*, 2009 WL 467265 *2 (Bankr.N.D.Miss. Feb. 24, 2009)(need for ombudsman is lessened where debtor provides only outpatient services); *In re North Shore Hematology–Oncology Assoc*., 400 B.R. 7, 12 (Bankr.E.D.N.Y.2008).

FN13. *Alternate Family Care*, 377 B.R. at 760 ("the children's inability to advocate or protect their own interests is not something that is heightened by virtue of the bankruptcy.")

***3** Factors five and seven require the court to look at the level of dependency of the patients on DFS and the potential injury to the patients if DFS drastically reduced its level of patient care. These factors will almost always support the appointment of an ombudsman.[FN14] The court has no doubt that DFS' clients currently depend upon the continuation of its services, and would be harmed if DFS was required to drastically reduce them. Such harm could be mitigated, however, because other options for treatment are available. Mr. Blair testified that two other entities provide similar, albeit less comprehensive, services for troubled children. The fifth and seventh factors support the appointment of an ombudsman under the circumstances of this case.

FN14. *In re Flagship Franchises of Minnesota, LLC*, 484 B.R. 759, 764–65 (Bankr.D.Minn.2013); *In re Valley Health System*, 381 B.R. 756, 763–764 (Bankr.C.D.Cal.2008); *Alternate Family Care*, 377 B.R. at 760.

The remaining factors weigh in favor of DFS' *Motion*. Its bankruptcy was precipitated by the discovery of substantial unpaid federal employment taxes rather than patient care issues.[FN15] Mr. Blair testified that, unbeknowst to DFS' board of directors, prior management elected to continue lease payments for unused space rather than pay its em-

ployment taxes, resulting in a substantial federal tax debt. DFS has filed bankruptcy to reorganize its operations, reject several leases, and establish a payment plan for the past due taxes. There is no evidence that the bankruptcy is related to the care of its clients or, more specifically, deficiencies in that care.

> FN15. The Internal Revenue Service has filed Proof of Claim No. 4 asserting a priority claim in the amount of $1,530,688.06 under 11 U . S.C. § 507(a)(8).

Because the bankruptcy is the result of a discrete financial problem, the court is also convinced that there is no tension between the interests of the debtor and its patients. Mr. Blair believes that the rejection or renegotiation of the excess leased space will allow DFS to return to financial health. Such business decisions should not affect patient care. Mr. Blair testified that the chapter 11 filing would not cause DFS to reduce either its patient services or its staffing levels. It is in DFS' best interests to maximize patient care which, in turn, will maximize its revenue.

As with most health care businesses, DFS is subject to governmental supervision of its patient care.[FN16] The Alaska Division of Behavioral Health closely supervises its patient care and audits its operations. DFS is also accredited by the Council of Accreditation. This is an international, not for profit, child and family service and behavioral health care accrediting organization that Mr. Blair described as the equivalent of the Joint Committee on Accreditation for Hospital Organizations.[FN17] Because DFS is already subject to governmental oversight, the appointment of an ombudsman would be redundant.

> FN16. DFS's operation of a preschool is also regulated by the Municipality of Anchorage.

> FN17. *See In re Barnwell County Hosp.*, 2011 WL 5443025 *2 (Bankr . D.S.C.2011) (considering debtor's accreditation by the Joint Committee); *Valley Health Systems*, 381 BR at 762 (same).

DFS also has a number of internal safeguards in place. Mr. Blair testified that all staff have structured training upon commencement of their employment with DFS and annual training requirements thereafter. New hires are mentored and receive ongoing supervision. All patient notes and encounters are audited and reviewed by a supervisor. All assessments and treatment plans are audited for review. DFS must make quarterly reports to the State of Alaska which it also uses to track client outcomes. Complaints about patient care may filed formally with DFS or the State of Alaska, as well as online. DFS has designated a "quality assurance person" who is responsible for all complaints, performs periodic audits and aggregates client data for reporting and performance review. This person essentially acts as an internal **patient care ombudsmen**. Finally, Mr. Blair advised the court that he will be stepping down as interim CEO, but will remain with the debtor on a part-time basis to provide supervision and conduct additional quality assurance review. DFS' existing internal safeguards weigh heavily against appointment of an ombudsman.

***4** Finally, courts have considered the impact the cost of an ombudsmen would have on a successful reorganization. This factor typically weighs against appointment of an ombudsman.[FN18] DFS has not presented any evidence as to this potential cost, but any additional administrative expense would obviously have a negative impact on the debtor's reorganization. DFS faces substantial priority tax claims that must be paid in full under any plan of reorganization. Any monies used for an ombudsman reduce the amounts available to promptly pay the tax debt and limit any return to the general unsecured creditors. Still, any negative cost impact must always be balanced against the potential risk to the debtor's patients if additional oversight from an ombudsman is not provided. Here, costs militate

against a need for appointment of an ombudsman, but only because the other factors discussed above—DFS' assurances that its bankruptcy has not affected its level of patient care, the absence of any objections, including the State of Alaska, and the existing internal safeguards and external supervision—demonstrate that patient care is already protected. Under the circumstances of this case, the cost of an ombudsman is accorded little weight.

> FN18. *Valley Health System*, 381 B.R. at 764. In an appropriate case, the ombudsman may be able to retain counsel as well, potentially incurring additional administrative expense. *See In re Synergy Hematology–Oncology Medical Assoc.*, 433 B.R. 316, 319 (Bankr.C.D.Cal.2010).

Having considered the totality of circumstances in this case, the court is persuaded that appointment of an ombudsman is not necessary for the protection of DFS's patients. Patient care issues did not precipitate DFS' bankruptcy, nor is there any indication that patient care will be jeopardized within the chapter 11. DFS filed bankruptcy to shed extraneous expenses and come to terms with its tax debt. It has identified specific steps to get there, and has already rejected two leases. The nature of DFS' outpatient services and the absence of overnight or extended stays minimizes the risk of harm to patients. DFS has further minimized that risk by creating internal procedures to identify and address problems with patient care. It already employs a quality assurance person that acts as an internal ombudsman. Moreover, there is sufficient regulatory oversight to ensure that any deterioration in patient care is promptly brought to the attention of the debtor, the U.S. Trustee, and this court. Appointment of an ombudsman under such circumstances would be redundant.

For these reasons, the court will grant DFS' *Motion*. That being said, § **333**(a)(1) is clear that the protection of patients' interests is paramount when a health care business seeks reorganization. Accordingly, if there is a change in circumstances such that the care to DFS' patients is jeopardized, or if new evidence is discovered that would raise concerns about such care, the United States Trustee or any party in interest may move for the appointment of a **patient care ombudsman** under Fed. R. Bank. P.2007.2(b).

An order will be entered consistent with this *Memorandum*.

Bkrtcy.D.Alaska,2013.
In re Denali Family Services
Slip Copy, 2013 WL 1755481 (Bkrtcy.D.Alaska), 57 Bankr.Ct.Dec. 262

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tracted from BHS's 2006 check stubs (Pl.'s Tr. Ex. 58). The $27,624.73 encompasses rental paid on defendant's residence ($14,020.00); American Express charges ($7,154.87); Florida Power & Light Company utility service for defendant's residence ($2,783.59); life insurance premiums paid to Prudential Financial ($1,638.59); attorneys' fees, including the fee paid to his bankruptcy counsel ($1,550.00); Allstate Insurance Company ($88.64); Adelphia Cable ($133.78); and a doctor's bill paid to a Dr. Gonsky ($255.00). Exclusions from income must be narrowly construed. *Commissioner v. Schleier*, 515 U.S. 323, 115 S.Ct. 2159, 132 L.Ed.2d 294 (1995). "[I]f the payment proceeds primarily from the constraining force of any moral or legal duty, or from the incentive of anticipated benefit of an economic nature, it is not a gift." *Commissioner v. Duberstein*, 363 U.S. 278, 285, 80 S.Ct. 1190, 4 L.Ed.2d 1218 (1960). In light of the defendant's employment by BHS, which is solely owned by Dr. Ginsberg, and considering the varying nature of the numerous payments made by BHS on behalf of defendant, the Court determines that the afore-referenced $27,624.73 constitutes income to defendant, which should have been included in the defendant's response to Question 1 of defendant's Statement of Financial Affairs. Considering the magnitude of the "oversight", the Court concludes that defendant's omission was made knowingly and fraudulently to mislead his creditors and his bankruptcy trustee.

Pursuant to Bankruptcy Rule 7054(a), the Court shall enter Judgment denying the issuance of a Discharge of Debtor to Harry Hale Marsh.

In re ALTERNATE FAMILY CARE, Debtor.

No. 07–18203–BKC–RBR.

United States Bankruptcy Court,
S.D. Florida,
Broward Division.

Oct. 30, 2007.

Background: United States Trustee (UST) filed motion for appointment of patient care ombudsman.

Holdings: The Bankruptcy Court, Raymond B. Ray, J., held that:

(1) debtor, a state-licensed child placing and caring agency, was a "health care business" within the meaning of the Bankruptcy Code, but

(2) an ombudsman was not necessary under the specific facts of this case.

Motion denied.

1. Bankruptcy ⚿3029.1

If a debtor is a health care business, the bankruptcy court must appoint a patient care ombudsman within 30 days of the commencement of the case unless the court determines an ombudsman is not required. 11 U.S.C.A. § 333(a)(1).

2. Bankruptcy ⚿2021.1

Under the *Pinellas* test, for a debtor to be a "health care business" within the meaning of the Bankruptcy Code (1) the debtor must be a private or public entity; (2) the debtor must be primarily engaged in offering to the general public facilities and services; (3) the facilities and services must be for the diagnosis or treatment of injury, deformity, or disease; and (4) the facilities must be for surgical care, drug treatment, psychiatric care, or obstetric care. 11 U.S.C.A. §§ 101(27A), 333(a)(1).

3. Bankruptcy ⚿2021.1

Debtor, a state-licensed child placing and caring agency that provided psychiatric residential treatment services to emotionally disturbed children, afforded temporary care for foster children, and facilitated placement of children in foster care relationships throughout the State of Florida, was a "health care business" within the meaning of the Bankruptcy Code; debtor was a public or private entity, debtor had a website and it was possible for members of the general public to access debtor's services, even though most of its business came through referrals from other agencies, the psychological and emotional issues that afflicted the children under debtor's care rose to the level of disease, and debtor's services or facilities were used for drug treatment and/or psychiatric care. 11 U.S.C.A. §§ 101(27A), 333(a)(1).

See publication Words and Phrases for other judicial constructions and definitions.

4. Bankruptcy ⚿3029.1

For purposes of determining whether to appoint a patient care ombudsman, if a condition is severe enough to warrant a course of medically supervised treatment, whether or not it involves pharmacological treatment, such a condition is sufficient to meet the requirements of the Bankruptcy Code's definition of "health care business," namely, that the debtor's services or facilities be used for the "treatment of injury, deformity or disease." 11 U.S.C.A. §§ 101(27A), 333(a)(1).

See publication Words and Phrases for other judicial constructions and definitions.

5. Bankruptcy ⚿3029.1

In evaluating whether the appointment of a patient care ombudsman is necessary for the protection of patients under the specific facts of a case, the bankruptcy court will examine the totality of the circumstances surrounding the bankruptcy filing and the operations of the debtor. 11 U.S.C.A. § 333(a)(1).

6. Bankruptcy ⚿3029.1

In evaluating whether appointment of a patient care ombudsman is necessary for the protection of patients under the specific facts of a case, the bankruptcy court analyzes the following non-exclusive list of nine salient factors: (1) cause of the bankruptcy, (2) presence and role of licensing or supervising entities, (3) debtor's past history of patient care, (4) ability of patients to protect their rights, (5) level of dependency of patients on the facility, (6) likelihood of tension between interests of patients and debtor, (7) potential injury to patients if debtor drastically reduced its level of patient care, (8) presence and sufficiency of internal safeguards to ensure appropriate level of care, and (9) impact of the cost of an ombudsman on likelihood of a successful reorganization. 11 U.S.C.A. § 333(a)(1).

7. Bankruptcy ⚿3029.1

Appointment of patient care ombudsman was not necessary under specific facts of case of debtor, a state-licensed child placing and caring agency that provided psychiatric residential treatment services to emotionally disturbed children, afforded temporary care for foster children, and facilitated placement of children in foster care; although children under debtor's care were highly dependent and were unable to adequately protect themselves without help and would suffer if debtor reduced its level of patient care, there was a tremendous amount of supervision and oversight of debtor from other state and private entities, as well as other in-house procedural safeguards, cause of debtor's bankruptcy, a fire at its primary facility, was not in any way related to patient care,

debtor had history of few patient care complaints, both debtor and patients had substantial interest in seeing debtor successfully reorganize, and cost of ombudsman would be waste of scarce financial resources. 11 U.S.C.A. § 333(a)(1).

Bradley S. Shraiberg, Esq., John E. Page, Boca Raton, FL, Eyal Berger, Esq., Miami, FL, for Debtor.

Denyse Heffner, Office of the U.S. Trustee, Miami, FL, for U.S. Trustee.

MEMORANDUM OPINION DENYING MOTION TO APPOINT HEALTH-CARE OMBUDSMAN

RAYMOND B. RAY, Bankruptcy Judge.

THIS MATTER came before the Court for hearing on October 26, 2007 upon the *Motion to Appoint Patient Care Ombudsman* [D.E. 20] filed by the United States Trustee and the Debtor's response thereto [D.E. 21]. At the hearing Alternate Family Care, the debtor, (hereafter "AFC") was represented by Counsel and Dr. Ronald Simon the secretary and treasurer of AFC. Also present at the hearing was the United States Trustee, through Counsel and the Guardian ad Litem for a minor child who is under the supervision of AFC. At the hearing the Court received into evidence proffered testimony of Dr. Simon. The Court has also thoroughly reviewed the file and the AFC's website. Based on the following analysis the Court declines to appoint a patient care ombudsman.

The facts of this case can be described as ugly, but relatively simple. AFC is a state licensed child placing and caring agency that provides psychiatric residential treatment services to emotionally disturbed children, affords temporary care for foster children and facilitates placement of children in foster care relationships throughout the State of Florida. AFC has been in business for over 20 years. Dr. Simon founded AFC on the premise that "specially selected, trained, and supported foster parents could successfully care for seriously emotionally disturbed children in a private residential home setting." *Affidavit of Dr. Simon* [D.E. 36].

At the timing of the filing AFC ran three group homes and two residential facilities. The children in these locations are under constant supervision of AFC. AFC also oversees the placement of children with foster parents. In total there are approximately 109 children under AFC's care or supervision. A slight majority of the children are in foster care placements, with the rest in one of the five facilities.

[1] Pursuant to 11 U.S.C. § 333(a)(1) [1], if a debtor is a healthcare business the Court must appoint an ombudsman within 30 days of the commencement of a case unless the Court determines an ombudsman is not required.

The appointment of an ombudsman is determined by the results of a two part test. First the Court must decide if AFC is a healthcare business as defined in § 101(27A). Second, if the Court finds AFC to be a healthcare business it must appoint an ombudsman unless it finds "such ombudsman is not necessary for the protection of patients under the specific facts of the case." § 333(a)(1).

1. 11 U.S.C. § 333 was added, effective for all cases filed on or after October 17, 2005, by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (''BAPCPA''). Unless otherwise noted, all code references are to Title 11 of the United States Code, also known as the Bankruptcy Code.

Is the Debtor a Healthcare Business?

At the same time that Congress added § 333 it also amended § 101 by adding § 101(27A) which defines the term "health care business". The definition section is divided into two parts. The first part § 101(27A)(A) proposes a general definition. The second part, § 101(27A)(B) is a rather large list of types of entities that are healthcare businesses. AFC does not fit into any of the businesses listed in § 101(27A)(B). Therefore, for AFC to be considered a healthcare business it must meet the § 101(27A)(A) definition.

[2] The leading case on § 101(27A)(A) is *In re Medical Assc. of Pinellas, LLC,* 360 B.R. 356 (Bankr.M.D.Fla.2007). In *Pinellas* the court distilled § 101(27A)(A) into a four part test: (1) the debtor must be a private or public entity; (2) the debtor must be primarily engaged in offering to the general public facilities and services; (3) the facilities and services must be for the diagnosis or treatment of injury, deformity or disease; and (4) the facilities must be for surgical care, drug treatment, psychiatric care or obstetric care. *In re Medical Assc. of Pinellas, LLC,* 360 B.R. at 359.

[3] The first element is undisputed. AFC is indeed either a private or public entity. This Court agrees with the observation made by Judge Williamson that the first prong of the test "includes almost every conceivable entity." *In re Medical Assc. of Pinellas, LLC,* 360 B.R. at 359.

The second prong requires that AFC be "primarily engaged in offering to the general public facilities and services". *See* § 101(27A)(A). In *Pinellas,* the court determined that the debtor was not a health care business. This determination was based primarily on the fact that the debtor was engaged in providing support services to doctors. *Pinellas* 360 B.R. at 357. The court noted that the debtor "did not advertise or procure patients on behalf of the member doctors nor were the doctors doing business under the name of [the debtor] but instead conducted business in their individual names or the names of their individual professional associations." *Pinellas* 360 B.R. at 360. According to the court this limitation on its services meant that the debtor failed the second prong of the test; namely, that the services were not offered to the public. *Id.* The court further noted that services provided were administrative in nature and not for the purposes of diagnosis or surgery. *Id* at 360.

The same result was reached in *In re 7–Hills Radiology LLC,* 350 B.R. 902 (Bankr.D.Nev.2006)(J. Markell). In that case the debtor was a radiology clinic that only tested patients who were there by referral. *Id* at 904. Further "after the tests are given, [the debtor] does not advise the patients of the test results. Instead it simply sends the reports to the treating physician, who reviews them with the patient." *Id.* The court held that because only referred patients could receive an x-ray, the business was not held out to the public and as such did not meet the definition of a health care business. *Id.*

AFC presents a more complicated situation. First, AFC has on its website a link titled "placement availability". This link includes a number to contact. Second, the very presence of the website suggests that AFC has a public presence and with the link mentioned it is plausible to suggest that it is offering its services to the general public. Third, Dr. Simon stated that it is possible for parents to approach AFC for help in dealing with their child's emotional or psychological problems. Dr. Simon also noted that such cases are exceedingly rare and represent a very small

minority of the children that are under the care of AFC. The vast majority of the children under AFC's care are referred to AFC from another agency.

The striking similarity between AFC and the *7–Hills Radiology* case is that referrals were the vital method which the debtor procured business. However, there are two key differences. In *7–Hills Radiology* referrals were the only way for a member of the public to access the debtor's services. Whereas, in AFC's case it is possible, though rare, for a member of the public to access AFC's services. Secondly, in *7–Hills Radiology* the debtor only administered the x-ray, it was otherwise uninvolved in the day to day care of the patients or their treatment. AFC on the other hand has extensive and continuing responsibilities for the well-being of the children in its custody or over which it has supervision. Accordingly, based on its website and the cases where members of the general public have contacted the debtor directly for services the Court finds that AFC is indeed offering services to the general public.

[4] The third prong requires the services or facilities be used for the "treatment of injury, deformity or disease." § 101(27A)(A). This prong is clearly met. In the opinion of the Court if a condition is severe enough to warrant a course of medically supervised treatment, whether or not it involves pharmacological treatment, such a condition is sufficient to meet the requirements of § 101(27A). The psychological and emotional issues that afflict the children under AFC's care rise to the level of disease.

The final prong requires that the services or facilities be used for surgical care, drug treatment, psychiatric care or obstetric care. This prong is also easily met. AFC's mandate is to provide psychiatric treatment services to emotionally disturbed children. Further, according to Dr. Simon as many as 90% of the children under AFC's supervision receive medications of some sort. This is sufficient to find that the fourth prong is met.

Accordingly, the Court finds that AFC does meet the definition of the a healthcare business. The Court now turns to examine the second step of the test and determine whether under the facts of this case a healthcare ombudsman is necessary.

Is an Ombudsman Necessary Under The Specific Facts of The Case?

[5, 6] Pursuant to § 333(a)(1) the Court must appoint an ombudsman "unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case." § 333(a)(1). In making this evaluation the Court will examine the totality of the circumstances surrounding the bankruptcy filing and the operations of the debtor. This determination will be made by analyzing the following non-exclusive list of nine salient factors:

(1) the cause of the bankruptcy;

(2) the presence and role of licensing or supervising entities;

(3) debtor's past history of patient care;

(4) the ability of the patients to protect their rights;

(5) the level of dependency of the patients on the facility;

(6) the likelihood of tension between the interests of the patients and the debtor;

(7) the potential injury to the patients if the debtor drastically reduced its level of patient care;

(8) the presence and sufficiency of internal safeguards to ensure appropriate level of care;

(9) the impact of the cost of an ombudsman on the likelihood of a successful reorganization.

[7] The first factor is the cause of the bankruptcy. In *In re: Saber* the debtor was a medical professional corporation that provided plastic surgery to patients. *In re William L. Saber, M.D., P.C.*, 369 B.R 631, 633 (Bankr.D.Colo.2007). The company was owned by the sole physician Dr. Saber. *Id.* His only other employees were a secretary, a medical assistant and a patient coordinator. *Id.* The court determined that the debtor did meet the *Pinellas* test and as such was a health care business. *Id* at 637. However, the court determined that under the facts of the case it was not necessary to appoint an ombudsman. *Id.* at 638. In reaching this conclusion the court noted the bankruptcy was not "precipitated by concerns relating to the quality of patient care or patient privacy matters." *Id.* at 637. Rather it was a contractual dispute between the debtor and former employee that caused the bankruptcy filing. *Id.*

This same factor was considered by the court in *In re The Total Woman Healthcare Center P.C.*, 2006 WL 3708164, 2006 Bankr.LEXIS 3411 (Bankr.M.D.Ga.2006). In that case the court noted that "[m]ost of [the debtor's] obligations appear to be for taxes. The obligations do not appear to arise from deficient patient care." *In re The Total Woman Healthcare Center P.C.*, 2006 WL 3708164 at *2, 2006 Bankr.LEXIS 3411 at *5 (Bankr.M.D.Ga.2006).

Similarly, the cause of the bankruptcy in this case was a fire at AFC's primary facility in Hollywood, Florida. AFC generates revenues by a per diem per child payment from either insurance companies or appropriate government entities. The Hollywood facility was the most profitable facility. AFC did not have adequate insurance to cover the costs of repair and rebuilding the facility. The loss of its most profitable revenue stream coupled with the costs of rebuilding are the direct cause of the bankruptcy. The fire was a result of an electrical failure. Thus the cause of the bankruptcy filing was not related to patient care in anyway. This finding militates against the appointment of an ombudsman.

The second factor looks to see if there are licensing or supervisory entities that are already supervising the level of patient care. In AFC's case they are licensed by several government agencies, including the Florida Department of Child Services. AFC is also subject to supervision by Childnet [2]. Most importantly the vast majority of the children under the supervision of AFC are also under the supervision of a State of Florida Circuit Court by virtue of them being in the foster care system. The child safety net in Florida is already a vast and diffuse bureaucracy. Adding an ombudsman for the pendency of this bankruptcy would be a total duplication of the efforts of the various public and private entities already overseeing the welfare of the children. Accordingly, this factor heavily weighs against the appointment of an ombudsman.

The third factor is the debtor's past history of patient care. The *Saber* court also examined this factor. In that case the court noted "Dr. Saber has practiced more than twenty years and remains in good standing in his profession." *Saber* 369 B.R. at 638. Dr. Simon testified that in the past 20 years there have been many hundreds, if not thousands, of children that have been under the supervision of AFC. In total there have been three complaints

2. ChildNet is a private, not for profit organization created specifically to manage the child protection system in Broward County as part of a statewide program to transfer the responsibility for child protection, foster care, adoptions and related services to community based organizations.

against AFC that related to patient care. The presence of a mere three complaints over the course of 20 years shows that AFC has a remarkable track record of excellence. The Court is convinced that the past history of AFC does not require the appointment of an ombudsman.

The fourth factor is the ability of the patients to protect their rights. If a patient has the faculties to preserve their interests as opposed to a patient that is incapable of articulating and protecting their interests, then the appointment of an ombudsman would be extraneous. In this case the patients are all minor children. By presumption children are generally unable to protect and preserve their interests. In this case it is highly unlikely that children with severe emotional and psychological issues would be able to protect their own interests. The Court is cognizant that many of the children do have guardians ad litem. This factor does seem to weigh somewhat in favor of the appointment of an ombudsman. However, the children's inability to advocate or protect their own interests is not something that is heightened by virtue of the bankruptcy. Accordingly, the Court finds that this factor marginally weighs in favor of the appointment of an ombudsman.

The fifth factor is the level of dependency of the patients on the facility. There is no doubt that all of the children under AFC's care or supervision are highly dependant on AFC for their safety and well being. Accordingly, this factor militates towards the appointment of an ombudsman.

The sixth factor is the likelihood of tension between the interests of the patients and the debtor. In AFC's case there is little tension. AFC is looking to recover from the disastrous effects of the fire at its Hollywood facility. The reduction of patient care would not help AFC's reorganization. This is because a decline in patient care, whether real or perceived, would severely impact AFC's ability to receive placements from referring agencies. These referrals constitute the bulk of the placements AFC receives and make up a large part of its revenue. Further, the largest cost currently facing AFC is the cost of rebuilding the damaged facility, making reductions to patient care absent shuttering the business would not materially affect the solvency of the company. The Court is convinced that there is a low likelihood that patient care will be sacrificed or compromised in order to effectuate the reorganization of AFC. Accordingly, this factor weighs against the appointment of an ombudsman.

The seventh factor is the potential injury to the patients if the debtor drastically reduced its level of patient care. In this case if AFC was to drastically reduce its level of care or cease operations the children could suffer severe trauma. Much of this trauma would be a result of having to move to another facility and possibly having to develop new relationships with new care givers. Furthermore, any substantial interruption in patient care would be negative for the children, if one or more of them did not receive their prescribed medications. Accordingly, the potential risk to the patients if AFC reduced its level of care is quite high, the Court finds that this factor weighs in favor of an ombudsman.

The eighth factor is the presence and sufficiency of internal safeguards to ensure appropriate level of care. Dr. Simon testified that there many internal safeguards to ensure that the children are well cared for. Overall, AFC is licensed and supervised by various state and private agencies. Within AFC the care of the children is handled by professionals. With respect to any medication, it is only given according to a prescription. The staff of AFC are responsi-

ble to make sure the children take the medication at the appropriate times. However, AFC does not prescribe or medicate the children, all prescriptions are made by a licensed doctor. At any given time the children are only handed a single dose of the medication. Finally, any changes to prescription medication, according to Dr. Simon, are made by the child's doctor and are explained to the State Court in charge of the child's well being. These procedures and safeguards are adequate. Accordingly, this factor weighs against the appointment of an ombudsman.

The ninth factor is the impact of the cost of an ombudsman on the likelihood of a successful reorganization. At the time of the filing AFC had assets of $996,825.00 and liabilities of $1,837,130.59. This case is, as the Court stated at the hearing, "dead on arrival." The only thing keeping AFC alive and functioning is the financial commitment of Dr. Simon. Dr. Simon lent AFC $75,000 in emergency post petition financing. He has also agreed to extend $500,000 in debtor-in-possession financing. The lack of cash and the inability to obtain financing from conventional sources are clear indicators that this case cannot afford an ombudsman. As such, this factor weighs against the appointment of an ombudsman.

Based on the foregoing it is evident that the patients are highly dependant on AFC and are unable to adequately protect themselves without help and would suffer if AFC reduced its level of patient care. However, there is a tremendous amount of supervision and oversight on AFC from other state and private entities. This supervision is coupled with extensive in house procedural safeguards. Furthermore, the cause of the bankruptcy was not in anyway related to patient care. In fact, the past history of AFC shows that it has been relatively free of patient care complaints. Finally, the lack of tension between the interests of the patients and AFC is readily apparent, both the patients and AFC have a substantial interest in seeing AFC successfully reorganize. To this end the cost of an ombudsman would be a waste of scarce financial resources and would merely add another layer of bureaucracy to an already heavily regulated and supervised company. Accordingly, the Court finds that under specific facts of the case the appointment of an ombudsman is not warranted.

Based on the foregoing it is,

ORDERED and ADJUDGED pursuant to 11 U.S.C. § 333(a)(1) that a patient care ombudsman is not necessary according to the specific facts of the case.

In re Kenneth HAWKINS, Debtor.

No. 05–22100–BKC–RBR.

United States Bankruptcy Court,
S.D. Florida,
Broward Division.

Oct. 30, 2007.

Background: Following creditor's filing, some 15 months after the closing of debtor's no-asset Chapter 7 case, of a state-court action seeking the imposition of a constructive trust and an equitable lien on debtor's marital home, debtor filed a motion for contempt and for sanctions for creditor's alleged violation of the discharge injunction.

Holdings: The Bankruptcy Court, Raymond B. Ray, J., held that:

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re:

BEAM MANAGEMENT, LLC d/b/a HARMONY HEALTHCARE AND REHABILITATION CENTER OF SARASOTA	CASE NO. 8:10-bk-08580-KRM Chapter 11

_____/

PATIENT CARE OMBUDSMAN INITIAL WRITTEN REPORT

Frank P. Terzo, the duly appointed Patient Care Ombudsman ("PCO") in this matter, pursuant to 11 U.S.C. §333 (b)(2), hereby files with this Court the PCO's Initial Written Report ("Report") on the status of quality of patient care being provided by the Debtor.

I. BACKGROUND:

A. Procedural Summary

Commenced by petition on April 13, 2010, this proceeding is an involuntary Chapter 11 bankruptcy for the Debtor, Beam Management, LLC ("Beam" or "Debtor") filed by its creditors. A Chapter 11 bankruptcy proceeding allows a debtor to stay in business through a plan of reorganization, which includes adjusting its debts.

Beam does business as Harmony Healthcare and Rehabilitation Center of Sarasota ("Harmony" or "Facility"), a Florida licensed nursing home with 120 beds. Harmony has been operating as a nursing home under Beam's management since 2006.

According to pleadings in this proceeding, Beam was formed as a Delaware limited liability company in 2000 and has been operating since 2004. The company is owned by Rivka Gelbtuch, Sara Ellman and Abby Baruch. The members' husbands, Ben Gelbtuch, Neil Ellman and Elliot Baruch, comprise Beam's Board of Directors. One of the owners of the Debtor, Elliot

Baruch, also served as Beam's manager from 2004 to late 2008 (officially noticed under filings with the Florida Division of Corporations in May, 2009). The other owners in this bankruptcy assert that Beam under Mr. Baruch's leadership "experienced serious financial difficulties," such as a significant tax liability (about $ 1.8 million from employee payroll taxes) owed to the Internal Revenue Service and considerable delinquencies to a number of its vendors, including a number of judgments against Beam.

The Court on May 25, 2010 found that the nursing home is a "health care business" and ordered the U.S. Trustee[1] to appoint a "Patient Care Ombudsman" ("PCO") in accordance with Section 333(a)(1) of the Bankruptcy Code. The obligation of the PCO under the Court's order and the applicable law is "to monitor the quality of patient care, to the extent necessary under the circumstances, and to represent the interests of the patients of the health care business." The Court's order also granted the PCO the right to review the confidential records of all Harmony patients. The US Trustee officially appointed Frank Terzo as PCO on May 27, 2010. The PCO gave an interim report at a hearing on June 17, 2010, which was noticed to all patients and their surrogate decision-makers, some of whom attended by telephone. The instant Report is the mandated full report required by law within sixty days of the appointment of the PCO.

On May 28, 2010, pursuant to the motion of the Debtor, the Court approved, on an interim basis, the retention of Michael Bokor, President and owner of Southern SNF Management, Inc. ("Southern") as Debtor's management company, effective retroactively to the date of commencement of this proceeding. On July, 23, 2010, however, Southern through Mr. Bokor gave notice of Southern's resignation as Harmony's manager. Simultaneously, Andrea

[1] The United States Trustee Program is the component of the Department of Justice responsible for overseeing the administration of bankruptcy cases. The U.S. trustee (Donald F. Walton is the United States Trustee for Region 21) plays a major role in monitoring the progress of chapter 11 cases and supervising their administration.

Pankhurst tendered her resignation as the Nursing Home Administrator for Harmony, both effective August 5, 2010.

The resignation of Southern and Ms. Pankhurst with such short notice created serious concerns on the part of the PCO and his team because the Agency for Health Care Administration ("AHCA") was due to survey the Facility before the end of July, 2010. The PCO and his team increased the onsite visits after Southern's resignation to ensure that the clinical supervisors involved in the Facility were prepared for the pending survey.

B. PCO and his team

The PCO possesses both bankruptcy and healthcare legal and operational experience. The following summarizes the background of the PCO and the team he has assembled to assist him:

> Frank P. Terzo: Mr. Terzo is AV -rated and is the Managing Director of the Restructuring and Creditor Rights Department at GrayRobinson. Prior to practicing law, Mr. Terzo spent eighteen years in the health care industry. He has a broad range of management experiences in the health care field, including clinical laboratory, hospitals and physician practices. In the six years prior to entering law school in 1998, he co-founded two public health care companies; one that performed comprehensive home healthcare services and another that offered hospital staffing services. Most recently he has used his healthcare experience in representing various constituents in healthcare insolvency cases and healthcare litigation matters
>
> Mark Levine: President of Levine & Associates, Mark Levine completed his Bachelors Degree at S.U.N.Y. at Cortland and later earned a Masters Degree in Health Care Administration from Cornell University. Concurrent with his formal education, Mr. Levine served in the U.S. Army Reserves as a Field Medic where he received clinical training and provided direct patient care. Mr. Levine started his career at Miami Jewish Home and Hospital, an organization with a national reputation for quality of care and innovation. He went on to manage senior care organizations, both as a licensed administrator and as a senior member for non-profit multi-level senior care providers. Mr. Levine now operates a multifaceted company geared to supporting the long term care industry.
>
> Jack P. Hartog: Prior to becoming of counsel to Gray Robinson in 2008, Mr. Hartog worked as an Assistant County Attorney for Miami-Dade County with Jackson Health

System (the Public Health Trust of Miami-Dade County) as his principal client. The Jackson Health System at that time owned and operated numerous hospital and other health care facilities, including two nursing homes. As counsel for over two decades to the largest health system in Florida and one of the largest and busiest hospitals in the country, Mr. Hartog has extensive experience in nearly all aspects of health care law. Mr. Hartog received his B.A. from Cornell University and law degree from Stanford University.

Tamra Hassler: Ms. Hassler is a seasoned Registered Nurse and a Risk manager. She has worked at River Garden, Hebrew Home for the Aged in Jacksonville and as the Director of Nursing for Oak Hammock, a non-profit CCRC sponsored by the University of Florida in which she served as the Director of Nursing. Ms. Hassler, who began her career as a certified nursing assistant, has been a caregiver in long term care for over 20 years. Ms. Hassler has very strong clinical foundation and a expertise in developing clinical systems that are both functional and employee friendly.

C. Skilled Nursing Facilities and Today's Regulatory Environment

Nursing homes provide long term and sub-acute care to persons in need of 24-hour nursing services or significant supportive services. The quality of care and quality of life for residents of nursing homes have been a concern for decades. Nursing home residents are generally frail, physically and psycho-socially compromised, heavily dependent upon others for basic care and sustenance, and in some cases, near the end of their lives. When residents live in an environment where they are totally dependent on others, they are especially vulnerable to abuse.

Due to the recognized vulnerability of their residents, today's skilled nursing home facilities operate in a very intensive regulatory environment. Nursing homes must adhere to extensive, detailed federal and state regulations. Starting in the late 1980s, regulatory oversight has been strengthened in response to public outcry over inadequate or poor care. Nursing facilities are now obligated to assure the proper health and well being of a patient/resident is being provided in accordance with written practice standards and enforcement guidelines regarding such matters as residents' health, memory, hobbies, habits and ability to walk, talk, eat,

dress, bathe and understand and communicate with other people. Facilities must have individualized plans to maintain and potentially improve each resident's condition. These heightened standards were accompanied by enhanced enforcement with associated penalties for non-compliance.

Florida has a particularly rigorous regulatory environment, overseen by the Agency for Health Care Administration ("AHCA"). The Center for Medicare and Medicaid ("CMS") is the federal regulatory body that oversees federal law pertaining to Skilled Nursing Facilities. Florida and federal laws and their accompanying regulations (by AHCA and CMS) subject nursing homes to detailed rules that seek to assure that nursing home residents are provided timely quality care and preserve residents' statutory rights and individual dignity. For example, recent legislation in Florida required nursing homes to implement comprehensive risk management and quality assurance programs, conform to new reporting guidelines, and satisfy increased staffing requirements. *See, e.g.,* §§ 400.147, Fla. Stat. (2009) (risk management and quality assurance) and 400.23, Fla. Stat. (2009) (staffing requirements). Evidence that care at nursing facilities generally has been improving is evidenced by less lawsuits against nursing facilities, less government fines due to noncompliance with regulations, and increased availability of liability insurance policies for nursing facilities.

D. ACHA Surveys/Inspections

To ensure compliance with applicable Florida and federal laws and rules, AHCA conducts standard, unannounced surveys every 9-15 months. For facilities with a history of regulatory non-compliance, AHCA surveys every six months or more often. It also conducts separate and regular fire, life and safety inspections as well as complaint investigations upon the filing of a complaint.

Standard surveys generally have four to five surveyors in the building for approximately five days, evaluating every aspect of residential life. As appropriate during any survey, inspection or investigation, AHCA personnel review clinical records, policies and procedures, and staffing reports. It also conducts interviews with patients/residents, family members, staff, visitors, and volunteers.

AHCA records the results of its reviews in what is called a "Statement of Deficiencies," which cites the facility for any failure to meet applicable regulations. The nursing home's licensed administrator responds to AHCA's statement of deficiencies by attesting that the deficiencies have been corrected, identifies a plan to systematically fix the problem and then develops a quality assurance plan to make sure the plan is working. AHCA performs follow up surveys as needed to ensure that the corrective action is working, reporting whether the facility has corrected the deficiencies. All these reports are public records that can be downloaded from AHCA's website.[2]

To categorize the nature and extent of deficiencies and their impact on residents, AHCA identifies each by a scope (meaning how many residents potentially or actually were affected, ranging from "isolated" to "widespread") and a severity (ranging from no impact and minimal harm to patients, to actual harm and immediate jeopardy, the most severe). See "Scope and Severity Chart," below.

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2 http://www.floridahealthfinder.gov/FacilityLocator/facloc.aspx

SCOPE AND SEVERITY CHART

SCOPE→→→→→→→→ SEVERITY/HARM ↓	ISOLATED (One or a very limited number of residents affected and/or one or a very limited number of staff involved, and /or the situation, occurred only occasionally or in a very limited number of locations.)	PATTERN (More than a limited number of residents affected, and/or more than a limited number of staff involved, and/or the situation occurred in several locations and/or the same resident(s) have been affected by repeated occurrences of the same practice.)	WIDESPREAD (Situation was pervasive throughout the facility or represented a systematic failure that affected a large portion or all of the facility's residents.)
(4) Immediate jeopardy to resident health or safety (Deficiencies practice caused or is likely to cause serious injury, serious harm, serious impairment or death AND there is a reasonable degree of predictability of a similar situation occurring in the future, Immediate corrective action is need.)	J Immediate Jeopardy	K Immediate Jeopardy	L Immediate Jeopardy
(3) Actual harm that is not immediate jeopardy (Deficiencies practice has lead to a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being.	G	H Substandard Quality of Care	I Substandard Quality of Care
(2) No actual harm with potential for more than minimal harm that is not immediate jeopardy (Deficiencies practice has lead to minimal physical, mental, and/or a psychosocial discomfort to the resident and/or a yet unrealized potential for compromising the resident's ability to maintain and/or reach his/her highest practicable level of physical, mental, and/or psychosocial well-being.)	D	E	F Substandard Quality of Care (tags 221-226, 240-258, & 309-333)
(1) No actual harm with potential for more than minimal harm (Deficiencies practice has the potential for causing no more than minor negative impact on residents.)	A Substantial Compliance	B Substantial Compliance	C Substantial Compliance

Under this system, the least serious "deficiencies" are A, B and C, which describe practices that have the potential for causing no more than minor negative impact on patient care. The most serious are I, J and K, termed "Immediate Jeopardy" ("I.J." in common parlance), which are practices that have caused or are likely to cause serious harm, serious impairment or death, and to reoccur absent immediate corrective action. Deficiency statements also are referred to as "tags" with the preface of "F" or "N" corresponding to a federal or state (respectively) requirement denoted by a number that corresponds with listed kinds of specific deficiencies.

When AHCA concludes that residents are at risk, it puts the facility on "Special Focus" status. "Special Focus Facility Designation" is not a sanction but targets non-compliant facilities for more frequent surveys, reflecting AHCA's concern about the welfare of the residents. As evidence of the seriousness of this designation (formerly referred to as a "watch list," terminology which AHCA has stopped using), in 2008, according to the last published data we could find, there were only five Florida nursing homes that were "special focus facilities."

E. PCO's Monitoring Activities:

Our initial monitoring, beyond gathering publicly available data, included tours of the facility; meeting with senior management (both Harmony and Southern), department supervisors and line staff; interviewing residents and following up on calls from guardians and family members; and reviewing document (such as patient charts, quality assurance reviews, weight and skin reports, and life safety records and various meeting minutes). We observed the general functioning of the facility, including mealtimes.

We devoted considerable attention to understanding the functioning, skills and performance of Southern SNF Management Inc. ("Southern"), the management consulting company that contractually assumed responsibility for operating Harmony in February and came

on site in March 2010. Southern, which specializes in long term care and skilled nursing facilities, quickly revamped the leadership structure at Harmony, appointing a new licensed nursing home administrator, assistant director of nursing, director of rehabilitation, nurse manager, staffing coordinator, weekend unit manager, activities director, and an internal admissions coordinator (who helps residents acclimate to facility). Southern made many significant operational changes very quickly. In addition, Southern's management structure gave the licensed nursing home administrator great autonomy.

To gain a better understanding of the operations and the emerging working "culture" of the facility, we were on-site during the day shift, evening shift and night shift. We also monitored and interviewed on the weekends, when most families visit and when the majority of the management team is not typically present. We viewed areas not available to the public, such as the kitchen, laundry rooms, maintenance work areas, bio-hazardous storage area, and medication rooms.

During virtually every on-site visit, we met with the Administrator and usually James Kestler, Chief Operating Officer of Southern. The PCO or his team met with most of the critical department supervisors, including the Director of Nursing, Assistant Director of Nursing, Social Services Director and Maintenance Director. We also met privately with certified nursing assistants (CNAs) and licensed nurses. Finally, we interviewed Robin Bleier, RN, President of RB Health Partners, Inc., licensed nurse and risk manager particularly skilled in assisting nursing facilities in their regulatory compliance activities, who assisted Harmony with its compliance activities following the December 2009 AHCA complaint survey; and Harold Williams, AHCA Area Director for the district where Harmony Healthcare is located.

We reviewed AHCA's survey results, which are summarized below in this Report. We also reviewed existing Harmony policies and procedures and operational systems to support full compliance with issues not related to AHCA findings.

The PCO and his team examined the following core areas:

Administration

Team members reviewed quality assurance and risk management meeting minutes, abuse/ neglect logs, grievances, resident council meetings, and safety committee reports. We examined the clinical systems supporting psychotropic drug reduction attempts, physical restraints, medication management as well compliance with the facility's Plan of Corrections.

Pharmacy

Team members checked medication storage rooms and medication carts (used for securely transporting pharmacy products to residents) for expired medications, appropriate and timely physician signatures, and for conformity of the products with the MAR (Medication Administration Record) for each respective resident. In those areas where Harmony had been cited as deficient (such as F tag 425 and F tag 431), we did a more intensive review. We also reviewed reports from Harmony's pharmacy consultant to ensure attempts were made to reduce use of psychotropic medications.

Building and Fire Safety

We reviewed the tests from the fire monitoring company, including fire sprinkler system, outside testing of alarm systems, reports for dampers and required generator testing. We reviewed internal fire drill reports (one per shift per quarter) and internal and external disaster drill reports. We checked various fire doors for appropriate ratings (30 minute, one hour, four

hour rating) and that doors release when a fire drill is activated. We did a walk through of the entire building to review ongoing and preventive maintenance.

Human Resources

We conducted a review of personnel charts for timely criminal background checks; license verification for nurses and therapists; and current certification for certified nursing assistants, confirming compliance with immigration status review requirements. We looked at whether staff has appropriate levels of mandatory education (all employees working in a SNF must have 12 hours of mandatory education and direct caregivers even more) had been done in a timely manner, including Alzheimer training within appropriate time frames, for changes in compensation inconsistent with policy, and the timeliness of personnel reviews. We reviewed time card reports to verify that facility was providing staffing consistent with minimum state standards for certified nursing assistants (2.9 hours per patient day) and licensed nurses (1 hour per patient per day). We reviewed turnover for the last six months and the last year.

Social Services

We reviewed whether residents were given opportunities to create or change their advanced directives, which are required for all nursing facility residents. We interviewed resident to hear whether their rights were honored and whether they felt that their concerns would be handled timely. We checked whether residents were asked to participate in their mandated plan of care. We reviewed complaint/grievance logs of all residents for the last year. We determined whether residents had reasonable access to their money within their Resident Trust Funds and that statements of the Resident Trust Funds are mailed out on a quarterly basis.

Dietary

We observed all three meals, conducted a sanitation review, and performed a temperature audit to confirm that meats and chickens reach appropriate, safe internal temperature. We evaluated whether the menu conforms to RFDA guidelines in terms of diversity and caloric intake, residents have appropriate eating devices to facilitate autonomy, and residents receive their hot foods and cold foods at the appropriate temperature. We reviewed the facility's weight loss policy under which residents are weighed and which calls for a multidisciplinary approach to weight loss.

MDS/Care Plan

Upon admission for all nursing home patients, Federally mandated "minimum data sets" (MDS) must be filled out and a plan of care completed. We confirmed that the facility develops a complete care plan within seven days of each admission. We reviewed a sample of assessments for accuracy and that they were coordinated by a RN and done and signed by the appropriate director. We reviewed that the care plan met all of the residents needs with timetable and actions that can be measured.

RN/Risk management/Quality Assurance

Tamra Hassler reviewed Harmony's clinical practice and quality assurance programs. She analyzed the Plans of Correction for clinical deficiencies and evaluated whether identified problems were solved such that a system existed to make sure the deficiency did not reappear and that the issue was effectively monitored through the QA process. She analyzed the following information:

- Quality rounds with Director of Nursing
- Chart review of selected charts (selected based on resident complaint or from our observations while touring, including all ventilator care residents)

- Clinical Review (checking systems supporting significant weight loss, skin integrity, medication dissemination and control, and various clinical practices)
- Particular "flagged" items in Deficiencies
- Sentinel Events (reportable incidents)
- Weight Loss Reports
- Decubitus Ulcer Reports
- Quality indicator Report (used to compare Harmony's Health care results to other outcomes across the state and country) (monthly and financial analyses)
- Ventilator patients charts for orders, care plans, omissions in MAR
- Dialysis patients charts for orders, care plans, communication between facility and dialysis center
- Director of Nursing chart audits
- Resident's on psychotropic medications and chemical restraint reductions attempts
- Pharmacy Consultant Recommendations and follow through

Patient/Family Interviews

We met with all the patients that were capable of consenting to their own care, a total of 18 residents, asking for feedback. Because many lack such capacity, guardians/surrogates were contacted. There were several family members that sought us out to make sure we were aware of their concerns and asked for our intervention. We investigated their individual concerns and often were able to crystallize the concern to administration and bring a satisfactory resolution. In total, there were four formal complaints that required us to communicate with administration to address the resident or their guardian/surrogate complaints or concerns. Their concerns all related to resident care issues, resident rights and or problems with their bills.

II. Harmony Healthcare and Rehabilitation Center

A. Description:

Harmony Healthcare is a 120 bed skilled nursing facility, certified by Medicare and Medicaid. It is licensed pursuant to Chapter 400, Part II, Florida Statutes.

It has 18 rooms that are private and 51 rooms that are shared. The facility is located in a largely residential neighborhood. The physical facility itself follows a "medical model" environment (giving the appearance more like a hospital than a residential setting), and has been

tastefully updated. It has common areas for the residents to congregate or use with visitors (three dining areas, TV and recreation room, sitting rooms and conference rooms).

The census fluctuates on a daily basis, usually in the 90s; as of July 24, 2010, for example, the resident population totaled 97. Shortly before the filing of this bankruptcy action, resident census was in the 70s. There are currently approximately 104 employees (both full and part time).

The facility cares for residents who primarily are frail and dependent. According to the Resident Census and Condition Form (an AHCA mandated form) dated July 9, 2010:

- 78% of the residents are bedfast or in a chair all or most of the time.
- 65% are incontinent.
- 48% have chronic loss of joint motion due to structural changes in non-bony tissue.
- 50% have a documented psychiatric diagnosis.
- 43% have a type of dementia.
- 7-8% are currently in Hospice.

In late July, 2010, the Facility housed four ventilator-dependent patients, with several others receiving ventilator care; the facility in the past has had double digit ventilator-dependent patients. A ventilator mechanically assists patients to breathe who are physically insufficiently able to breathe for themselves. Harmony is the only facility from Naples to St. Petersburg providing this high acuity service. Discontinuance of such service would result in long drives for visiting families or friends as well as creating dissatisfaction among those Patients currently receiving ventilator care at Harmony.

Most of the ventilator care residents are currently paid through Medicaid. Unlike several other states, Florida's Medicaid program offers providers no appreciable financial difference for the intense care of residents on ventilators, paying a set rate for all nursing home residents, regardless of the intensity of medically necessary care.

In May of 2010, there were approximately ten residents on Medicare and four private pay patients. The remaining residents are on Medicaid, meaning they have very little, if any, income or assets.

Complicating matters at Harmony Healthcare, most residents lack any routine visits from family or have no active family involvement to effectively advocate for them when care issues arise, which unfortunately is common for Medicaid nursing home patients. Several residents who do have families actively sought out the PCO to seek to improve their loved one's care in a timely manner.

B. Facility History: Opened in 1987, the facility has always been known as "Harmony"). Harmony Healthcare at one time had a licensed capacity of 180 beds, which included a separate, 60 bed, secured Alzheimer's patient unit. The facility was "mothballed" for about 4 years – the timing of closing the facility coincided with the "insurance crises" that caused many operators to leave the state due to runaway insurance premiums or the inability to secure insurance. Beam Management purchased the Facility in 2005 and submitted an application to CMS for Medicare and Medicaid certification on December 29, 2005. The opening of the Facility in 2006 required the coordination of several local, state and federal governing bodies and careful administrative coordination. This coordination did not occur causing a delay in the approval of Harmony's application. Adding further delay and expense were the hurricanes that hit the area in 2005 causing the owners to conform to new building standards and placing significant unanticipated financial pressures. Ultimately, the initial application to CMS was approved in December, 2005 but payments did not begin until March, 2008 when the AHCA certification was formally completed.

C. AHCA Surveys of Harmony

AHCA surveys of Harmony show its regulatory compliance problems date back to its first survey under the Debtor's management in 2007. The AHCA Survey reports demonstrate that year after year Harmony has incurred deficiencies in the same categories: Quality of Care, Resident Assessments, Resident Rights, Pharmacy, and Administration.

In response to a family/resident complaint, AHCA from December 21- 23, 2009, surveyed Harmony, issuing a 100 plus page statement of deficiencies (an unusually lengthy survey report) that included four Immediate Jeopardy ("I.J.") deficiencies, AHCA's most serious level of deficiency. An I.J. deficiency is not common; it is issued only in the most egregious situations. To get more than four at one time demonstrates a serious system breakdown and absent clinical standards. The four I.J.s were[3]:

- Failure to give each resident care and services to get or keep the highest quality of care.
- Failure to give professional services that meet professional services that meet a professional standard of quality.
- Failure to administer services in a way that leads to the highest possible level of well being for each resident.
- Failure to choose a Doctor to be the Medical Director.

Some examples of the conduct involved included:

- Failure to follow physician order: A physician wrote an order that a patient on a ventilator was to be suctioned and assessed every two hours; this was not done and the resident died.

- Failure to follow physician order: A resident had a tracheotomy and physician order indicated nothing to be fed by mouth. The resident was fed solid food, such as cookies and fruit. The resident aspirated and died.

3. Note that several incidents are repeated under a more than one IJ (for instance, failure to tell the doctor immediately on a change of condition and listed under failure to keep the highest quality of life possible):

- Failure to follow physician order: Ventilator settings were to be checked every 4 hours per doctor and tracheotomy care each shift and changed every 30 days. These orders were not carried over on the month to month so that physician orders for trach and related care were not being followed.

- Other serious problems: 12 out of 15 sampled residents showed physician orders not followed; 7 out of 7 respiratory therapists were providing care without physician orders or direction in the ventilator unit; 7 out of 13 licensed nurses had no required training on how to use a central line to administer medications; several nurses administering care had no verifiable license.

Harmony also had two level 3 deficiencies (G, H or I), which means actual harm compromising a resident's ability to maintain and/or reach his/her highest practicable physical, mental, and/or psychosocial well-being. These deficiencies related to failing to give residents proper treatment to prevent new bed sores and a failure to tell the doctor, resident and family member if there is a major change in a residents condition.

The Facility submitted and AHCA approved a plan of corrections on February 4, 2010 for these deficiencies, but a regularly scheduled routine survey dated February 12 revealed significant additional deficiencies. These were:

- failing to give residents care to keep highest quality of life;
- an actual harm deficiency related to improper treatment;
- failure to use licensed or registered staff;
- Employed nurses that were working under expired licenses, had a police record (including narcotic diversions), with an inadequate system to do criminal background checks;
- no reliable mandatory staff training programs;
- failure to develop timely, accurate measurable care plans;
- poor medication management (given too many doses or for too long of narcotics or psychoactive medications).

The Facility submitted a plan of correction for these deficiencies, certifying it had a system in place to prevent similar problems. The follow up resurvey on March 23, however, identified that

the last two bulleted deficiencies above remained uncorrected. These deficiencies were finally cleared on another follow up survey on May 7, 2010.

AHCA reported that from January 1, 2009 through March 31, 2010, Harmony had incurred 20 separate deficiencies, a number well above the state annual average of eight deficiencies. On-site visits from AHCA are summarized in the following chart:

AHCA Inspection Reports of Harmony

	Inspection Type	Document Type	Visit Date	Pages	Inspection Status
Select	Standard	Statement of Deficiencies	5/7/2010	4	Deficiencies Corrected
Select	Complaint	Statement of Deficiencies	4/5/2010	2	No Deficiency Cited
Select	Standard	Statement of Deficiencies	3/23/2010	10	Deficiencies Cited
Select	Fire/Life/Safety	Statement of Deficiencies	2/19/2010	4	No Deficiency Cited
Select	Standard	Statement of Deficiencies	2/12/2010	29	Deficiencies Cited
Select	Complaint	Statement of Deficiencies	2/4/2010	5	Deficiencies Corrected
Select	Complaint	Statement of Deficiencies	12/23/2009	116	Deficiencies Cited

D. Comparison With Other Nursing Facilities:

Harmony does not compare favorably with other nursing facilities in the country, both presently and in the recent past.

Each federally certified nursing home must complete a standardized assessment of each resident (Minimum Data Set – MDS) at the time of the resident's admission, whenever a significant change in condition occurs, and each calendar quarter. The MDS is used to identify resident conditions and produce "Quality Indicators" for each nursing home. Quality Indicators are used during inspections and monitoring visits to target areas of potential concern. For

example, if a resident is considered "low-risk" for the development of pressure sores, but develops a pressure sore while in the nursing home, the care would be reviewed as a potential concern.

The Quality Indicator Report from January 1, 2010 to June 30, 2010 (from the "Minimum Data Set" that every skilled nursing facility must use, thereby allowing comparisons of nursing homes throughout the country) indicates that Harmony is at the bottom 10% percent in residents with pressure ulcers. It is in the bottom 5% for resident who may be unnecessarily on a catheter, residents without a toileting plan, residents who have moderate to severe pain, residents who spend most of their time in a bed or chair and residents who are on 9 or more medications.

A non-clinical specific example is the percentage of long stay residents who spend most of their time in a chair or bed. The state and national average of all nursing homes were 4%; at Harmony it is 20% -- 5 times higher.

A "star rating" system of one to five (with one being the worst and five the best) is also used nationally to rate nursing homes. It considers a number of factors—the level of staffing in the building, regulatory compliance averaged over three years and quality indicator reports. Harmony's overall rating is one star, demonstrating a "much below average" rating.

Finally, as a result of its adverse surveys, Harmony presently is a Special Focus facility, subject to standard surveys every six months. There is better news on the horizon, however. On July 26- July 30, Harmony had its first unannounced survey under its Special Focus status. The results of this survey demonstrated significant improvement in the quality of care Harmony is delivering. Most of the deficiencies were "isolated" and none of the deficiencies observed by AHCA adversely impacted residents' health. There were deficiencies related to housekeeping, kitchen sanitation, medication management, medication control, and incomplete charting in the

medical records. Prior to this survey, an internal "mock survey" identified several of these areas as being vulnerable to becoming a deficiency at a formal survey. In addition, four out of the five deficiencies in the July survey were previously identified in prior surveys, meaning the facility still failed to follow its own plan of correction.

E. Harmony Management

In part as response to its troubles with AHCA, in February, 2010 Beam decided to hire a health care and skilled nursing facility management services company, Southern SNF Management Inc., to manage the Facility's day-to-day operations. Southern has provided some degree of improved management services. During its tenure, Southern was able to streamline Harmony's operations, increase the resident census, conduct a mock survey, and in many respects enhanced resident care.

The PCO has expressed two concerns over Southern's management services. First, Southern was managing over 17 skilled nursing facilities throughout the State of Florida and had limited ability to provide Beam with oversight and support capabilities in the areas of physical therapy, quality assurance, risk management, and pharmaceutical delivery. Second, Beam's Management Agreement with Southern paid Southern a percentage of gross revenue. As it relates to Southern's oversight of the marketing efforts to admit Medicaid and Medicare patients, this method of payment raised legal concerns relative to anti-kickback laws.

Due to disagreements that developed between Beam and Southern, Southern announced on July 23, 2010 its decision to terminate its Management Agreement with Beam. Simultaneously with Southern's termination, Ms. Andrea Pankhurst also resigned. Both Southern and Ms. Pankhurst provided only a two-week notice of termination requesting that they be relieved of their duties by no later than Thursday, August 5, 2010.

III. FINDINGS AND CONCLUSIONS:

A. FINDING: Harmony has had several AHCA surveys since 2007 with below average results, the most serious occurring in December 2009, which caused Harmony to become a "special focus facility" subject to additional oversight. Cumulatively, these surveys reflect a lack of developed, enforced and dependable clinical and operational systems, and have generated for Harmony consistent federally recognized ratings in the bottom 10% of all nursing facilities. New management needs to continue improving and strengthening these systems.

Harmony has a "one star" facility rating because for its last three years its surveys, staffing ratio and its quality indicator reports have consistently been worse than its peers. Its last annual standard survey (February 12, 2010) resulted in a finding of 20 deficiencies, well above the state average of 8. While many of its most severe problems stem from the challenges of operating a ventilator program (at least two of its four I.J. citations stemming from the December 29, 2010 AHCA complaint survey involved ventilator patients), its low ratings also consistently reflect inadequate clinical systems and poor management.

Since Southern and Ms. Pankhurst assumed management responsibility, we have witnessed more accountability of and teamwork among staff, an improving customer service mentality and progress in the development of systems. These advances in turn have improved overall care.

The latest survey that occurred in the last week of July indicated five deficiencies. They involved the following federal tags:

- F253 (Failure to provide) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior (pattern)

- F371(Failure to) Store, prepare, distribute and serve food under sanitary conditions (widespread)
- F425 (Failure to) Provide routine and emergency drugs (isolated)
- F431(Failure to) Label drugs and biologicals in accordance with currently accepted professional principles (pattern)
- F514--(Failure to) Keep accurate and medical records (isolated)

It is disconcerting that four out of five deficiencies were previously cited in recent AHCA surveys. These repeat deficiencies reinforce our perception that operational management systems to prevent deficiencies either are not in place or are unreliable. Strong management oversight can stop these preventable deficiencies. Nonetheless, the July survey was a much improved survey; all cited deficiencies were generally isolated with no negative impact on patient care.

B. FINDING: Harmony has shown it can correct deficiencies. Its response in several cases, however, reveals the clinical and operational systems that led to the deficiencies were not corrected, so that similar problems can reappear.

We are concerned about regulatory compliance, even when the Facility has corrected a deficiency. For example, our observations and conversations with staff indicate there still is no reliable system to hire properly and conduct appropriate background checks of new employees, who start at the facility without mandatory education, criminal background checks and verification of licenses, even though this was a repeat deficiency in the immediate past.

Some clinical systems are still not reliable, resulting in care not compliant with regulations and in some cases causing avoidable adverse impact. Prior to the July 26 ACHA survey, two examples from our own review of patient records showed: a failure to send information to a provider in a timely manner for a patient undergoing dialysis, and nurses failing

to follow a physician orders, which ultimately resulted in a preventable hospitalization. While we were pleased to see that the facility was encouraging an alert and oriented resident to take medication without assistance, this was done without the benefit of a physician's approval, which is against regulations. All the foregoing examples had been cited as deficiencies in 2010 by AHCA, yet they are being repeated.

A noteworthy exception to this finding is the respiratory therapy department, particularly its current director. It has significantly improved its clinical management ensuring that physician orders for those receiving ventilator care are followed.

C. FINDING: Although management has shown it will respond to problems brought to its attention, Harmony's Quality Assurance program is not sufficiently proactive either in identifying problems or in implementing follow up systems that solve or prevent the identified problem from recurring.

It is the PCO's belief that all too often the Facility fixes its shortcomings without repairing its underlying systems, which repairs are then enforced; this is the responsibility of Harmony's quality assurance ("QA") program. Through the QA program, interdisciplinary teams are supposed to analyze problems, come up with solutions, develop system to resolve, and then do ongoing monitoring to ensure they are followed. Examples where this process is to be applied include clinical processes to address significant weight loss, chemical restraint reduction or lessen the number of decubitus.

The repeat deficiencies are evidence that an effective quality assurance program is not in place. Early on in the PCO's monitoring of the QA function, he brought to management's attention the lack of coordination regarding significant weight loss among residents, but to date we have seen no system response to this fairly obvious problem. Another example is

management's response to a patient complaint about selection of an outside physician. While this individual complaint was noted, no system was put in place to honor resident's right to choose licensed health care providers. The facility has demonstrated, however, good success in having very few residents on restraints.

D. FINDING: Cutbacks to save expenditures on employees have resulted in a reduction in employee hourly compensation rates, benefit packages and hours worked, which cuts can lead to morale issues, which consequently may affect quality of care. Extensive staff turnover at Harmony also can negatively affect patient care.

Southern implemented a plan that reduced the hourly rates of line staff and shortened their scheduled work week. It remains to be seen what effect this reduction will have on turnover and employee satisfaction. It has been demonstrated that facilities with low turnover have better quality of care. In addition there is a direct correlation between staff satisfaction and nursing home resident satisfaction.

All certified nurse assistants had their workday reduced from a 8 hours to 7 ½ hours a day. This reduction precludes the CNAs from sharing information during working time about the residents from one shift to another. While there are no regulations requiring crossover time between CNA shifts, it is the prevailing standard among better care providers to allow for crossover to assure 24 hour nursing care. Although there is crossover among the licensed nurses, we believe this change for CNAs may have a deleterious effect on quality patient care as it relates to informing the next shift of changes in resident care.

Our analysis of Harmony reports to AHCA shows that 61 out of its 104 employees were employed for less than one 1 year. This represents an annual turnover rate of 58%. High turnover rates can have a negative impact on resident care.

E. FINDING: Harmony's physical plant is well maintained and its general presentation is clean, positive, and attractive. Its residents appear well dressed, are treated respectfully and participate in a vibrant activity program and for the most part speak favorably about the facility, its staff and management.

Many of the residents indicated that they were satisfied with care and many were complimentary to staff and management. Some of the higher functioning residents expressed concern with turnover and more recently were worried that Southern's rapid departure meant their home would be closing. Several of the residents were at the Facility the last time it was closed and remembered how difficult relocation can be.

After the last serious deficiency in December, 2009, ACHA noted that Harmony needed to honor residents' requests for different types of activities and activities that are tailored to individual resident desires. Since then, an activity consultant was brought on and programmatically, the activity program has improved. The PCO toured the facility several times and saw that few residents were in their room—a sign of a vibrant activity program.

F. FINDING: Harmony needs to continue improving its culture of caring.

During our visits we witnessed employees walking past residents obviously in some distress who could easily have been calmed down through behavioral based interventions. While we can understand that the bankruptcy and new management has been a turbulent time for Harmony employees, we recognize there is more work to be done in changing a culture to one that promotes positive staff–resident interaction.

We also see problems, particularly in social services, which among its many duties is acting to champion resident rights in bringing problems to closure. We were made aware of three resident complaints regarding transfer issues and timely discharge planning. Families made

their needs known, but the facility did not move on this timely. There were two complaints about the accuracy of a resident's bill. There were meritorious complaints about failure to choose a doctor, provide individualized care, and pain management protocols. Two family members expressed that if they were not present, the care of their loved one was not assured. These issues should be addressed by social services directly, without the need for a PCO to convey these concerns and issues.

In addition, resident grievance logs were not done in a clear manner and follow up with residents is problematic both in its documentation and level of resident satisfaction. Additional education and training for the social services director is necessary immediately so that he can more effectively advocate for the residents and document his interventions. For example, one of the residents complained that the facility did not try to find outside placement. The social services director produced a sheet of places of six places he tried and the patient's admission was turned down. Placement was however immediately identified when the PCO became involved.

G. **FINDING: Despite the need for ventilator care in Sarasota, Harmony's ventilator care program is currently managed in a way making it a financial drain.**

Harmony's ventilator program is challenged economically by Medicaid's funding all nursing home patients at a set rate, regardless of the actual costs of their care. Offering a ventilator care program can become cost effective through expanding and managing a minimum number of Medicare and private pay residents. In fact, several well-respected operators, including Miami Jewish Home and Hospital provide the community ventilator care and have found a way to make this economically viable through carefully accessing and balancing several payer types. Preservation of the ventilator program is important to area residents.

IV. RECOMMENDATIONS

A. Strengthening of Quality Assurance practices and continued education and support for the Director of Nursing are necessary.

Care is improving as evidenced by findings of fewer deficiencies by AHCA. Some existing systems, however, either fail to capture the benefits of the entire interdisciplinary care team, are not viable or are not consistently implemented because staff is not always held accountable. Interdepartmental communication is a problem and many challenges have occurred because the different departments are not always working together.

B. Education for staff on resident rights and Alzheimer's is required. In an effort to bolster resident rights, the social services director needs additional education.

These issues have either been the subject of deficiencies or directly observed. Our monitoring shows a lack of pro-active activity in social services areas.

C. It is a mandatory priority that a progressive and experienced management company be retained to supervise Harmony.

The departure of Southern has made essential the finding of a new manager for the Facility as soon as possible.

D. The Court should allow the PCO to remain in its role for an additional 60 days to monitor the effects on the quality of patient care by the introduction of a new management company and licensed nursing home administrator to operate the Facility.

V. CONCLUSION

This report is the initial report of the Patient Care Ombudsman and is a summarization of numerous interviews, meetings and document reviews conducted with management at all levels, staff and patients. Management at all levels, staff and patients have been cooperative in

providing information, producing data and reports and responding to questions in an honest and open fashion. The PCO has made a best effort, within the time constraints, to conduct a comprehensive review and assessment of the quality of care at Harmony as set forth in this Report.

I HEREBY CERTIFY that a true copy hereof was furnished via electronic mail to all parties on the Court's CM/ECF list maintained by the Court, and by U.S. mail to any parties who have requested a copy, on this 3rd day of August, 2010.

GRAYROBINSON, P.A.
1221 Brickell Avenue, Suite 1650
Miami, Florida 33131
Tel: 305-416-6880
Fax: 305-416-6887

By: /s/ Frank P. Terzo
Frank P. Terzo, Esquire
Florida Bar No.: 906263

310852 v1

GT GreenbergTraurig

Alan J. Brody
Tel 973.443.3543
Fax 973.295.1333
brodya@gtlaw.com

January 12, 2015

VIA ECF

Honorable Rosemary Gambardella
United States Bankruptcy Court
District of New Jersey
M.L. King, Jr. Federal Building and Courthouse
50 Walnut Street, 3rd Floor
Newark, New Jersey 07102

Re: In re Horizon Health Center, Inc.
Bankr. Case No. 13-26348 (RG)

Dear Judge Gambardella:

On behalf of Suzanne Koenig, the Patient Care Ombudsman appointed in the above-referenced debtor's (the "Debtor") Chapter 11 case, please accept this letter in response to the motion of IJKG Opco LLC, trading as Bayonne Hospital ("Bayonne") (I) compelling immediate surrender of the premises pursuant to 11 U.S.C. § 365(d)(4); (II) in the alternative (A) granting relief from the automatic stay to proceed with State Court possession action pursuant to 11 U.S.C. § 362(d) and (B) waiving the fourteen day stay pursuant to Fed. R. Bankr. P. 4001(A)(3); and (III) declaring that the Transfer and Affiliation Agreement is terminated (the "Motion") [Docket No. 761].

The Debtor is a federally qualified health center ("FQHC") governed by the United States Department of Health and Human Services, Health Resources and Services Administration (HRSA"). The Debtor and Bayonne are parties to a commercial lease for the premises located at 29 East 29th Street, Bayonne, New Jersey (the "Premises"), which Premises is essential to the outpatient ambulatory care of the Debtor's patients. By its Motion, Bayonne seeks to compel the Debtor to vacate the Premises.

The Debtor has advised Bayonne that it is willing to do so, however, it needs time to locate a suitable replacement site and comply with HRSA required regulations regarding FQHCs. Specifically, the Debtor has requested sixty (60) days to vacate the Premises and relocate its outpatient ambulatory service to ensure that its patients have access to such essential medical services. Absent the sixty (60) day extension, the Debtor may not have sufficient time to comply with state and federal regulations required to transfer the license for these services to a

new location, causing the patients to lose access to their primary care provider which could impact the patients' ongoing and future care.

Accordingly, it is respectfully requested that that the Debtor be granted the extension in an effort to protect the health and well-being of the Debtor's patients.

Respectfully Submitted,

Alan J. Brody

cc: Suzanne Koenig, Patient Care Ombudsman
Anthony Sodono, III, Esq. (*via ECF*)
Louis M. Modugno,, Esq. (*via ECF*)
Walter J. Greenhalgh, Esq. (*via ECF*)

GREENBERG TRAURIG, LLP
NANCY A. PETERMAN
77 West Wacker Drive, Suite 2500
Chicago, IL 60601
Telephone: (312) 456-8400
Facsimile: (312) 456-8435
Email: petermann@gtlaw.com

GREENBERG TRAURIG, LLP
PAUL R. GLASSMAN (SBN 76536)
ADAM M. STARR (SBN 222440)
2450 Colorado Avenue, Suite 400E
Santa Monica, California 90404
Telephone: (310) 586-7700
Facsimile: (310) 586-7800
Email: starra@gtlaw.com

Attorneys for Patient Care Ombudsman, Suzanne Koenig

UNITED STATES BANKRUPTCY COURT

CENTRAL DISTRICT OF CALIFORNIA

LOS ANGELES DIVISION

In re BROTMAN MEDICAL CENTER, INC., a California corporation, Debtor.	CASE NO. LA 07-19705 (BB) Chapter 11 **RESPONSE OF PATIENT CARE OMBUDSMAN TO EMERGENCY MOTION TO COMPEL DEBTOR IN POSSESSION FUNDING AND FOR IMMEDIATE AUTHORITY TO USE CASH COLLATERAL** **Emergency Hearing** Date: April 8, 2008 Time: 10:00 a.m. Place: Courtroom 1475 255 E. Temple Street Los Angeles, CA 90012

TO THE HONORABLE SHERI BLUEBOND, UNITED STATES BANKRUPTCY JUDGE; THE UNITED STATE TRUSTEE; THE OFFICIAL COMMITTEE OF UNSECURED CREDITORS; CAPITAL SOURCE FINANCE, INC.:

Suzanne Koenig, the patient care ombudsman appointed in the above-captioned Chapter 11 case (the "Ombudsman"), files this statement (the "Statement") regarding the Emergency Motion to Compel Debtor In Possession Funding and For Immediate Authority to Use Cash Collateral (the "Emergency Motion") and respectfully states as follows:

1. The Ombudsman was appointed pursuant to 11 U.S.C. § 333 for purposes of "monitoring the quality of patient care provided to patients of the Debtor." [See, Notice of Appointment of Patient Care Ombudsman Under 11 U.S.C. § 333(a)(1), Dkt. No. 218].

2. The Ombudsman files this Statement due to concerns over patient care in light of the ongoing dispute between the Debtor and its lender concerning funding of business expenses. The Ombudsman does not wish to take a position in this dispute other than to highlight patient care concerns.

3. The Emergency Motion highlights the Debtor's lack of committed funding for critical medical supplies and staff. The absence of funding for medical supplies, staff and other items would severely and detrimentally impact the quality of patient care at the Hospital and, therefore, is of grave concern.

4. Regardless of the outcome of the Emergency Motion, the Debtor must have sufficient funding to provide care to the approximately 160 patients who have entrusted their health, welfare and lives to the Hospital. The Hospital must be able to pay for medical supplies, staff and any other items critical to the delivery of care to these patients. This funding is vital to any reorganization, liquidating, sale or closing. Unlike other types of businesses, if the Debtor loses the Emergency Motion, it cannot close its doors and send the patients overnight to new facilities. To do so would put patients at risk of transfer trauma --- a life and death situation. As this Court may be aware, many states, including California, require the development and implementation of closure plans over 90 days or more to ensure a smooth, orderly transition of the patients to new

facilities and thus to minimize any risk of transfer trauma. *See, e.g.*, California Health & Safety Code §§ 1255.1 and 1255.2.

5. The 2005 healthcare bankruptcy amendments to the Bankruptcy Code were intended to specifically address situations such as this one. The purpose of these amendments was to give the patients a voice in the process, mainly through the patient care ombudsman, and to ensure that patients' rights and lives were safeguarded. *See, e.g.,* Statement of Keith J. Shapiro, United States Senate Committee on the Judiciary Subcommittee on Administrative Oversight and the Courts, Hearing Regarding S. 1914 The Business Bankruptcy Reform Act -- Preserving the Quality of Patient Care in Health Care Bankruptcies, p. 9, 6/1/98.[1]

6. For all of the reasons set forth above, the Ombudsman urges this Court to provide funding for those items critical to ongoing patient care. The patients should not be victims in this process. Rather, they should be provided with the level of care they expected when entering the Hospital. With patients' health, welfare and lives at stake, the Ombudsman urges all parties to resolve these disputes promptly.

DATED: April 8, 2008

GREENBERG TRAURIG, LLP

By /s/ *Adam M. Starr*
Nancy Peterman
Adam M. Starr
Attorneys for Patient Care Ombudsman,
Suzanne Koenig

[1] "The ombudsman will act as the patients' advocate in the bankruptcy case and will give patients a voice during the bankruptcy case of the health care business. Furthermore, the appointment of an ombudsman will provide the bankruptcy court and all parties in interest with the invaluable information regarding the quality of the patient care to avoid a crisis similar to that encountered at the Reseda Care Center in California." Id. at 9.

26-OCT Am. Bankr. Inst. J. 16

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Column
Intensive Care

*16 RECOUPMENT IN HEALTH CARE BANKRUPTCIES: A SHRINKING ISSUE?

Harold L. Kaplan [a1]
DrinkerBiddleGardnerCarton; Chicago
harold.kaplan@dbr.com
Timothy R. Casey [a1]
DrinkerBiddleGardnerCarton; Chicago
timothy.casey@dbr.com

If one looks back several years, perhaps the biggest issue in health care insolvency--bigger than patient care ombudsmen, patient records and the regulatory role of the states in the sale or transfer of assets--was the right of Medicare and Medicaid to recoup pre-petition overpayments against their accruing post-petition obligations to the same provider. The primacy of that issue has seemed to subside as courts, when pushed, have generally authorized such governmental recoupments. Moreover, this result may be fortified by new Bankruptcy Code §362(b)(28), (enacted as part of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (BAPCPA)), which authorizes the exclusion, without stay, of an offending bankrupt provider's participation in the Medicare or other federal health care program. While difficult to test, it also may be that Medicare and Medicaid recoupment may be pushed more selectively on a case-by-case basis to generally avoid situations that would materially threaten the viability of significant community providers.

Recoupment and Medicare/Medicaid

In the bankruptcy context, the equitable doctrine of recoupment allows a creditor's claim against a debtor to be reduced by reason of some claim the debtor has against the creditor arising either pre-petition or post-petition out of the same contract that gives rise to the creditor's claim. [1] The core requirement for recoupment is that the claims of both the creditor and the debtor arise from the same contract or transaction. Recoupment further differs from set-off, which is an alternative theory by which a creditor's claim may be reduced on account of some claim that the debtor has against the claimant so long as the claims are mutual, meaning that the claims must be between the same entities and must both be either pre-petition claims or post-petition claims. Although set-off, unlike recoupment, is incorporated into the Bankruptcy Code, [2] it nevertheless tends to be a less useful or applicable theory of recovery in the Medicare/Medicaid context because set-off is limited to mutual pre-petition (or post-petition) claims between a debtor and a creditor. Recoupment, if its other elements are met, seems to more closely fit the typical fact pattern in which there exist outstanding pre-petition Medicare/Medicaid overpayments to the provider, with Medicare/Medicaid amounts accruing for post-petition provider services against which Medicare/Medicaid may wish to recoup the pre-petition over-payments.

On the other hand, it should be recognized that even if the Centers for Medicare and Medicaid Services (CMS) [3] or state Medicaid agencies may have a right to exercise recoupment, they are not compelled to recoup, but rather can use their discretion based on such factors as the impact that recoupment would have on the viability of a provider and the importance of the provider as a community institution.

Medicare is the federal health insurance program for the aged, which reimburses qualified health care providers for the care they administer to qualified Medicare program beneficiaries. Medicaid is a cooperative program, jointly funded by the federal and state governments, that provides medical assistance to needy persons regardless of age. [4] Medicare and Medicaid's system of estimated interim payments to health care providers, with subsequent yearly audits and adjustments for **overpayments** and underpayments, increases the likelihood that **CMS** and participant health care providers who file for or are subject to bankruptcy will have claims against each other.

Case Law Development

The recent decision in *Ravenwood Health Care Inc. v. State of Maryland, Department of Health and Mental Hygiene*, 2007 WL 1657421 (D. Md., June 5, 2007), while recognizing the pre-existing split of authority regarding whether Medicare and Medicaid can **recoup** pre-petition **overpayments** against post-petition amounts owed to bankrupt health care providers, broadly read the right of Medicare/Medicaid to **recoup** and also highlighted and exemplified the continuing trend allowing Medicare and Medicaid to effect such **recoupment**, a trend which may be further aided by the application of BAPCPA's new §362(b)(28).

The Integrated Transaction and Logical Relationship Tests

As the *Ravenwood* court explained, the split in authority among the circuits (with the Third Circuit on one side, and the First, Seventh, Ninth and District of Columbia Circuits on the other) over Medicare and Medicaid's ability to **recoup** pre-petition **overpayments** against amounts owed to a provider post-petition has resulted from two different tests for determining whether a creditor's claim arises from a single contract. The first ***58** test, which was adopted by the Third Circuit in *Univ. Med. Ctr. v. Sullivan* (*In re Univ. Med. Ctr.*), 973 F.2d 1065 (3rd Cir. 1992), the first appeals court decision on the issue, and is more restrictive, is known as the integrated transaction test and holds that each yearly payment to a Medicare or Medicaid provider constitutes a separate transaction. That court wrote:

> [T]he relationship between HHS [now **CMS**] and a Medicare provider entails transactions that last over an extended period. However, each of these transactions begins with services rendered by the provider to a Medicare patient, includes payment to the provider, and concludes with HHS's recovery of any **overpayment**. Recovery of the 1985 **overpayment**, therefore, is the final act of the transactions that began in 1985. UMC's 1988 post-petition services were the beginning of transactions that would stretch into the future, but they were not part of the 1985 transactions. To conclude that these claims arose from the same transaction for the purposes of equitable **recoupment** would be to contort that doctrine beyond any justification for its creation. [5]

The second test, which was later adopted by the First, [6] Seventh, [7] Ninth [8] and District of Columbia Circuits, [9] is known as the logical relationship test and holds that Medicare and Medicaid **overpayments** and subsequent post-petition underpayments to the same recipient are all part of the same transaction even though they are not in the same year or rendered to the same patient. By way of example, in *Sims v. U.S. Dept. of Health and Human Servs.* (*In re TLC Hosps. Inc.*), 224 F.3d 1008 (9th Cir. 2000), the Ninth Circuit held:

The fact that the **overpayments** and underpayments relate to different fiscal years does not destroy their logical relationship or indicate that they pertain to separate transactions. The Medicare statute creates a sufficient relationship between different cost years to permit **recoupment** ....

Sound equitable considerations support HHS's right to **recoup**. The Medicare system reimburses estimated costs without waiting for an audit in order that providers like TLC may maintain a cash flow; those providers would otherwise find it difficult or impossible to function. **Overpayments** (and underpayments) are inherent in that system. It is fair for HHS to adjust for such

overpayments in the operation of that system whether or not a bankruptcy has intervened. If a provider in bankruptcy does not wish to be subject to Medicare's system of adjustments, it can cease providing Medicare services. If it chooses to continue to provide those services during bankruptcy, it is not inequitable for the bankrupt or its creditors that those services be provided on the same, generally favorable, terms as those governing other providers.

The *TLC Hosps. Inc.* court also emphasized the netting inherent in applying the Medicare cost accounting rules. Although the *Univ. Med. Ctr.* and *TLC Hosps. Inc.* cases addressed only Medicare's right of recoupment, later courts have had little difficulty extending the principle to state-run Medicaid programs. A majority of courts that have addressed the issue--and all recent cases of which we are aware--have adopted the so-called logical relationship test. [10]

Extensions of Medicare and Medicaid Recoupment Rights

Two more recent cases add further support for the seemingly uninterrupted trend allowing recoupment of prior Medicare and Medicaid overpayments against subsequent post-petition payments. In *In re Doctor's Hospital of Hyde Park Inc.*, 337 F.3d 951 (7th Cir. 2003), the Seventh Circuit affirmed a district court ruling that allowed the state of Illinois to recoup amounts owed to it by the debtor for separate hospital and bed taxes by withholding post-petition Medicaid payments. The court found that every state Medicaid contract necessarily includes an implied term allowing the state to offset unpaid taxes under the 1851 Illinois Comptroller Act. And in *In re District Memorial Hospital of Southwestern North Carolina Inc.*, 297 B.R. 451 (Bankr. W.D.N.C. 2002), the court reasoned that compelling public policy considerations supported the conclusion that a Medicaid Provider Agreement creates a unique, continuous transaction, subject to periodic audits and adjustments, in which a health care provider acts as a surrogate in implementing an important governmental social welfare program.

Finally, in the more recent *Ravenwood Health Care* case, the court rejected the debtor's argument seeking to place a limitation on Medicaid's exercise of its recoupment rights by permitting Medicaid to recoup only on a services-specific basis (*i.e.*, that overpayments for nursing services, for example, could only be recouped from subsequent payments for the same services). The court stated that "it would be unsound to limit the application of the doctrine of equitable recoupment to a situation in which, within a single transaction, an overpayment for a specific type of cost was recouped only by reducing a later payment for the same specific type of cost." [11]

Equitable Limits to Recoupment

While some recent decisions, from the First Circuit in particular, nonetheless have been read to suggest certain narrow limits to the application of the recoupment doctrine, warning that it is an equitable remedy and that it does not always necessarily require courts to direct recoupment based upon balancing of the equities, these decisions have continued to find broadly in favor of CMS's general right to recover overpayments by deducting those ***59** amounts from current and future reimbursements that are viewed as arising from the same transaction. In *Slater Health Center Inc. v. United States; Blue Cross & Blue Shield of Rhode Island (In re Slater Health Center Inc.)*, 398 F. 3d 98 (1st Cir. 2005), the First Circuit upheld the district court's ruling that a bankruptcy court, in applying the equitable recoupment doctrine, had ranged too broadly to balance the equities. While the bankruptcy court in *Slater* adopted the *TLC Hosps. Inc.* approach to Medicare's recoupment, it nevertheless denied Medicare's exercise of recoupment, emphasizing that recoupment, as an equitable doctrine, is not simply automatic, and that to have permitted Medicare's recoupment would have caused greater harm to certain third-party providers who were exclusively to have been paid from the specific Medicare proceeds. In affirming the district court's reversal of the bankruptcy court, the First Circuit, recognizing the narrow circumstances of the case, held that "in at least most cases, analysis of the recoupment issue should both begin and end with the same transaction question without discussing other equitable issues." [12] Similarly, in another First Circuit case, [13] the appeals court upheld the bankruptcy court's decision, which followed the reasoning of the *TLC Hosps. Inc.* line of cases that HCFA's efforts to adjust for past overpayments by deducting amounts from current reimbursement requests

were in the nature of recoupment and did not constitute voidable preferential transfers or violations of the automatic stay. The appeals court also rejected the debtor's argument that the case should have been remanded to the bankruptcy court to determine the appropriate equitable balance to be struck, noting (1) that recoupment is an equitable doctrine precisely because it would be inequitable for an entity receiving payments from CMS to enjoy the benefits of the same transaction without meeting its obligations and (2) the equitable powers of the bankruptcy court do not grant "a roving commission to do equity." [14]

New Bankruptcy Code §362(b)(28)

Some commentators have suggested that new Bankruptcy Code §362(b)(28) was intended to, and would, impact the recoupment/setoff issue, possibly by giving the government some new, indirect leverage (*i.e.*, threatening exclusion from the Medicare program) in order to be able to compel debtors to allow Medicare to recoup pre-petition overpayments against post-petition payments. Bankruptcy Code §362(b)(28) states:

> The filing of a petition under ... this title, or of an application under §5(a)(3) of the Securities Investor Protection Act of 1970, does not operate as a stay ... of the exclusion by the Secretary of Health and Human Services of the debtor from participation in the Medicare program or any other federal health care program (as defined in §1128B(f) of the Social Security Act pursuant to title XI or XVIII of such Act).

Other commentators have suggested, however, that the new §362(b)(28) was intended simply to codify existing judicial interpretations that hold that the police and regulatory power exemption to the automatic stay [15] is applicable only where the governmental unit is seeking to prevent fraud or protect patients or to implement some other sound public policy (as opposed to furthering its own pecuniary interests). [16]

Whatever the intent, it seems that, while not directly addressing Medicare/ Medicaid's recoupment rights, §362(b)(28) adds a significant arrow in the quiver, where the government wishes to force providers' hands, to compel providers to come current on their payments to Medicare and Medicaid if they wish to remain in the programs and ***60** in business. On the other hand, it is open to question as to whether in practice the Office of the Inspector General (OIG) of the Department of Health and Human Services would generally move to exclude a provider from the Medicare program based on the provider's delinquency or unwillingness to permit recoupment of pre-petition over-payments. [17]

To date, there have been no reported decisions to our knowledge involving the new §362(b)(28), so there is little evidence to suggest how courts will interpret the new provision. [18] Nor does it appear that HHS/CMS has, to date, issued any regulations or guidelines for interpreting §362(b)(28) suggesting how the government will exercise its seeming additional power. In one of the only cases involving an attempt by HHS to terminate or exclude a bankrupt provider since §362(b)(28) went into effect on Oct. 17, 2005, a brief by HHS in opposition to a debtor's motion for injunctive relief from the government's termination of the debtor's Medicare provider agreement adopted a more expansive reading of the new provision. [19] HHS/CMS argued that because BAPCPA does not define the word "exclusion," the word must be understood in its plain meaning. "The 'act or instance of excluding' is, of course, what occurs when a provider is no longer eligible to receive Medicare payments because of its termination; this is the ultimate in exclusion from the Medicare program." [20] It is useful to bear in mind that HHS/CMS was seeking in this case to terminate the debtor's provider agreement, not to exclude the debtor from the program, which is usually understood as a more serious sanction, and which, in the case of a mandatory exclusion, is based on a conviction for a crime relating to such things as patient abuse or neglect, fraud or embezzlement, or distribution or dispensation of controlled substances. Nevertheless, the relative lack of decisions and cases testing the limits of the new §362(b)(28) may itself be suggestive of the extent to which Medicare and Medicaid have broadly succeeded in the courts on -- while only selectively asserting -- their recoupment arguments.

Conclusion

Most courts that have recently addressed the issue have found that a sufficiently logical relationship exists between individual Medicare/Medicaid cost-years to constitute them into a single transaction, thereby allowing Medicare and Medicaid to **recoup** pre-petition **overpayments** to bankrupt providers by reducing post-petition amounts owed to the debtor/provider. While the Third Circuit -- which includes the Delaware bankruptcy courts, a venue for many large, complex cases -- may still have precedent based on an integrated transactions test that views each cost-year as a single, discrete transaction, the enactment of new Bankruptcy Code §362(b)(28), in conjunction with the overall judicial trend in other circuits allowing Medicare/Medicaid **recoupment**, would seem to give to the government a major advantage in any disputes it may wish to pursue over **recoupment** from bankrupt providers. Thus, the **recoupment** issue that held the attention of health care lenders and insolvency practitioners for more than a decade may prove to be of diminishing significance or prevalence as we enter the next phase of health care bankruptcies under BAPCPA and the rest of the Bankruptcy Code.

Footnotes

a1 *Harold Kaplan is co-chair and Timothy Casey is a partner in the Corporate Restructuring Practice Group at DrinkerBiddleGardnerCarton in Chicago.*

1 **Recoupment** is also available outside of the bankruptcy context.

2 11 U.S.C. §553.

3 **CMS**, formerly known as the Health Care Financing Administration (HCFA), is the agency through which the Department of Health and Human Services (HHS) administers the Medicare program.

4 A provider who qualifies to participate in the Medicaid program enters into agreements with both **CMS** and the state agency responsible for administering the Medicaid program in a particular state.

5 *Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.)*, 973 F. 2d 1065, 1081-82.

6 *In re Slater Health Center Inc.*, 2003 WL 21465161 (Bankr. D. R.I.); *In re Holyoke Nursing Home Inc.*, 273 B.R. 305 (D. Mass. 2002).

7 *In re Doctor's Hospital of Hyde Park Inc.*, 337 F.3d 951 (7th Cir. 2003).

8 *Sims v. U.S. Dept. of Health and Human Servs. (In re TLC Hosps. Inc.)*, 224 F.3d 1008 (9th Cir. 2000).

9 *U.S. v. Consumer Health Health Care Services of America*, 108 F.3d 390 (D.C. Cir. 1997).

10 Other cases that have adopted the logical relationship approach recognizing Medicare and Medicaid's right of **recoupment** across different program years include: *In re District Memorial Hospital of Southwestern North Carolina Inc.*, 297 B.R. 451 (Bankr. W.D.N.C. 2002); *In re Slater Health Center Inc.*, 2003 WL 21465161 (Bankr. D. R.I.); *In re Holyoke Nursing Home Inc.*, 273 B.R. 305 (D. Mass. 2002); *In re Home Comp Care*, 221 B.R. 202 (N.D. Ill. 1998); *In re Tri County Home Health Services Inc.*, 230 B.R. 106 (Bankr. W.D. Tenn. 1999); *In re AHN Homecare LLC*, 222 B.R. 804 (Bankr. N.D. Tex. 1998); *In re Heffernan Memorial Hospital District*, 192 B.R. 228 (Bankr. S.D. Cal. 1996); *In re Advanced Professional Home Health Care. Inc.*, 94 B.R. 95 (E.D. Mich. 1988); and *In re Yonkers Hamilton Sanitorlum*, 34 B.R. 385 (S.D.N.Y. 1983); *see also U.S. v. Consumer Health Health Care Services of America*, 108 F.3d 390 (D.C. Cir. 1997) (recognizing that an allowance of a right of set-off is consistent with the doctrine of equitable **recoupment**).

11 *Ravenwood Health Care*, 2007 WL 1657421, at *5-6.

12 398 F. 3d 98, 104.

13 *In re Holyoke Nursing Home Inc.*, 273 B.R. 305 (D. Mass. 2002).

14 In some earlier cases, dealing with some unusual exigencies, courts, recognizing the equitable nature of **recoupment**, affirmatively found against the exercise of and overrode Medicare/Medicaid's right of **recoupment**. In an unpublished decision dated Nov. 18, 1998, a Florida bankruptcy court allowed the sale of provider agreements free and clear of HHS's asserted **recoupment** rights, stating that a quick sale of the debtors' assets, including provider agreements, was the only alternative to immediate liquidation. *See In re BDK Health Management Inc., et al.*, Case Nos. 98-609-B1 through 98-614-B1 (jointly administered) (Bankr. M.D. Fla. Nov. 16, 1998). And the Delaware Bankruptcy Court, which is in and under the jurisdiction of the Third Circuit, following the Third Circuit's *Univ. Med. Ctr.* decision, has held that the entry of a DIP financing order limiting and enjoining the right of **recoupment** by any governmental unit to transactions within the same cost-year was not only consistent with *Univ. Med. Ctr.*, but was not barred by the 11th Amendment's sovereign immunity doctrine. *See In re Sun Health Care Group Inc., et al.*, 245 B.R. 779 (Bankr. D. Del., Feb. 25, 2000), *aff'd* 2002 WL 31155179 (D. Del. 2002). Similar DIP orders were entered in *In re Vencor Inc., et al.*, Case No. 99-3199 (Docket No. 127, Oct. 1, 1999). *In re Mariner Post-Acute Network Inc., et al.*, Case No. 00-0113 (Docket No. 746, March 20, 2000), and *In re Integrated Health Services Inc., et al.*, Case No. 00-0389 (Docket No. 359, March 6, 2000).

15 11 U.S.C. §362(b)(4).

16 *See* Maizel and Caplan, "Chicken Little Comes to Roost in Bankruptcy," *ABI Journal*, Vol. XXV, No. 6 (July/August 2006). *See also* Johnson, Rodney A. and Cogan, John Aloyius Jr., *Medicare, Medicaid, and Insolvency Handbook: Jurisdiction, Payment, and Enforcement*, 2006, stating that new §362(b)(28) "promptly resolves the ambiguity surrounding the viability of OIG exclusion actions in bankruptcy and again demonstrates the OIG's ability to influence Congress in a manner favorable to its interests" (p. 484). Such commentators argue that to the extent the government attempts to use §362(b)(28) to exclude providers from the Medicare program for failing to allow Medicare's right of **recoupment**, courts might apply the test that has traditionally been employed in determining whether a governmental act fails within the police and regulatory power exception to the automatic stay pursuant to §362(b)(4), namely whether the government is acting to further a sound public policy or merely to further its own pecuniary interests.

17 It has been argued that exclusion is a very specific term under the Medicare statutes and is a serious remedy reserved for the most egregious conduct. The four mandatory grounds for exclusion under the Medicare statutes are: (1) conviction for a crime related to the delivery of an item or service related to Medicare or state health care program; (2) conviction for a crime relating to patient neglect or abuse; (3) a felony conviction relating to health care fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct; and (4) a felony conviction relating to the manufacture, distribution, prescription or dispensing of a controlled substance. The Medicare statutes also enumerate 15 grounds for permissive or discretionary exclusion from the program. *See* 42 U.S.C. §1320a-7(a)-(b). Of the 15 discretionary grounds for exclusion, one ground in particular that relates to the government's pecuniary interest is the exclusion that may be permitted for default on health education loan or scholarship obligations by individuals who have received government educational loans and failed to pay those loans when they come due. *See* §42 U.S.C. 1320a-7(b)(14). By its very terms, of course, this ground for exclusion seems to apply to individuals and not to health care businesses that are seeking to reorganize through chapter 11.

18 There also appear to be very few unreported decisions relating to §362(b)(28).

19 HHS did not rely solely on §362(b)(28), claiming, additionally, that its administrative action to terminate the debtor's Medicare provider agreement for failure to comply with Medicare program health and safety standards for a period of six months fell squarely within the police and regulatory power exception to the automatic stay under §362(b)(4).

20 *See* "Federal Defendant's Opposition to Motion/Application for Injunctive Relief; Memorandum of Points and Authorities; Declarations in Support; Exhibits A-J," filed July 21, 2006, in *In re King Solomon Management Inc.*, Case No. LA 05-5000-VZ (C.D. Cal.). The debtor operated a 58-bed nursing home in Glendale, Galif. The court denied the debtor's request for injunctive relief and also dismissed an adversary proceeding, which the debtor subsequently filed against HHS. It appears that the debtor's Medicare provider agreement was reinstated in March 2007, and that the debtor successfully reorganized and emerged from chapter 11 in August 2007.

2007 WL 1657421
Only the Westlaw citation is currently available.
United States District Court,
D. Maryland.

RAVENWOOD HEALTHCARE, INC., Plaintiff
v.
STATE of Maryland, Department of Health and Mental Hygiene, Defendant.

Civil Action No. MJG–06–3059. | June 5, 2007.

Attorneys and Law Firms

Joel I. Sher, Paul Vincent Danielson, Kimberly Ann Manchester Stoker, Shapiro Sher Guinot & Sandler, Baltimore, MD, for Plaintiff.

Paul Jennings Ballard, Maryland Department of Health and Mental Hygiene, Office of Health Care Quality, Catonsville, MD, Brett Jason Bierer, Elizabeth Mary Kameen, Office of the Attorney General, Baltimore, MD, for Defendant.

DECISION ON APPEAL

MARVIN J. GARBIS, United States District Judge.

***1** The Court has before it Ravenwood Healthcare, Inc.'s ("Ravenwood") Appeal [Paper 9] of a final order of the United States Bankruptcy Court for the District of Maryland (Schneider, J.), Ravenwood's Motion to Strike Factual Exhibits Attached to Appellee's Brief [Paper 14], and the State of Maryland, Department of Health and Mental Hygiene's (the "State") Motion to Dismiss [Paper 19], and the materials related thereto. The Court has considered the materials submitted by the parties, has conducted a hearing and has had the benefit of the arguments of counsel.

I. *BACKGROUND*

A. *Procedural Posture*

On June 13, 2002, Appellant Ravenwood, a not-for-profit doing business as Ravenwood Nursing and Rehabilitation Center, filed a petition for bankruptcy protection. On March 30, 2004, Ravenwood initiated an adversary proceeding against the State pursuant to sections 541, 542 and 550 of the Bankruptcy Code seeking $971,410.10 in Medicaid funds that Ravenwood claimed the State of Maryland improperly withheld from it. [1]

After the completion of discovery, both the State and Ravenwood filed motions for summary judgment. On October 12, 2006, the Bankruptcy Court granted summary judgment in favor of the State and denied Ravenwood's motion. This appeal followed.

B. *Medicaid*

The Federal Medicaid Program, 42 U.S.C. § 1396 et *seq*. ("Medicaid") provides federal and state funding for individuals who are unable to afford medical care. Medicaid was instituted in 1965 with the passage of Title XIX of the Social Security Act (SSA), as added 79 Stat. 343, 42 U.S.C. § 1396 et *seq*. (2000 ed. and Supp. III). *See Arkansas Dep't of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 1758, 164 L.Ed.2d 459 (2006). Although states are not required to participate in the Medicaid program, they all do. *Id*. The federal government covers between 50–83% of patient care costs, while the states also pay a portion. *Id*. Even though numerous federal requirements govern the administration of Medicaid, the states

do have some discretion in how they will expend Medicaid funds. *See Cmty. Health Ctr. v. Wilson–Coker,* 311 F.3d 132, 134 (2d Cir.2002)(citing *Schweiker v. Gray Panthers*, 453 U.S. 34, 36–37, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981)). The Eleventh Circuit has explained that:

> Medicaid is a cooperative venture of the state and federal governments. A state which chooses to participate in Medicaid submits a state plan for the funding of medical services for the needy which is approved by the federal government. The federal government then subsidizes a certain portion of the financial obligations which the state has agreed to bear. A state participating in Medicaid must comply with the applicable statute, Title XIX of the Social Security Act of 1965, as amended 42 U.S.C. § 1396, *et seq*., and the applicable regulations.

Silver v. Baggiano, 804 F.2d 1211, 1215 (11th Cir.1986).

In Maryland, Medicaid is funded with equal parts of federal and state money. The federal government requires Maryland to provide nursing facility services for Medicaid recipients. *See*42 U.S.C. § 1396d (a)(4)(A). Each Medicaid provider of nursing facility services enters into a "Provider Agreement" with the State of Maryland agreeing to be bound by the State's policies and regulations, including the Medicaid reimbursement system. The Provider Agreement remains in effect until the provider's Medicaid participation ends.

***2** Medicaid providers in Maryland are reimbursed their allowed costs at the end of the fiscal year. Interim payments, based on the prior year's reimbursed costs and other factors, are made to the Medicaid provider during the year. *See*COMAR 10.09.10.07(C). At the close of the fiscal year, the State's accountant audits the provider's costs and reconciles the interim payments with the actual amount of allowable costs to be reimbursed to a facility. *Id*. After the audit has been completed, the State issues the Medicaid provider a "Final Cost Settlement," which sets forth the final calculation of the facility's Medicaid reimbursement. COMAR 10.09.10.14. The Final Cost Settlement notifies the provider whether it has been overpaid or underpaid by the interim payments made throughout the year and gives appeal rights. Overpayments must be returned to the State. COMAR 10.09.10.26(B). If the Medicaid provider has been underpaid, the State of Maryland must reimburse the provider the amount of the shortfall. COMAR 10.09.10.14(D).

II. *STANDARD OF REVIEW*

When a District Court reviews a Bankruptcy Court final Order, the District Court acts as an appellate court. Matters within the Bankruptcy Court's discretion are reviewed under an abuse of discretion standard. *In re Arnold,* 806 F.2d 937, 938 (9th Cir.1986). That is, the Bankruptcy Court's decisions within its discretion will be reversed only if they were "based on an erroneous conclusion of law or when the record contains no evidence on which the [Bankruptcy Court] rationally could have based [the decisions]." *In re Windmill Farms, Inc*., 841 F.2d 1467, 1472 (9th Cir.1988) (citing *In re Hill,* 775 F.2d 1037, 1040 (9th Cir.1985)). Accordingly, legal conclusions are reviewed *de novo*, whereas findings of fact may be set aside only if clearly erroneous. *See In re Bulldog Trucking, Inc*., 147 F.3d 347 (4th Cir.1998).

A grant of summary judgment by the Bankruptcy Court is reviewed by the District Court *de novo* under the standards prescribed by Rule 56 of the Federal Rules of Civil Procedure. Pursuant to Rule 56, summary judgment is appropriate if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. Pro. 56(c). Only "facts that might affect the outcome of the suit under the governing law" are material. *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 247, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). "Factual disputes that are irrelevant or unnecessary will not be counted." *Id*.

III. *DISCUSSION*

A. *Recoupment in Medicare/Medicaid Context*

In the bankruptcy context, it has been said that: "Recoupment is the right of a defendant to have a plaintiff's monetary claim reduced by reason of some claim the defendant has against the plaintiff arising out of the very contract giving rise to the plaintiff's claim."*See Powell v. FELRA and UFCW Health and Welfare Fund (In re Powell)*, 284 B.R. 573, 576 (Bankr.D.Md.2002) (quoting *First Nat'l Bank of Louisville v. Master Auto Serv. Corp.*, 693 F.2d 308, 310, n. 1 (4th Cir.1982)). The doctrine of equitable recoupment is not limited to the bankruptcy context. For example, in the tax context, the doctrine is applied to allow a party to avoid an inequitable consequence that would result from the strict application of normally applicable limitations *See Bull v. United States*, 295 U.S. 247, 55 S.Ct. 695, 79 L.Ed. 1421 (1935); *Stone v. White*, 301 U.S. 532, 57 S.Ct. 851, 81 L.Ed. 1265 (1937). In bankruptcy, the doctrine can be applied to avoid an inequitable consequence of the strict enforcement of the "border" between pre and post-petition actions.

***3** The automatic stay in bankruptcy imposed by 11 U.S.C. § 362 does not prevent the application of the equitable doctrine of recoupment. *In re Powell*, 284 B.R. at 575. Judicial approval is not required prior to recoupment because the " 'right of recoupment does not constitute a debt which is dischargeable.' " *Id.* (quoting *Aetna Life Ins. Co. v. Bram*, 179 B.R. 824, 827 (Bankr.E.D.Tx.1995)).

"Recoupment is not limited to pre-petition claims and thus may be employed to recover across the petition date." *Sims v. United States Dept. of Health and Human Servs. (In re TLC Hosps., Inc.)*, 224 F.3d 1008, 1011 (9th Cir.2000)(citing 5 *Collier on Bankruptcy* ¶ 553.10 at 553–104). In order for the doctrine of recoupment to apply, " 'both the creditor's claim and the amount owed to the debtor must arise from a single contract or transaction.' " *In re Powell*, 284 B.R. at 576 (quoting *Kosadnar v. Metro. Life Ins. Co.*, 157 F.3d 1011, 1013 (5th Cir.1998)).

Courts have recognized two different, somewhat inconsistent, tests in determining whether a creditor's claim arises from a single contract. The first, the logical relationship test, provides a flexible approach concentrating on the relationship between the creditor and debtor. Under the logical relationship test "a transaction may include a series of many occurrences, depending not so much upon the immediateness of their connection as upon their logical relationship." *In re Powell*, 284 B.R. at 576–77. A second, more restrictive, test is "the integrated transaction test." Pursuant to the integrated transaction test "both debts must arise out of a single integrated transaction so that it would be inequitable for the debtor to enjoy the benefits of that transaction without also meeting its obligations." *Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.)*, 973 F.2d 1065, 1081 (3rd Cir.1992).

There is a split of authority on whether Medicaid or Medicare overpayments to a recipient and offsetting subsequent underpayments are considered part of one transaction for purposes of recoupment in bankruptcy. Currently, the Third Circuit applies the integrated transaction test and concludes that each yearly payment to a Medicare provider constitutes a separate transaction. *See Univ. Med. Ctr.*, 973 F.2d at 1081. However, the First, Ninth and District of Columbia Circuits hold that Medicare overpayments and subsequent post-petition underpayments to the same recipient are all part of the same transaction even though not in the same year. *See Slater Health Ctr., Inc. v. United States (In re Slater Health Ctr., Inc.)*, 398 F.3d 98 (1st Cir.2005); *In re TLC Hosps.*, 224 F.3d at 1013;*United States v. Consumer Health Servs. of America, Inc.*, 108 F.3d 390 (D.C.Cir.1997). The Fourth Circuit has not yet adopted either test, and lower courts within this Circuit have taken inconsistent positions.

The initial Circuit Court of Appeals to examine the issue of recoupment in the context of Medicare or Medicaid was the Third Circuit. In *In re University Medical Center*, the Third Circuit considered whether the Department of Health and Human Services ("HSS") could withhold post-petition Medicare payments to University Medical Center ("UMC") in an attempt to recover pre-petition overpayments. The Third Circuit concluded that for purposes of recoupment, payments made for services in one year were not part of the same transaction as payments for services in later years. *See*973 F.2d at 1081. The court stated:

> ***4** [t]he relationship between HHS and a Medicare provider entails transactions that last over an extended period. However, each of these transactions begins with services rendered by the provider to a Medicare patient, includes payment to the provider, and concludes with HHS's recovery of any overpayment. Recovery of the 1985 overpayment, therefore, is the final act of the transactions that began in 1985. UMC's 1988 post-petition services were the beginning of transactions that would stretch into

> the future, but they were not part of the 1985 transactions. To conclude that these claims arose from the same transaction for the purposes of equitable recoupment would be to contort that doctrine beyond any justification for its creation. We conclude that the Department's post-petition withholding of the amount previously overpaid to UMC cannot be considered as equitable recoupment.

Id. at 1081–82.

In *Consumer Health Services*, the District of Columbia Circuit reached a contrary conclusion. *See*108 F.3d at 394–95. The *Consumer Health Services* court looked to the wording of the Medicare statue to determine that post-petition payments to the provider could be withheld to recoup Medicare overpayments made pre-petition because they were part of the same transaction. 108 F.3d at 395–96. The court noted:

> [s]ince [the Medicare statute] requires the Secretary to take into account pre-petition overpayments in order to calculate a post-petition claim ... Congress rather clearly indicated that it wanted a provider's stream of services to be considered one transaction for purposes of any claim the government would have against the provider. The Third Circuit said that '[t]he [pre-petition] overpayments ... cannot be deemed advance payments for [the provider's subsequent] services.' [*In re Univ. Med. Ctr.*, 973 F.2d at 1081.] That observation, in our view, is contrary to manifest congressional intent.

Id. at 395. Hence, the District of Columbia Circuit found that, even under the more restrictive integrated transaction test, post-petition services and pre-petition overpayments for services constituted one transaction for recoupment purposes. *Id*.

The Ninth Circuit applied the logical relationship test and agreed with the District of Columbia Circuit's *Consumer Heath Services* analysis. *See In re TLC Hosps.*, 224 F.3d at 1013. The *TLC Hospitals* court reasoned:

> [t]he fact that the overpayments and underpayments relate to different fiscal years does not destroy their logical relationship or indicate that they pertain to separate transactions. The Medicare statute creates a sufficient relationship between different cost years to permit recoupment.... [T]he fiscal intermediary generally will not begin an audit until after the provider has supplied its cost report. This cost report is not due until five months after the conclusion of the reporting period. 42 C.F.R. § 413.24(f)(2). Consequently, a reality of the complex Medicare system is that any overpayments will not be discovered, and accordingly the 'retroactive adjustment' will not occur, until after the end of the cost year in which the overpayments were made. The timing of the audit is not material to the logical relationship between the overpayments and underpayments.

***5** *Id*. The court added:

> [s]ound equitable considerations support HHS's right to recoup. The Medicare system reimburses estimated costs without waiting for an audit in order that providers like TLC may maintain a cash flow; those providers would otherwise find it difficult or impossible to function. Overpayments (and underpayments) are inherent in that system. It is fair for HHS to adjust for such overpayments in the operation of that system whether or not a bankruptcy has intervened. If a provider in bankruptcy does not wish to be subject to Medicare's system of adjustments, it can cease providing Medicare services. If it chooses to continue to provide those services during bankruptcy, it is not inequitable for the bankrupt or its creditors that those services be provided on the same, generally favorable, terms as those governing other providers.

Id. at 1014.

In *Holyoke Nursing Home, Inc. v. Health Care Financing Administration (In re Holyoke Nursing Home, Inc.)*, 372 F.3d 1, 4 (1st Cir.2004), the First Circuit allowed recoupment because it found that prior overpayments to the bankrupt Medicare provider were part of the same transaction as the provider's reimbursement claim for post-petition medical services. 372 F.3d at 4. In

reaching this conclusion, the First Circuit agreed with the position taken by the District of Columbia Circuit and the Ninth Circuit on this issue and noted that their position has been "embraced by the overwhelming majority of district and bankruptcy courts nationwide." *Id.; see also In re Slater Health Ctr.*, 398 F.3d at 105 (holding that Medicare payments spanning several years constitute one transaction, thereby allowing recoupment in bankruptcy).

In *In re District Memorial Hospital of Southwestern North Carolina, Inc.*, 297 B.R. 451 (W.D.N.C.2002), the District Court for the Western District of North Carolina adopted the reasoning of the *Consumer Health Services* and *In re TLC Hospitals* decisions and held that post-petition Medicaid payments could be withheld to recoup pre-petition overpayments because the payments all stemmed from one transaction. 297 B.R. at 456.*In re District Memorial Hospital*, like this case, concerned Medicaid payments. In reaching its decision, the court disagreed with two earlier, unreported bankruptcy court opinions from the same district, *In re Quality Link–Bertie, LP*, 2001 WL 34388128 (Bankr.W.D.N.C.2001) and *In re Colonial Health Investors, LLC*, 2001 WL 34388127 (Bankr.W.D.N.C.2001). *See In re Dist. Mem. Hosp.*, 297 B.R. at 455.

Both *In re Quality Link–Bertie* and *In re Colonial Health Investors*, like the instant case, involved Medicaid payments. The bankruptcy court in those cases adopted the reasoning of the Third Circuit in holding that recoupment was not available because the payments and reimbursements did not arise from the same transaction.

This Court agrees with the majority view and the Bankruptcy Court below that the pre-petition and post-petition payments amount to one transaction. Thus, it holds that recoupment is appropriate.

***6** Although this case involves Medicaid, not Medicare, this distinction is irrelevant.[2] The court in *In re District Memorial Hospital* noted:

> [t]he federal law that created the Medicaid Program and engendered the State Medicaid Program provided for recoupment of overpayments made to the States. In accordance with the requirements for implementing Medicaid in this State, North Carolina statutes and regulations provide for recoupment of overpayments made to health care providers. The continuous balancing process outlined in the parties' Provider Agreement is based on these federal and state law provisions. Therefore, application of the rules from *Consumer Health Serv.* and *TLC Hosps.* requires a holding that the ongoing stream of services, advances, and reconciliations constitutes a single transaction, and that recoupment be allowed in this case.
> 297 B.R. at 456.

It is noteworthy that Medicare cost principles of reimbursement are applied to Maryland's Medicaid program, unless those provisions conflict with Maryland regulations. *See e.g.*COMAR 10.09.10.08(B)(1); COMAR 10.09.10.09(B)(1); COMAR 10.09.10.10(B); COMAR 10.09.10.07(C)(5). Further, as in the Medicare recoupment cases, there is one Medicaid Provider Agreement at issue in this case.[3] The State makes interim payments to its Medicaid providers and reconciles those payments with the provider's actual costs on an annual basis. If payments to the provider exceed the provider's costs, the State is entitled to reimbursement of the excess funds. Thus, the operation of the Maryland Medicaid program does not differ in any material way from the operation of the federal Medicare program, and therefore, the treatment of payments to bankrupt providers likewise should not differ.

Equitable principles support recoupment in this case. As noted above, the Medicaid system is premised on continuous payments and reconciliations that span fiscal years. This system gives those providers the cash flow they need to furnish services throughout the year. Overpayments occur routinely. It would be inequitable to deny the State the right to recoup those overpayments from current reimbursements when the Medicaid provider continues to receive the benefits of the Medicaid program.

B. *SB 794*

Although Ravenwood and the State dispute the exact nature of funds made available to Maryland nursing facilities under Senate Bill 794 ("SB 794"), any such dispute is not material to the resolution of this matter.

Ravenwood claims that the $476,312.90 it seeks from the State is primarily payment under SB 794 for nursing services. Ravenwood also claims that those SB 794 funds differ from other Medicaid funds and, in fact, were not even eligible for the federal Medicaid match. Ravenwood argues that because of the special nature of SB 794 funds, the State is unable to recoup overpayments for pre-petition general Medicaid costs from the current payment of SB 794 funds owed to Ravenwood.

***7** The State disputes Ravenwood's characterization of both the payments currently owed Ravenwood as well as the nature of SB 794 funds. First, the State denies that the payments owed Ravenwood involve SB 794 monies. Rather, the State maintains that the current payments are for services that should have received a special reimbursement rate under the communicable disease incentive payment program. *See* Appellee's Brief [Paper 10] at 32. Second, the State argues that even if the current payments are for services under SB 794, there is no reason to treat those payments any differently than payments for any other Medicaid-eligible costs. *Id*.

Undeniably, Medicaid regulations can be complex. They authorize reimbursement for many different types of provider services. This Court is unaware of any other court basing recoupment on the specific types of services being reimbursed. Even assuming that the $476,312.90 currently owed Ravenwood represents payment for SB 794 services, and even if SB 794 services were in some way "special" or different from other services receiving federal Medicaid funds, the State is entitled to recoup prior overpayments from the payments currently due Ravenwood. It would be unsound to limit the application of the doctrine of equitable recoupment to a situation in which, within a single transaction, an overpayment for a specific type of cost was recouped only by reducing a later payment for the same specific type of cost. It is sufficient that the overpayment and later underpayment are of Medicaid payments.

C. *Jurisdiction*

1. *Exhaustion of Administrative Remedies*

The State argues that this Court has no jurisdiction to entertain disputes over the amount currently due Ravenwood under the Medicaid program because federal courts have no jurisdiction to review regulatory actions undertaken by state health departments administering programs like Medicaid. *See* Appellee's Brief [Paper 10] at 38–47. It is true that under federal regulations states must provide administrative review for Medicaid provider disputes over payment rates. *See*42 C.F.R. § 447.253(e). Maryland therefore provides for administrative review of the State's cost determinations under the Medicaid program. *See*COMAR 10.09.10.14. However, Ravenwood does not dispute the *amount* of current payments or prior overpayments, and therefore, the sole issue to be decided is whether recoupment is available to the State. [4]

In *University Medical Center* the court determined that the Bankruptcy Code provided jurisdiction under 28 U.S.C. §§ 157, 158, and 1334 and that the appeal was proper under 28 U.S.C. §§ 158(d) and 1291. 973 F.2d at 1072. The court reached this conclusion by finding that the dispute did not "arise under" the Medicare statute. [5] *Id*. In so finding, the court noted that neither party disputed the amount of the reimbursement. *Id*. at 1073. The court held that the debtor's claim arose under the Bankruptcy Code, and not the Medicare statute. *Id*.

***8** As in *University Medical Center*, this Court finds that the Bankruptcy Code provides jurisdiction for this dispute to the extent that there is no dispute over the *amount* that is subject to recoupment. The amount in controversy is undisputed and the only issue before the Court is whether the State may recoup a prior Medicaid overpayment from a current payment or must "get in line" with other creditors. If there were a dispute over the amount of money subject to recoupment, this Court would have no jurisdiction. Similarly, this Court would not have jurisdiction to determine whether state administrative policies and procedures were followed. However, since there is no issue as to the amount subject to recoupment, this Court has jurisdiction to determine whether recoupment is proper.

2. ***Sovereign Immunity***

The State did not appeal from the Bankruptcy Court's denial of dismissal based upon sovereign immunity. Moreover, in this appellate court, the issue was not raised until four days before the hearing. Of course, the defense of sovereign immunity is jurisdictional and can be raised at any time, even for the first time on appeal.[6] *Schlossberg v. Maryland (In re Creative Goldsmiths of Washington D.C., Inc.),* 119 F.3d 1140, 1144 (4th Cir .1997).

The State urges the Court to resolve the sovereign immunity issue before addressing the merits of the appeal. This approach may well be sensible in a typical case in which sovereign immunity is raised at a time when the issue can be fully briefed and carefully considered prior to the appellate hearing.

In the instant case, the Court finds it appropriate to first reach and resolve the merits of the appeal. Having held for the State on the merits of the appeal, the sovereign immunity issue is—as a practical matter—moot.

If required to rule on sovereign immunity, the Court would affirm the Bankruptcy Court's holding that Appellant's action is not barred by the doctrine of sovereign immunity in light of *Central Virginia Community College v. Katz,* 546 U.S. 356, 126 S.Ct. 990, 163 L.Ed.2d 945 (2006).

D. ***Ravenwood's Motion to Strike***

Ravenwood argues in its appeal that SB 794 funds were not eligible for federal Medicaid matching funds and that therefore, they were different from other Medicaid funds. In response to this argument, the State submitted two exhibits that were not part of the record below. The exhibits are both Nursing Home Transmittals dated June 22, 2001 from the Maryland Department of Health and Mental Hygiene to Nursing Home Administrators. Each Nursing Home Transmittal indicates that reimbursement rates for the nursing cost center (which was the recipient of the funds authorized by SB 794) will be increased, with the federal and state governments each bearing half of the reimbursement amount. The State maintains that it did not include the two exhibits in the record below because Ravenwood had not argued before the Bankruptcy Court that SB 794 funds were ineligible for federal matching Medicaid funds.

***9** A federal court is permitted to supplement the record on appeal when it is in the interest of justice. *See Dakota Indus., Inc. v. Dakota Sportswear, Inc.,* 988 F.2d 61, 63–64 (8th Cir.1993). Supplementation of the record is appropriate when there has been a mischaracterization that should be addressed. *Id*. Because it appears that SB 794 funds were, contrary to Ravenwood's assertion, entitled to matching federal funds, Ravenwood's motion to strike is denied.

Nevertheless, the Court does not find the issue of federal matching funds to be meaningful to the determination of whether recoupment was proper in this case. Regardless of whether the recouped funds were SB 794 funds or whether those funds received federal matching money, the State's regulations provide for the reconciliation of estimated payments with actual costs and the reimbursement of overpayments. *See*COMAR 10.09.10.07(C)(1); COMAR 10.09.10.07(C)(5); COMAR 10.09.10.26(B); COMAR 10.09.36.07(B). This process does not depend on the source of monies received by Ravenwood, *i.e.*, federal or state Medicaid funds.

IV. ***CONCLUSION***

For the foregoing reasons:

1. The October 12, 2006 Order Granting the State of Maryland, Department of Health and Mental Hygiene's Motion for Summary Judgment shall be AFFIRMED.

2. A separate Order affirming the Bankruptcy Court shall be issued herewith.

SO DECIDED, on *Monday, June 4, 2007*.

Footnotes

1 Since filing the Complaint, the State paid Ravenwood $495,097.20, leaving $476,312.90 in dispute. *See* Appellant's Brief [Paper 9] at 2.

2 The decisions from the First, Third, Ninth and D.C. Circuits dealing with recoupment in the Medicare context did not address Medicaid.

3 Ravenwood and the State entered into the Medicaid Provider Agreement in 1996.

4 To be sure, Ravenwood disputes the timing and calculation of the recoupment. Ravenwood maintains that the State improperly recouped $327,741 for fiscal year ("FY") 2000 because Ravenwood had appealed the State's FY 2000 audit and that appeal was pending when the State recouped its money. *See* Appellant's Brief [Paper 9] at 9–11. Ravenwood argues that its debt of $327,741 should have been eliminated under relevant Maryland regulations during the pendency of the appeal. *Id*. Although Ravenwood acknowledges that it has subsequently withdrawn its appeal and FY 2000 overpayment is now finalized at $327,741, Ravenwood contends that it is inequitable to allow the State's recoupment of that money to stand since the recoupment occurred when the debt was not due. As is discussed further above, this Court has no jurisdiction to decide whether the State adequately followed its own regulations and whether the recoupment of the $327,741 was proper prior to the conclusion of the State administrative proceedings.

5 The Medicare Act requires that a provider dispute a final determination of the amount of Medicare reimbursement before the Provider Reimbursement Review Board if the amount in controversy exceeds $10,000. *See*42 U.S.C. § 1395*oo* (a). The Board's decision is reviewable by the Secretary of the Department of Health and Human Services. *Id*. at § 1395*oo* (f)(1). Only after a final agency determination may the provider seek judicial review. *Id*.

6 The State filed a motion to dismiss before the Bankruptcy Court on the basis that the Eleventh Amendment to the United States Constitution grants it sovereign immunity. The Bankruptcy Court denied the State's motion to dismiss. Instead of appealing that decision, the State filed a new motion to dismiss before this Court under Rule 8011 Federal Rules of Bankruptcy Procedure.

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UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re:	**Chapter 11**
AXCESS MEDICAL IMAGING CORPORATION,	**Case No. 8:09-bk-12180-CED**
US IMAGING HOLDING, LLC,	**Case No. 8:09-bk-12181-CED**
U.S. IMAGING CENTER CORP., LLC,	**Case No. 8:09-bk-12182-CED**
AXCESS DIAGNOSTICS BRADENTON, LLC,	**Case No. 8:09-bk-12183-CED**
AXCESS DIAGNOSTICS SARASOTA, LLC,	**Case No. 8:09-bk-12184-CED**
CLEARWATER RESOURCES, INC.,	**Case No. 8:09-bk-12186-CED**
BRADENTON RESOURCES, INC.,	**Case No. 8:09-bk-12187-CED**
MRI-SOUTH UMBERTON, INC.,	**Case No. 8:09-bk-12189-CED**
MORGAN MEDICAL CORPORATION,	**Case No. 8:09-bk-12190-CED**
CHARLOTTE RESOURCES, INC.,	**Case No. 8:09-bk-12192-CED**
JACKSONVILLE RESOURCES, INC.,	**Case No. 8:09-bk-12194-CED**
AXCESS MANAGEMENT GROUP, LLC,	**Case No. 8:09-bk-12197-CED**
Debtors. _____/	***Jointly Administered Case No. 8:09-bk-12180-CED***

ORDER GRANTING DEBTORS' EMERGENCY MOTION FOR ENTRY OF AN ORDER (I) APPROVING BIDDING PROCEDURES IN CONNECTION WITH THE SALE OF SUBSTANTIALLY ALL OF THEIR ASSETS, (II) ESTABLISHING PROCEDURES FOR THE ASSUMPTION AND/OR ASSIGNMENT BY THE DEBTORS OF CERTAIN EXECUTORY CONTRACTS AND UNEXPIRED LEASES, (III) APPROVING MINIMUM OVERBID AMOUNT AND A BREAK-UP FEE, (IV) APPROVING FORM AND MANNER OF NOTICE OF BIDDING PROCEDURES, AND (V) SETTING OBJECTION DEADLINES

THIS CASE came on for hearing before the Court on November 20, 2009, at 10:00 a.m. (the "Hearing"), upon the Debtors' Emergency Motion for Entry of an Order (I) Approving Bidding Procedures in Connection with the Sale of Substantially All of Their Assets, (II) Establishing

Procedures for the Assumption and/or Assignment by the Debtors of Certain Executory Contracts and Unexpired Leases, (III) Approving Minimum Overbid Amount and a Break-Up Fee, (IV) Approving Form and Manner of Notice of Bidding Procedures, and (V) Setting Objection Deadlines [Doc. No. 341] (the "Procedures Motion").[1] In the Procedures Motion, the Debtors requested an expedited hearing for the Court to consider the entry of an order (i) approving bidding procedures in connection with the sale of substantially all of their assets to Altamonte Springs Diagnostic Imaging, Inc. or another Bidder (as defined below), (ii) establishing procedures for the assumption and/or assignment by the Debtors of certain executory contracts and unexpired leases to which the Debtors are a party, (iii) approving a minimum overbid amount and a break-up fee in connection with such sale, (iv) approving the form and manner of notice of the bidding procedures, and (v) setting deadlines for objections to the sale. No objections were filed to the Procedures Motion, except for the Objection filed by HCI Secured Medical Receivables Special Purpose Corporation ("HCI") [Doc. No. 357] (the "HCI Objection").

The Court finds that the Debtors have entered into an Asset Purchase Agreement dated as of November 13, 2009 (the "Purchase Agreement"), with Altamonte Springs Diagnostic Imaging, Inc., a Florida corporation (the "Purchaser"), providing for the sale by the Debtors to the Purchaser and the purchase by the Purchaser, pursuant to 11 U.S.C. §§ 363 and 365, of substantially all of the assets (the "Assets") of the Debtors for $5,000,000 in cash plus the assumption of certain liabilities of the Debtors. The Purchase Agreement is attached as Exhibit A to the Procedures Motion.

The Court considered the Procedures Motion, together with the record and the arguments of counsel at the Hearing, and being otherwise duly advised in the premises, and for the reasons

[1] Unless otherwise defined herein, capitalized terms used herein shall have the meaning ascribed to such terms in the Procedures Motion.

announced on the record at the Hearing, finds that the relief requested in the Procedures Motion is necessary and appropriate, and that the Procedures Motion is well taken and shall be granted in accordance with the terms and conditions set forth herein. Specifically, the Court finds that it would be in the best interest of the Debtors, their creditors and their estates that an orderly procedure for the selection of the highest and best offer for the sale of the Assets be established. The Court thus finds that it is appropriate to provide other prospective purchasers with the opportunity to submit competing bids, such that notice of the proposed sale of the Assets to the Purchaser shall be sent to all parties that were notified pre-petition and post-petition by the Debtors or their agents of the potential opportunity to acquire the Assets and all parties that have expressed interest to the Debtors or their agents in acquiring the Assets (collectively, the "Bidder List"). The Court also finds that it is appropriate to require any such prospective purchasers to comply with certain requirements in connection with the submission of competing bids, and that the bidding procedures proposed by the Debtors, as set forth in the Procedures Motion and as modified herein, are reasonable. The Court further finds that it is appropriate under the circumstances to approve a break-up fee and a minimum overbid amount as set forth below. The Court also finds that it is appropriate to establish deadlines for the filing and service of written objections to the Sale Motion (as defined below) and the sale of the Assets to the Purchaser as set forth in the Purchase Agreement.

The Court also finds that it is appropriate that, upon the filing of the Assignment Motion with the Court, (i) notice of the proposed assumption and/or assignment of any Contract to the Purchaser be sent to each lessor or other party to any Contract to be assumed and/or assigned to the Purchaser (collectively, the "Contract Parties"), and (ii) the time set forth in Section 365(d)(4) of the Bankruptcy Code for the Debtors to assume their non-residential real property leases shall be extended until the closing of the sale of the Assets as provided below in this Order. The Court finds

that it is also appropriate to require the establishment of a deadline for the filing and service by the Contract Parties of written objections to, and/or the assertion of any cure claims, defaults or any other claims against the Debtors in connection with, the proposed assumption and/or assignment of any Contract to the Purchaser.

The Court finds that the Procedures Motion and the notice of the Hearing on the Procedures Motion were served upon (i) Amegy Bank, N.A. ("Amegy") and its counsel, (ii) HCI and its counsel, (iii) counsel to the Committee, (iv) the Purchaser and its counsel, (v) the Office of the United States Trustee, and (vi) the parties set forth on the Local Rule 1007(d) Parties in Interest List for these Chapter 11 cases. The Court finds that notice of the Procedures Motion and the Hearing to creditors and other parties in interest was sufficient, that it complied with the Bankruptcy Code, the Federal Rules of Bankruptcy Procedure, and the Local Rules of this Court, and that the parties have proceeded in good faith.

ACCORDINGLY, IT IS ORDERED, ADJUDGED AND DECREED that:

1. The Procedures Motion is GRANTED to the extent set forth hereinbelow.

2. The Debtors shall, within two (2) business days from the date of this Order, mail a copy of this Order, by United States first class mail, to (a) all parties on the Bidder List, (b) all Contract Parties, and (c) all parties listed on the Local Rule 1007(d) Parties in Interest List, and thereafter file a certificate of service with the Court.

3. By no later than five (5) business days after the date of this Order, the Debtors shall file with the Court (a) a motion to approve the transactions contemplated by the Purchase Agreement (the "Sale Motion"), which Sale Motion shall seek the Court's entry of the Sale Order (as defined in the Purchase Agreement), including approval of the Purchase Agreement and of the Debtors' performance under the Purchase Agreement consistent with the terms, conditions and dates set forth

in this Order, and (b) a motion for authority to assume and/or assign the Contracts to the Purchaser (the "Assignment Motion"). The Debtors shall serve the Sale Motion and the Assignment Motion on all parties set forth on the Local Rule 1007(d) Parties in Interest List and all creditors of the Debtors, and thereafter file a certificate of service with the Court.

4. The Debtors or their agent, Berenfeld Capital Markets, LLC, shall promptly serve a copy of the Purchase Agreement, the Sale Motion, and the Assignment Motion, by United States first class mail or electronic mail transmission, to all parties on the Bidder List and to the Contract Parties, to the extent not already delivered, and the Debtors shall thereafter file a certificate of service with the Court.

5. A hearing (the "Sale Hearing") to consider approval of the Sale Motion and the Purchase Agreement (including that it is the highest and best offer for the Assets) and the Assignment Motion and to consider any timely filed objections thereto, as well as any Bids (as defined below), shall be held before the Honorable Caryl E. Delano at the United States Bankruptcy Court, Courtroom 10B, Sam M. Gibbons United States Courthouse, 801 North Florida Avenue, Tampa, Florida, on **January 15, 2010, at 9:00 a.m.** immediately following the Auction. The Sale Hearing may be adjourned and/or continued in open Court from time to time without further notice.

6. The Court approves the following procedures (the "Bid Procedures") for the submission and consideration of any written competing bid ("Bid") by any competing bidder ("Bidder") for all or any of the Assets:

(a) Any Bidder desiring to make a Bid for all or any of the Assets shall deliver the Bid, by electronic transmission, to counsel to the Debtors, Charles A. Postler, Esq., Stichter, Riedel, Blain & Prosser, P.A., 110 E. Madison Street, Suite 200, Tampa, Florida 33602 (cpostler@srbp.com), **by no later than 12:00 p.m. (Eastern Standard Time) on January 11, 2010** (or such later date agreed to by the Debtors) (the "Bid Deadline"). Counsel to the Debtors shall file each such Bid with the Court by 5:00 p.m. on January 11, 2010 and

simultaneously serve each such Bid on the following parties by facsimile or electronic mail transmission or the Court's CM/ECF system: (i) counsel to the Purchaser, Cort A. Neimark, Esq., Fowler White Burnett P.A., One Financial Plaza, Suite 2100, 100 Southeast Third Avenue, Fort Lauderdale, Florida 33394, (ii) counsel to the Committee, Frank P. Terzo, Esq., GrayRobinson, P.A., 1221 Brickell Avenue, Suite 1650, Miami, Florida 33131, (iii) counsel to Amegy, John J. Lamoureux, Esq., Carlton Fields, P.A., 4221 West Boy Scout Boulevard, 10th Floor, Tampa, Florida 33607-5736, (iv) counsel to HCI, David B. Tatge, Esq., Epstein Becker & Green, P.C., 1227 25th Street, N.W., Suite 700, Washington, DC 20037, and (v) the Office of the United States Trustee, Attn: Theresa Boatner, Timberlake Annex, 501 East Polk St., Suite 1200, Tampa, Florida 33602.

(b) **By no later than 5:00 p.m. (Eastern Standard Time) on January 12, 2010**, the Debtors shall file a notice with the Court of the Bids received by the Bid Deadline (including the Purchaser's offer in the Purchase Agreement), which notice shall set forth the name of each Bidder, the Assets offered to be purchased and the purchase price therefor, and the Bidder's allocation of its purchase price among the Assets. The Debtors will serve such notice, by facsimile or electronic mail transmission or the Court's CM/ECF system, on the parties listed in subparagraph (a) above and counsel to all Bidders.

(c) Prior to receipt by a prospective Bidder of any information (including business and financial information and access to the Debtors) from the Debtors, each such Bidder will be required to execute a confidentiality agreement in form and content acceptable to the Debtors, to the extent not already executed. Upon the execution of a confidentiality agreement, each Bidder will be granted full and complete access to the Debtors' virtual data room.

(d) A Bid shall include the following:

i) A copy of the initial written purchase offer in the form of an asset purchase agreement, executed by such Bidder, in substantially the form of the Purchase Agreement (the "Bidder's Agreement"); provided, however that any Bidder's Agreement which contains terms different from the Purchase Agreement must be black-lined to show any changes made by such Bidder to the form of the Purchase Agreement, and must be signed by such Bidder and be subject to acceptance by the Debtors solely by their execution thereof and necessary Court approval. The Debtors may accept modifications to the Purchase Agreement as submitted by a Bidder who otherwise complies with the Bid Procedures if the Debtors determine, in the exercise of their business judgment, that the proposed modifications

result in a higher and better offer for the Assets or the proposed modifications are necessary due to the fact that the Bidder is not seeking to purchase substantially all of the Debtors' Assets. The Debtors shall promptly furnish a copy of the Purchase Agreement in Microsoft Word format to any Bidder requesting a copy.

ii) **Notwithstanding anything to the contrary in this Order, any Bidder may submit a Bid to purchase only such Assets owned by or utilized by the Debtors as it deems necessary or appropriate, whether or not any specific Assets owned or utilized by the Debtors are proposed to be purchased by the Purchaser pursuant to the Purchase Agreement. By way of example but not by way of limitation, a Bidder may submit a Bid to purchase the Assets of a single Debtor or the Assets of more than one of the Debtors, including only the accounts receivable of one or more of the Debtors, only one locationof the Debtors, and so forth. There shall be no restrictions of any nature as to the number and type of Assets that a Bidder may seek to purchase.**

iii) To the extent practicable, a statement that specifically sets forth the extent to which the Bid is higher and better than the offer set forth in the Purchase Agreement, including an allocation of the Bid as to the Assets being purchased by the Bidder.

iv) A designation of any executory contracts or unexpired leases such Bidder desires the Debtors to assume and/or assign to it (the "Designated Contracts").

v) A purchase price which is cash only (unless otherwise agreed by the Debtors and the Committee).

vi) A designation of those liabilities of the Debtors such Bidder intends to assume.

vii) Relevant background and financial information reasonably satisfactory to the Debtors and the Committee (including without limitation the latest available financial statements) demonstrating the Bidder's financial ability to close and to consummate an acquisition of the Assets, such as (1) evidence of the Bidder's ability to assume or satisfy the terms and obligations of the Bidder's Agreement, pay the purchase price provided for therein and provide adequate assurance of future performance as to any Designated Contracts pursuant to Section 365 of the Bankruptcy Code, (2) an unconditional lending commitment from a recognized financial institution or cash sources in the amount of the Bid, (iii) a letter of credit from a

recognized financial institution in the amount of the Bid, and/or (iv) proof of cash on deposit exceeding the amount of the Bid.

viii) In the event a Bidder submits a Bid to purchase all of the Assets offered to be purchased by the Purchaser, a good faith deposit in immediately available funds in the amount of $50,000 (the "Bid Deposit"), which shall be made payable to and delivered to Stichter, Riedel, Blain & Prosser, P.A. ("SRBP"), counsel to the Debtors, by no later than the Bid Deadline (or such later date agreed to by the Debtors). The Bid Deposit shall be deposited into a non-IOTA interest-bearing trust account maintained by SRBP. Such Bid Deposit will be non-refundable to the Bidder in the event such Bidder's Bid is approved by the Court at the Sale Hearing as the highest and best offer and such Bidder fails to close on the purchase of the Assets for any reason. The Bid Deposit will be applied against the purchase price at the closing. Within fifteen (15) days following the entry of the Sale Order, SRBP will return the Bid Deposit of any Bidder (except the Backup Bidder) that is not selected as having the highest and best offer at the Sale Hearing. In the event a Bidder submits a Bid to purchase less than all of the Assets offered to be purchased by the Purchaser, then the Debtors will attempt to negotiate the amount of the good faith deposit from such Bidder prior to the Auction; provided that, if the Debtors and such Bidder are unable to agree on the amount of the deposit, the Court will determine the amount of such deposit prior to the Auction and such Bidder will be required to deliver such deposit to SRBP immediately following the Auction if it is the winning Bidder for such Assets.

(e) An auction ("Auction") to consider any competing bids in respect of the Assets will be held at the Court on **January 15, 2010, at 9:00 a.m.** immediately preceding the Sale Hearing. Prior to the Auction, the Debtors will inform the Court of the differences between any Bids and the Purchase Agreement, and recommend to the Court the offer that the Debtors consider to be the highest and best offer to the Debtors' estates for the Assets, after taking into account all aspects of the Bids and the Purchase Agreement (including, without limitation, the amount of the purchase price, the method and timing of the payment of the purchase price, conditions to closing, the time for closing, the representations, warranties and covenants to be provided by the Debtors, the indemnification obligations of the Debtors, and the proceeds to be received by the Debtors from one transaction for the purchase of all of their Assets as compared to the aggregate proceeds to be received by the Debtors from piecemeal sales of their Assets). All potential Bidders or their authorized representatives must be present at the Auction and the Sale Hearing. The Court will determine the highest and best offer at the Sale Hearing.

(f) In the event a Bidder submits a Bid to purchase all of the Assets offered to be purchased by the Purchaser, the initial Bid must provide for a purchase price for the Assets of $100,000 above the $5,000,000 cash purchase price offered by the Purchaser plus the amount of the liabilities of the Debtors to be assumed by the Purchaser under the Purchase Agreement. The Purchaser and all other Bidders shall be entitled to submit further bids at the Auction. All subsequent higher Bids above the initial Bid (including any subsequent Bid which may be made by the Purchaser) must be in incremental increases of at least $50,000 and be payable in cash (the "Overbid Amount"). In the event a Bidder submits a Bid to purchase less than all of the Assets offered to be purchased by the Purchaser, then the Court will determine the amount of any overbid for such Assets prior to the start of the Auction.

(g) Any Bid shall not be contingent upon receipt of financing or due diligence past the Bid Deadline.

(h) Any Bidder shall provide satisfactory evidence (as determined by the Debtors) that it is (i) financially able to consummate the transaction contemplated by such Bid and (ii) able to consummate the transaction on the date and on the terms contemplated by the Bidder's Agreement.

(i) Any Bid shall not contain any conditions precedent to such Bidder's obligation to purchase the Assets and assume and perform any liabilities to be assumed, other than as may be included in the Purchase Agreement.

(j) Any Bid shall set forth (1) any applicable governmental, regulatory, or other approvals and any applicable consents that would be required to be obtained were the Bidder to be the successful Bidder, (2) all actions taken to obtain such approvals or consents, (3) any approvals or consents obtained, and (4) the Bidder's best estimates as to the likelihood and timing of any such approvals or consents.

(k) If any Bid does not conform to all of the requirements set forth above, such Bid will not be considered by the Court or be admissible at the Sale Hearing, unless otherwise agreed by the Debtors and the Committee in their sole discretion or otherwise ordered by the Court.

(l) The Court shall register the second highest Bid and Bidder (the "Backup Bidder"), whose Bidder's Agreement shall be a binding contract with the Debtors and shall close in the event the successful Bidder fails to consummate the acquisition of the Assets in accordance with the provisions described above and in the Sale Order. Any closing with the Backup Bidder shall occur within five (5) days of notification that the successful Bidder failed to close.

(m) In the event a Bidder (including the Purchaser) is the winning Bidder (as approved by the Court), and such winning Bidder fails to close on the transaction in accordance with the Bidder's Agreement (or the Purchase Agreement in the case of the Purchaser), the Debtors may keep the earnest money deposit of such winning Bidder as set forth in the Bidder's Agreement (or the Purchase Agreement in the case of the Purchaser) and reserve the right to pursue all available remedies, whether legal or equitable, available to the Debtors.

(n) Except for the Purchaser, no Bidder submitting any Bid shall be entitled to any expense reimbursement or any break-up, termination or similar fee or payment.

7. This Order is without prejudice to the rights of Amegy to exercise its credit bid rights under Section 363(k) of the Bankruptcy Code as to any of the Assets that Amegy asserts constitutes its collateral (the "Amegy Collateral"). This Order is also without prejudice to the rights of HCI to exercise its credit bid rights under Section 363(k) of the Bankruptcy Code as to any of the Assets that HCI asserts constitutes its collateral (the "HCI Collateral"). Any such credit bid shall be filed with the Court by **no later than 5:00 p.m. (Eastern Standard Time) on January 13, 2010** and, if not filed by that time, then Amegy and/or HCI will not be entitled to submit a credit bid at the Auction. Any bid by Amegy or HCI that exceeds its credit bid rights shall comply with the overbid procedures set forth above. Notwithstanding anything to the contrary contained in this Order, the Debtors and the Committee reserve all rights (i) to object to, limit or strike any credit bid by Amegy or HCI, and (ii) to object to the right of Amegy or HCI to credit bid with respect to the Amegy Collateral or the HCI Collateral, respectively, including the issue of whether Section 363(k) applies to the sale of the Debtors' Assets.

8. Any creditor or other party in interest objecting to the Sale Motion or the sale of the Assets to the Purchaser must file written objections with the Court and serve same upon counsel to the Debtors and the parties set forth in Paragraph 6(a) above so as to be actually received by all such

parties **by no later than 12:00 p.m. (Eastern Standard Time) on January 11, 2010**. Any such objection shall set forth with specificity the grounds for such objection. Any creditor or other party in interest not timely filing such written objection shall be conclusively deemed to have waived any objection it may have to the sale of the Assets to the Purchaser or the selection of the Purchaser's offer as the highest and best offer for the Assets, without prejudice to the Court's authority to conduct an auction between the Purchaser and qualified Bidders at the Sale Hearing. Any timely filed objections to the Sale Motion or the sale of the Assets to the Purchaser will be heard at the Sale Hearing, as well as any objection to the offer of any other Bidder (which objection may be made at the Sale Hearing).

9. Any lessor or other party to any Contract to be assumed and/or assigned to the Purchaser that objects to, and/or asserts any cure claims, defaults or any other claims against the Debtors in connection with, the proposed assumption and/or assignment of its Contract must file with this Court, **by no later than 12:00 p.m. (Eastern Standard Time) on January 11, 2010**, any objection to the assumption and/or assignment of its Contract and/or assertion of claim or default (the "Objection"), which Objection shall set forth:

(a) the specific grounds for such Objection;

(b) any and all defaults of the Debtors (whether monetary or non-monetary) that it alleges are in existence under such Contract and, (i) if such alleged defaults are monetary, the nature of such monetary defaults (including the date and amount of any payment allegedly due under the Contract) and cure amounts, if any, due and owing by the Debtors pursuant to 11 U.S.C. §365(b) and, (ii) if such alleged defaults are non-monetary, the nature of such non-monetary defaults and the amount of money or the type of action required to cure such non-monetary defaults; and

c) any and all claims of any nature whatsoever against the Debtors.

10. Any lessor or other party to any Contract who fails to timely file written Objection to the proposed assumption and/or assignment of its Contract as set forth above shall be conclusively

deemed to have waived any such Objection and to have consented to the assumption and/or assignment of its Contract to the Purchaser. Any lessor or other party to a Contract not specifying any default or claim as required herein shall be deemed to have conclusively acknowledged that no default or claim exists under any such Contract.

11. Any creditor, any lessor or other party to a Contract to be assumed and/or assigned to the Purchaser, or any other party in interest filing an Objection to the Assignment Motion must serve the same upon counsel for the Debtors and the parties listed in Paragraph 6(a) above in a manner designed to assure actual receipt by such parties by the Bid Deadline.

12. **The filing of the Assignment Motion by the Debtors prior to the Sale Hearing shall extend the time set forth in Section 365(d)(4) of the Bankruptcy Code for the Debtors to assume any non-residential real property leases to which the Debtors are a party until the closing of the sale of the Assets to the Purchaser or any other winning Bidder pursuant to the Sale Order. Any landlord that is a party to a non-residential real property lease with the Debtors shall have twenty (20) days following the date of this Order to object to such extension of the time set forth in Section 365(d)(4) of the Bankruptcy Code. If no such objection is filed, a landlord shall be deemed to have conclusively acknowledged and consented to such extension.**

13. On account of the Purchaser's time, expenses, fees, costs, trouble and lost opportunity costs in respect of the transactions contemplated by the Purchase Agreement, the Court hereby approves a break-up fee for the Purchaser in the amount of $50,000 (the "Break-Up Fee"), provided that the Purchaser submits its opening bid (as set forth in the Asset Purchase Agreement) at the start of the Auction with no contingencies and is not the winning Bidder at the Auction. The Court finds that the Break-Up Fee is fair and reasonable under the circumstances. The Break-Up Fee shall be

paid out of the first proceeds of the sale of the Debtors' Assets prior to the satisfaction of any of the Debtors' other claims or indebtedness. The Break-Up Fee shall be paid only from such proceeds.

14. The Court also finds that the Overbid Amount of $50,000 is reasonable under the circumstances and approves the Overbid Amount in connection with any Bids to purchase substantially all of the Debtors' Assets.

15. The granting of the Procedures Motion as set forth herein shall not constitute the approval of any sale of the Assets or any term or provision of the Purchase Agreement, except with regard to the Break-Up Fee and Overbid Amount specifically approved herein. All parties reserve all rights and defenses with respect to the Sale Motion and the Purchase Agreement.

16. To the extent not addressed above in this Order, the HCI Objection is overruled.

17. To the extent there is any inconsistency between the provisions of this Order and the terms of the Purchase Agreement, the provisions of this Order shall control.

DONE and **ORDERED** in Chambers at Tampa, Florida, on _____.

_____
CARYL E. DELANO
United States Bankruptcy Judge

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re:

BEAM MANAGEMENT, LLC d/b/a HARMONY HEALTHCARE AND REHABILITATION CENTER OF SARASOTA,	CASE NO. 8:10-bk-08580-KRM Chapter 11
Debtor. /	

ORDER APPROVING BID PROCEDURES RELATING TO SALE OF THE CERTIFICATE OF NEED AND LICENSE FOR THE DEBTOR'S NURSING HOME

This matter came before the Court at a hearing on November 2, 2011, upon the Trustee's Emergency Motion for Entry of Orders (A) Approving Bidding Procedures and Scheduling Bid Deadline, Auction and Sale Hearing to Approve Sale of Certificate of Need and License (collectively, the "**CON**"); (B) Authorizing the Trustee to Sell CON, to the Highest or Otherwise Best Bidder, Free and Clear of All Liens, Claims, Interests and Encumbrances, and (C) Granting Related Relief (Doc. No. 417) (the "**Motion**").[1] The Court having reviewed the Motion; the Court having jurisdiction over this matter pursuant to 28 U.S.C. §§ 157 and 1334; this matter being a core matter pursuant to 28 U.S.C. § 157(b)(2); notice of the Motion and the hearing on the Motion were sufficient under the circumstances and no further notice need be given;

IT IS HEREBY ORDERED that:

1. The Motion is GRANTED.

[1] All capitalized terms used but not defined herein shall have the meanings ascribed to such terms in the Motion.

2. The following Bid Procedures are hereby approved and shall apply with respect to the proposed Sale of the CON:

- **Qualified Participant:** In order to be qualified to participate in the auction sale of the CON (the "**Auction**"), a potential bidder must:
  - execute a non-disclosure agreement in form and subject acceptable to the Trustee;
  - acknowledge that the due diligence information provided by the Trustee has been prepared solely for the convenience of potential bidders to assist them in their determination of whether they wish to submit a proposal to purchase the CON;
  - acknowledge that the Trustee makes no representation or warranty that such due diligence information is complete or accurate and any and all representations or warranties, express or implied, are hereby expressly disclaimed;
  - acknowledge that the potential bidder will not and should not reasonably rely on this information in arriving at a decision to purchase the CON; and
  - Provide sufficient financial information that satisfies the Trustee, in her sole discretion, of such potential bidder's ability to close a transaction.

- **Qualified Bidders:** Only qualified bidders (the "**Qualified Bidders**") may submit bids for the CON, or otherwise participate in the Auction. Persons or entities who propose to become Qualified Bidders ("**Proposed Qualified Bidders**") shall:
  - comply with the requirements of the paragraph above (*i.e.*, the requirements for becoming a Qualified Participant); and
  - on or before December 8, 2011 (the "**Bid Deadline**"), submit an offer that complies with the requirements in the paragraph below (*i.e.*, the requirements to become a Qualified Bidder) to the Trustee, c/o Adam Heavenrich, Heavenrich & Company, Inc., 203 N. LaSalle Street, Suite 2100, Chicago, IL 60601, via facsimile at 312-896-1501 or via email at adam@heavenrich.com; with a copy to Nancy A. Peterman, Greenberg Traurig, LLP, 77 West Wacker Drive, Suite 3100, Chicago, IL 60622, via facsimile at 312-456-8435 or via email at petermann@gtlaw.com;

- **Qualified Bid:** Each Qualified Bid must:
  - be subject to no conditions, contingencies, due diligence or board approval unless otherwise agreed to by the Trustee;
  - disclose the (a) identity of each person or entity that will be bidding for the CON (including any equity holder or financial backer if a Qualified Bidder has been formed solely for the purpose of purchasing the CON) and (b) relationship or connection, if any, to (1) the Debtor, (2) any insider of the Debtor as defined under section 101(31) of the Bankruptcy Code, (3) the Office of the United States Trustee, or (4) the Trustee and her professionals.

- be for cash (or cash equivalent), payable in full at the closing, and not subject to any financing contingencies;
- be accompanied by evidence, as determined by the Trustee that the proposed Qualified Bidder has sufficient financial wherewithal and ability to close and consummate the proposed purchase of the CON;
- remain open and irrevocable until the consummation of a sale to the Successful Bidder (as defined below);
- be accompanied by a certified check, bank check or cashier's check in the amount of ten percent (10%) of the amount of the Qualified Bid (the "**Deposit**"), made payable to the estate; and
- state that if party making the Qualified Bid is the Successful Bidder for the CON and fails to consummate the sale and close title, then the Trustee shall be entitled to retain the Deposit as liquidated damages.

- **Stalking Horse:** The Trustee reserves the right, in consultation with Heavenrich and the Official Committee of Unsecured Creditors, to designate a stalking horse bidder (a "**Stalking Horse Bidder**") prior to the Bid Deadline.

- **Bid Notification.** The Trustee will notify all Qualified Bidders no later than **December 12, 2011** of her determination of the Qualified Bids, after consultation with Heavenrich, the Official Committee of Unsecured Creditors and other interested parties, and the identity of the Qualified Bidders, submitting the highest or best bid for the CON.

- **Auction Sale.** If one or more Qualified Bids is received, the Trustee will conduct the Auction at the office of Greenberg Traurig, P.A., Courthouse Plaza, Suite 100, 625 East Twiggs Street, Tampa, FL 33602 on **December 14, 2011, commencing at 10:00 a.m.** (EST) or such other location as determined by the Trustee. Bidding for the CON will commence with the highest Qualified Bid(s) for the CON determined in accordance with the foregoing paragraph. Bidding will then be permitted at such increments as the Trustee deems appropriate, in her sole discretion, after consultation with Heavenrich and the Official Committee of Unsecured Creditors, until all Qualified Bidders have made their final offers and until such time as the highest or best offer(s) is determined by the Trustee. The Trustee may adopt rules for the bidding process that, in her judgment, will better promote the goals of the bidding process.

- **Winning Bid(s):** At the conclusion of the Auction, the Trustee will announce her determination of the highest and best bid for the CON (each, a "**Successful Bid**") obtained from the Qualified Bidder(s) (each a "**Successful Bidder**") and the second highest and best bid for the CON (the "**Back Up Bid**") obtained from the Qualified Bidder(s) (each a "**Back Up Bidder**"), after consultation with Heavenrich and the Official Committee of Unsecured Creditors. Formal acceptance of the Successful Bid and Back Up Bid shall not occur unless and until the Court enters an Order or

approving the Successful Bid and Back Up Bid and authorizing the Trustee to consummate the sale following the conclusion of the hearing to approve the sale of the CON to the Successful Bidder(s) (the "**Sale Hearing**").

- **Back Up Bid:** In the event the Successful Bidder(s) fails to close the purchase of the CON by the Closing Deadline (defined below) for any reason other than the Trustee's default, the Back Up Bidder(s) shall become the Successful Bidder(s) and the Trustee may close the sale of the CON to the Back Up Bidder(s) without further Order of this Court.

- **The Deposit:** If a Qualified Bidder becomes a Successful Bidder(s), the Deposit shall be applied towards the amount of the Successful Bid. In the event that a Qualified Bidder is not the Successful Bidder, the Trustee will return the Deposit to such Qualified Bidder within ten (10) days of the Auction.

- **The Transfer Agreement.** The Trustee reserves the right to prescribe the form of agreement to be entered into between the Trustee and the Successful Bidder(s).

- **The Sale Hearing:** The Court will conduct the Sale Hearing to approve the sale of the CON to the Successful Bidder(s) on **December 15, 2011 at 3:00 p.m.** or such other day which is convenient for the Court. At the Sale Hearing, the Trustee will seek, among other relief, entry of an Order (the "**Sale Order**") (A) authorizing her to sell the CON to the Successful Bidder(s) under sections 363(b) and (f) of the Bankruptcy Code and granting to the Successful Bidder(s) the protections set forth in 363(m) of the Bankruptcy Code. A form of this Sale Order will be filed with the Court prior to the Sale Hearing.

- **The Closing Deadline:** The Successful Bidder shall consummate the purchase of the CON on the fifteenth (15^{th}) day after entry of the Sale Order, unless otherwise ordered by this Court.

- **Contact Information:** Any person requesting information concerning any or all of the CON should contact Adam Heavenrich, Heavenrich & Company, Inc., 203 N. LaSalle Street, Suite 2100, Chicago, IL 60601, via telephone at 312-558-1590 or via email at adam@heavenrich.com..

3. The Trustee, with Court approval, reserves the right, upon notice to all parties-in-interest, to: (a) waive terms and conditions set forth herein with respect to any or all potential bidders, (b) impose additional terms and conditions with respect to any or all

potential bidders, (c) extend the deadlines set forth herein, or (d) amend the Bidding Procedures as she may determine to be in the best interest of the estate.

DONE and **ORDERED** _____.

_____
K. RODNEY MAY
United States Bankruptcy Judge

Copies to be provided by CM/ECF service.

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re: UNIVERSAL HEALTH CARE GROUP, INC., Debtor.	Chapter 11 Case No. 8:13-bk-01520-KRM

ORDER ESTABLISHING BIDDING AND SALE PROCEDURES FOR SALE OF STOCK OF DEBTOR'S SUBSIDIARIES AND CERTAIN OTHER ASSETS FREE AND CLEAR OF LIENS, CLAIMS, AND ENCUMBRANCES PURSUANT TO 11 U.S.C. § 363, APPROVING BIDDING INCENTIVES, APPROVING FORM AND MANNER OF NOTICE, SCHEDULING AUCTION, AND GRANTING RELATED RELIEF

THIS CASE came on for hearing before the Court on February 19, 2013, at 2:00 p.m. (the "**Bid Procedures Hearing**") upon requests (II), (III), (IV), (V), and (VI) of the *Debtor's Emergency Motion for Entry of an Order (I) Authorizing the Sale of Stock and Assets of the Subsidiaries of Debtor Universal Health Care Group, Inc. Free and Clear of Liens, Claims and Encumbrances Pursuant to 11 U.S.C. § 363; (II) Establishing Bidding and Sales Procedures; (III) Approving Bidding Incentives; (IV) Approving Form and Manner of Notices; (V) Scheduling Auction; and (VI) Granting Related Relief* (ECF Doc. No. 41) (the "**Motion**").[1] By the Motion, the Debtor has requested that the Court

[1] Unless otherwise defined in this Order, capitalized terms shall have the meaning ascribed to them in the Motion.

approve the sale of the stock of certain of the Debtor's operating subsidiaries (the "**Stock**"), together with certain other assets (the "**Assets**") to a Qualified Bidder (as defined below), submitting the highest and best offer for the Stock and Assets (the "**Prevailing Bidder**"), approve sale and bidding procedures in connection with the proposed sale, approve a minimum overbid amount and a breakup fee in connection with the sale, approve the manner of notice of the sale and bidding procedures, and set deadlines for objections to the sale. In addition, in light of the agreements stated on the record at the hearings held on February 14 and 19, 2013, on the motion of BankUnited, N.A., as administrative agent ("**BankUnited**") for itself and certain other secured lenders (the "**Lenders**") of the Debtor, for relief from the stay or dismissal of the chapter 11 case, the Debtor requests that certain other relief be granted in this Order concerning certain carveouts from the Lenders' collateral for the benefit of the estate and its creditors and the appointment of a chief restructuring officer.

At the Bid Procedures Hearing, counsel for the Debtor informed the Court of the Debtor's proposal to enter into a purchase agreement substantially in the form as filed by the Debtor with the Court (the "**Purchase Agreement**")—(i) providing for the sale of the Stock and Assets, as more fully described in the Purchase Agreement, to a purchaser free and clear of all liens, claims, and encumbrances against the Stock and Assets, to the fullest extent permitted by applicable bankruptcy law, in exchange for payment by such purchaser to the Debtor of consideration as described in, and subject to the terms and conditions of, the Purchase Agreement (the "**Purchase Price**"), and (ii) requiring that, upon entry of an order of this Court authorizing and approving the sale of the Stock and

Assets to the Prevailing Bidder, the Prevailing Bidder will use commercially reasonable efforts to obtain the requisite federal and state regulatory authority and approval to own the Stock and Assets ("**Regulatory Authority**") on or before March 20, 2013. The Debtor requests that the Court approve requests (II) through (VI) of the Motion (as modified on the record at the Bid Procedures Hearing), which describe the procedures for submission and consideration of Bids, conducting an auction if there are at least two Qualified Bidders, and obtaining approval of a sale. In consultation with parties in interest, including BankUnited, the Debtor requests that the following deadlines and dates with respect to the Motion be established:

Bid Deadline:	**Monday, February 25, 2013, at 5:00 p.m. (EST)**
Sale Objection Deadline:	**Tuesday, February 26, 2013, at 5:00 p.m. (EST)**
Hearing to resolve disputes concerning Qualified Bid status (the "Qualifiedness Hearing") (if necessary):	**Tuesday, February 26, 2013, at 1:30 p.m. (EST)**
Auction:	**Tuesday, February 26, 2013, at later of (i) 1:30 p.m. EST or (ii) immediately upon conclusion of the Qualifiedness Hearing (if necessary)**
Sale Hearing:	**Wednesday, February 27, 2013, at 2:00 p.m. EST**
Submission of Form A to Florida regulatory authorities and equivalent form to other regulatory authorities whose approval is required:	**5:00 p.m. EST on the second business day following the conclusion of the Sale Hearing**

The Court finds that the Motion and notice of the Bid Procedures Hearing on the

Motion were served upon (i) BankUnited, (ii) the parties shown on the list of 20 largest unsecured creditors, (iii) the United States Trustee, and (iv) the parties shown on the Local Rule 1007-2 Parties in Interest List for this case. The Court finds that notice of the Motion and of the Bid Procedures Hearing was sufficient and in compliance with the Bankruptcy Code, the Federal Rules of Bankruptcy Procedure, and the Local Rules of this Court and that the parties have proceeded in good faith.

The Court has considered the Motion, the record, and the argument of counsel and is fully advised in the premises. For the reasons announced on the record at the Bid Procedures Hearing, the Court finds that the forms of relief set forth in requests (II), (III), (IV), (V), and (VI) of the Motion, as modified at the Bid Procedures Hearing, are necessary and appropriate, and that the Motion is well taken and should be granted in accordance with the terms and conditions set forth in this Order. Specifically, the Court finds that it is in the best interests of the Debtor, its creditors, and its estate that an orderly procedure for the selection of the highest and best offer for the sale of the Stock and Assets be established. The Court thus finds that it is appropriate to provide other prospective purchasers with the opportunity to submit competing bids for the Stock and Assets and that notice of the proposed sale of the Stock and Assets be sent to all parties that have expressed an interest to the Debtor's investment banking firm, Morgan Joseph TriArtisan LLC ("**Morgan Joseph**"), in acquiring the Stock and Assets of the Debtor. The Court also finds it appropriate to require any such prospective purchasers to comply with certain requirements in connection with the submission of competing bids, and that the bidding procedures proposed by the Debtor, as set forth in the Motion (as modified at

the Bid Procedures Hearing) and contained in this Order are reasonable. The Court further finds it appropriate under the circumstances to approve a breakup fee and a minimum overbid amount, as set forth below, if a stalking horse bidder is designated as described below. The Court also finds it appropriate to establish deadlines for the filing and service of written objections to the proposed sale of the Stock and Assets.

Accordingly, it is

ORDERED:

1. The Motion is granted as to requests (II), (III), (IV), (V), and (VI), as set forth in this Order. The Court reserves ruling on the Debtor's request to approve a sale to the Prevailing Bidder pending the conclusion of the Sale Hearing.

2. The Court approves the procedures set forth in this Order (the "**Bid Procedures**") for the submission and consideration of any written bid (a "**Competing Bid**") by any competing bidder (a "**Competing Bidder**") to purchase the Stock and Assets.

3. Any Competing Bidder must deliver a Competing Bid for the Stock and Assets by electronic transmission, so as to be received **by no later than 5:00 p.m. (EST) on Monday, February 25, 2013** (the "**Bid Deadline**"), to the following persons (the "**Notice Parties**"):

Kenneth E. Noble, Esq. Jeff J. Friedman, Esq. **KATTEN MUCHIN ROSENMAN LLP** 575 Madison Avenue New York, New York 10022-2585	kenneth.noble@kattenlaw.com jeff.friedman@kattenlaw.com

Harley E. Riedel, Esq. Russell M. Blain, Esq. Barbara A. Hart, Esq. **STICHTER, RIEDEL, BLAIN & PROSSER, P.A.** 110 East Madison Street, Suite 200 Tampa, Florida 33602	hriedel@srbp.com rblain@srbp.com bhart@srbp.com
James D. Decker, Managing Director Marc A. Cabrera, Managing Director Alex H. Fisch, Director **MORGAN JOSEPH TRIARTISAN LLC** 600 Fifth Avenue New York, New York 10020	jdecker@morganjoseph.com mcabrera@morganjoseph.com afisch@morganjoseph.com
Denise E. Barnett, Esq. **OFFICE OF THE UNITED STATES TRUSTEE** 501 East Polk Street, Suite 1200 Tampa, Florida 33602	denise.barnett@usdoj.com
Frank P. Terzo, Esq. Steven J. Solomon, Esq. **GRAYROBINSON, P.A.** 1221 Brickell Avenue, Suite 1600 Miami, Florida 33131	frank.terzo@gray-robinson.com steven.solomon@gray-robinson.com
Tina E. Dunsford, Esq. **GRAYROBINSON, P.A.** 401 East Jackson Street, Suite 2700 Tampa, Florida 33602	tina.dunsford@gray-robinson.com

4. A Competing Bid submitted by a Competing Bidder must include the following:

(a) A copy of the initial written purchase offer in the form of a purchase agreement, executed by such Competing Bidder, substantially in the form of the Purchase Agreement to be filed

with the Court (the "**Bidder's Agreement**"); provided, however that any Bidder's Agreement submitted to the Debtor that contains terms different from the Purchase Agreement must be accompanied by a redlined version as well to show any changes made by such Competing Bidder to the form of the Purchase Agreement. Such Bidder's Agreement must be subject to acceptance by the Debtor solely by the Debtor's execution of that agreement and necessary Court approval. The Debtor, in consultation with its professionals and BankUnited, may accept modifications to a Bidder's Agreement submitted by a Competing Bidder who otherwise complies with the Bid Procedures if the Debtor determines, in the exercise of its business judgment and in consultation with its professionals and BankUnited, that the proposed modifications will result in a higher and better offer for the Stock and Assets.

(b) A purchase price for the Stock and Assets of $250,000, plus the amount of the Breakup Fee (as defined below) if a Stalking Horse Bidder (as defined in paragraph 6 below) is selected, above the Purchase Price offered by the Stalking Horse Bidder (the "**Overbid Amount**").

(c) A written commitment (i) to take all commercially reasonably actions necessary to obtain Regulatory Authority on or before March 20, 2013, and (ii) to submit, by 5:00 p.m. EST on the second business day following the conclusion of the Sale Hearing, a Florida Office of Insurance Regulation "Form A" or such equivalent document in other jurisdictions as required in to obtain a certificate of authority or its equivalent in each appropriate jurisdiction, as provided in paragraph 14 of this Order.

(d) Relevant background and financial information reasonably satisfactory to the Debtor, in consultation with its professionals and BankUnited, demonstrating the Competing Bidder's financial ability to close and to consummate an acquisition of the Stock and Assets, including without limitation the latest available audited and unaudited financial statements and information demonstrating the Competing Bidder's likelihood of obtaining Regulatory Authority.

(e) The Competing Bid shall not be contingent upon receipt of financing necessary to its consummation.

(f) The Competing Bid shall not be contingent upon due diligence past the Bid Deadline.

(g) The Competing Bid shall be valid and enforceable and binding on the Competing Bidder through the closing date of the sale transaction.

(h) The Competing Bid shall not contain any conditions precedent to such Bidder's obligation to purchase the Stock and Assets other than the Competing Bidder obtaining Regulatory Authority and such other conditions as are contained in the form of Purchase Agreement filed with the Court or the Bidder's Agreement of a Stalking Horse Bidder.

(i) A good faith deposit in an amount of the greater of—(A) $1,000,000 or (B) ten percent (10%) of the proposed Purchase Price for the Stock and Assets that are the subject of the Competing Bid—or such other amount as is determined by Morgan Joseph in its reasonable discretion, in immediately available funds by wire transfer as provided in the Purchase Agreement (each such deposit, the "**Bid Deposit**"), which shall be delivered to Stichter, Riedel, Blain & Prosser, P.A. ("**SRBP**"), local counsel to the Debtor, by no later than the Bid Deadline. Each Bid Deposit shall be deposited into an escrow account maintained by SRBP and shall be held in escrow subject to the terms of this Order and an escrow agreement with SRBP. A Bid Deposit will be returned as appropriate in accordance with paragraph 17 below. SRBP shall provide wire transfer instructions upon request of a Bidder.

5. Any Competing Bid meeting the foregoing requirements shall be a "**Qualified Bid**" and such Competing Bidder a "**Qualified Bidder**." Any Competing Bid that does not conform to all of the requirements set forth above may not be considered by the Court or be admissible at the Sale Hearing, unless otherwise agreed by the Debtor, after consultation with its professionals and BankUnited.

6. Morgan Joseph, after consultation with the Debtor, BankUnited, and their respective professionals, is authorized without further order of this Court to designate, in a writing filed with the Court, a Qualified Bidder as the "**Stalking Horse Bidder**," subject to the rights, responsibilities, and protections provided in this Order.

7. If one or more Competing Bids are received, the Debtor, in consultation with its professionals and BankUnited, will make a determination as to which of the Competing Bids constitute Qualified Bids. If there is no dispute as to whether any particular Competing Bid is a Qualified Bid, an auction will be conducted commencing on **Tuesday, February 26, 2013, at 1:30 p.m. EST** (the "**Auction**").

8. In the event of disputes as to whether one or more Competing Bids constitute Qualified Bids, the Court will conduct a "**Qualifiedness Hearing**" on **Tuesday, February 26, 2013, at 1:30 p.m. EST** to resolve such disputes, in which case the Auction will be commenced immediately upon the conclusion of the Qualifiedness Hearing.

9. The Auction, if required, will be conducted at the offices of Stichter, Riedel, Blain & Prosser, P.A., 110 East Madison Street, Suite 200, Tampa, Florida, or at such other location as is designated by the Debtor. All Qualified Bidders with full authority to participate in the Auction must be present in person at the Auction. At the Auction, the Debtor may request a Qualified Bidder to provide additional information that the Debtor, in consultation with its professionals and BankUnited, deems necessary to determine whether a particular Competing Bid is the highest and best offer for the Stock and Assets.

10. The Auction shall be conducted as an open-cry auction on such terms as the Debtor, in consultation with its professionals and BankUnited, shall determine to be in the best interest of the estate after reviewing all Bids. Unless otherwise determined, bidding shall begin at the purchase price stated in the highest and best Qualified Bid as selected by the Debtor in consultation with its professionals and BankUnited. The Stalking Horse

Bidder (if one has been designated) shall be entitled to submit further bids at the Auction and, in any such further bid, to credit-bid the amount of the Breakup Fee (as defined below). Any subsequent higher bid at the Auction after the initial Competing Bid, including any subsequent bid made by the Stalking Horse Bidder (if one has been designated) at the Auction, must be in an incremental increase of at least $100,000, unless the Debtor, in consultation with its professionals and BankUnited, determines that a different increment would be preferable. During the Auction, any successive overbid shall be irrevocable unless and until it is declared to not be the highest and best bid. The competitive bidding process among Bidders shall continue according to these Bid Procedures until the Debtor determines, in the exercise of its business judgment and in consultation with its professionals and BankUnited, that a Competing Bidder has made the highest and best offer to purchase the Stock and Assets, that such Competing Bidder is the "**Prevailing Bidder**," and that the Auction should be concluded. The Debtor may accept two or more bids for a combination of components of the Stock and Assets that taken together would, in the Debtor's business judgment and in consultation with its professionals and BankUnited, constitute a Qualified Bid and the highest and best offer for the Stock and Assets.

11. If the Debtor, in consultation with its professionals and BankUnited, has designated a Stalking Horse Bidder, the Debtor shall be authorized to pay the Breakup Fee to the Stalking Horse Bidder from sums paid at Closing by a Prevailing Bidder other than the Stalking Horse Bidder.

12. The Court will conduct a Sale Hearing on **Wednesday, February 27,**

2013, at 2:00 p.m. EST to consider the results of the Auction, to resolve any outstanding disputes in connection with the sale of the Stock and Assets arising as a result of the Auction or otherwise, and if, asserted by the Lenders, to consider the Lenders' rights under sections 363(f) and 363(k) of the Bankruptcy Code. The Court will determine the highest and best Bid and the Prevailing Bidder and whether approval of the sale of the Stock and Assets to the Prevailing Bidder is merited. Upon such determination, the Court may enter an order (the "**Sale Order**") authorizing and approving the sale of the Stock and Assets to the Prevailing Bidder. The Court may order and direct that the Sale Order become effective immediately and not be stayed under Rule 6004(h) of the Federal Rules of Bankruptcy Procedure. The Court will also consider inclusion in the Sale Order of provisions stating that the Prevailing Bidder and the Backup Bidder have acted in good faith and are entitled to the protections of section 363(m) of the Bankruptcy Code.

13. The Prevailing Bidder shall close on the purchase of the Stock and Assets pursuant and subject to the terms set forth in its Bidder's Agreement.

14. By 5:00 p.m. EST on the second business day following the conclusion of the Sale Hearing, the Prevailing Bidder and the Backup Bidder (as defined below) shall complete and submit a Florida Office of Insurance Regulation "Form A" or such equivalent document as may be required in other jurisdictions to obtain a certificate of authority or its equivalent in each appropriate jurisdiction.

15. The Court shall register the second highest Qualified Bid and Qualified Bidder determined at the Auction (the "**Backup Bidder**"). The Bidder's Agreement of the Backup Bidder shall constitute a binding contract. The bid of the Backup Bidder shall

remain irrevocable, and the Debtor shall retain the deposit of the Backup Bidder, until the Prevailing Bidder has closed, but in no event later than May 15, 2013, absent an agreement of the Debtor (in consultation with its professionals and BankUnited) and the Backup Bidder to extend such deadline. The Debtor shall notify the Backup Bidder of its intent to close with the Backup Bidder promptly after the Prevailing Bidder has failed to close or been unable to obtain Regulatory Authority (the "**Backup Bidder Notice**"). Upon receipt of such notification, the Backup Bidder shall close on its purchase of the Stock and Assets pursuant and subject to the terms set forth in its Bidder's Agreement. The Bid Deposit of the Prevailing Bidder shall be nonrefundable in the event that the Prevailing Bidder fails to close on the purchase of the Stock and Assets for any reason not permitted by the Bidder's Agreement submitted by the Prevailing Bidder. In such event, the Bid Deposit shall become property of the Debtor (subject to the Lenders' lien rights, if any) as agreed-upon liquidated damages to the Debtor and not as a penalty to the Prevailing Bidder. Otherwise, the Bid Deposit of the Prevailing Bidder will be applied against the purchase price at the closing in accordance with the Bidder's Agreement of the Prevailing Bidder.

16. Following the Backup Bidder's receipt of the Backup Bidder Notice, pursuant to paragraph 15 above—(i) if the Backup Bidder fails to close on the purchase of the Stock and Assets for any reason not permitted by the Bidder's Agreement between Debtor and the Backup Bidder, the Bid Deposit of the Backup Bidder shall be nonrefundable to the Backup Bidder and shall become property of the Debtor (subject to the Lenders' lien rights, if any) as agreed upon liquidated damages to the Debtor and not

as a penalty; (ii) the Backup Bidder will use commercially reasonable efforts to obtain Regulatory Approval within twenty-one (21) days of receipt of the Backup Bidder Notice; and (iii) upon the closing of the sale of the Stock and Assets to the Backup Bidder in accordance with the Bidder's Agreement between Debtor and the Backup Bidder, the Bid Deposit of the Backup Bidder will be applied toward the purchase price at the closing in accordance with the Bidder Agreement between Debtor and the Backup Bidder.

17. Within two (2) business days following the termination of any Bidder's Agreement (including the Purchase Agreement) between the Debtor and any Bidder (including the Stalking Horse Bidder, if any, the Prevailing Bidder, or the Backup Bidder) in accordance with the terms of such Bidder's Agreement (other than a termination of such Bidder's Agreement by the Debtor as a result of a breach of such Bidder Agreement by the Bidder party to that agreement), SRBP, in consultation with the Debtor's professionals and BankUnited, shall return the Bid Deposit to such Bidder (including the Stalking Horse Bidder, the Prevailing Bidder, or the Backup Bidder). In any event, SRBP shall return the Bid Deposit of each Bidder (including any Stalking Horse Bidder) that is not selected as the Prevailing Bidder or the Backup Bidder (each such Bidder, a "**Non-Selected Bidder**") to each Non-Selected Bidder (including the Stalking Horse Bidder, if any) within two (2) business days following the entry of the Sale Order. SRBP shall return the Bid Deposit of the Backup Bidder within two (2) business days following the earlier of—(i) the closing of the sale of the Assets to the Prevailing Bidder; (ii) the termination of the Bidder Agreement between Debtor and the Backup Bidder in accordance with the terms of such Bidder's Agreement (other than a termination of such

Bidder's Agreement by Debtor as a result of a breach of such Bidder's Agreement by the Backup Bidder); and (iii) May 15, 2013, absent an agreement of the Debtor (in consultation with its professionals and BankUnited) and the Backup Bidder to extend such deadline.

18. Except for the Stalking Horse Bidder (if any has been designated), no Competing Bidder submitting any Competing Bid shall be entitled to any expense reimbursement or any breakup, termination, or similar fee or payment.

19. On account of and as compensation for the time, expenses, fees, costs, trouble, and lost opportunity costs of the Stalking Horse Bidder, if any, in respect of the transactions contemplated by the Bidder's Agreement of Stalking Horse Bidder, and so long as such Bidder's Agreement has been executed by the Stalking Horse Bidder and the deposit required thereunder made, and such Bidder's Agreement has not been terminated by the Stalking Horse Bidder prior to the conclusion of the Sale Hearing, the Court approves the payment of a breakup fee by the Debtor to the Stalking Horse Bidder in an amount (as determined by Morgan Joseph) up to three percent (3%) of the consideration offered by the Stalking Horse Bidder for the Stock and Assets (the "**Breakup Fee**") in the event that a sale of the Stock and Assets consummated thereafter with the Prevailing Bidder (other than the Stalking Horse Bidder or the Lenders) or the Backup Bidder (other than the Stalking Horse Bidder or the Lenders). The Court finds that such a Breakup Fee is fair and reasonable under the circumstances. The Breakup Fee shall be paid from the sale proceeds for the Stock and Assets immediately following the closing by the Prevailing Bidder (other than the Stalking Horse Bidder or the Lenders) or the Backup

Bidder (other than the Stalking Horse Bidder or the Lenders).

20. The Court also finds that in the event a Stalking Horse Bidder is designated, the Overbid Amount is reasonable under the circumstances and approves the Overbid Amount.

21. Any creditor or other party in interest that objects to the sale of the Stock and Assets, to the transactions contemplated by the Purchase Agreement, or to the bid protections referenced in this Order must file such objection with the Court **on or before the Bid Deadline of 5:00 p.m. (EST) on February 25, 2013** (the "**Sale Objection Deadline**") and serve such objection by electronic mail upon the Notice Parties defined and set forth in paragraph 3 above so as to be actually received by the Notice Parties by the Sale Objection Deadline. Any objection must be in writing and must set forth with specificity the grounds for such objection. Any creditor or other party in interest not timely filing such written objection shall be conclusively deemed to have waived any objection it may have to the sale of the Stock and Assets. Any timely filed objections to the sale of the Stock and Assets will be heard at the Sale Hearing.

22. The approval of the Bid Procedures and the granting of requests (II), (III), (IV), (V), and (VI), as modified at the Bid Procedures Hearing and as set forth in this Order, shall not at this stage constitute the granting of the Debtor's request for the approval of any sale of the Stock and Assets or any term or provision of the Purchase Agreement except as provided in this Order.

23. To the extent of an inconsistency between the provisions of this Order and the terms of the Purchase Agreement, the provisions of this Order shall control.

24. The Debtor's Chief Financial Officer, Alec Mahmood, shall have the additional role of Chief Restructuring Officer until the closing of a sale of the Stock and the Assets. Mr. Mahmood shall report to the Debtor's Board of Directors, and, in consultation with the Debtor's professionals and BankUnited and following the approval of a sale in consultation with the Prevailing Bidder (or Backup Bidder, as the case may be), shall have authority to make and implement all decisions necessary to preserve regulatory compliance of the Debtor and its subsidiaries. With regard to all other expenditures, Mr. Mahmood shall have authority to expend funds up to $25,000 per expenditure item (not to exceed $100,000 in the aggregate) and shall submit to the Board of Directors any proposed expenditure greater than $25,000. Mr. Mahmood shall also make all decisions for the Debtor regarding the sale and the sale process, including, without limitation, whether any particular Competing Bid is a Qualified Bid and whether a particular Qualified Bid is the highest and best offer for the Stock and the Assets. Mr. Mahmood further shall have authority to execute and deliver all documents necessary to consummate a sale of the Stock and Assets as approved by this Court.

25. From the date of this Order until the earlier of the closing of a Sale of the Stock and Assets or a further order of this Court, the Debtor shall operate and shall cause its subsidiaries to operate solely in the ordinary course of business, with Mr. Mahmood serving as Chief Restructuring Officer, and shall not take any action, except in the ordinary course of business, to terminate any employees of the Debtor or its subsidiaries, alter the compensation paid to any employees of the Debtor or its subsidiaries or otherwise materially alter the day-to-day operations of the business of the Debtor and its

subsidiaries.

26. By agreement between the Debtor and the Lenders, three separate carveouts will be funded specifically from the proceeds of the Sale (the "**Carveouts**"):

(a) a carveout to compensate Morgan Joseph for its services and to reimburse Morgan Joseph for its expenses as investment banker to the Debtor in accordance with this Court's order authorizing the retention of Morgan Joseph (the "**Morgan Joseph Carveout**");

(b) $500,000 carveout for the benefit of the Debtor's estate, including its professionals (other than Morgan Joseph and in addition to all prepetition retainers paid to the Debtor's professionals), administrative expense claimants, and priority and unsecured creditors (the "**Estate Carveout**"); and

(c) an additional incentive carveout to induce Mr. Mahmood to remain in his roles as Chief Financial Officer and Chief Restructuring Officer through the earlier of a closing of a Sale of the Stock and Assets (including any necessary post-closing transition as contemplated by the Bidder's Agreement of the Prevailing Bidder or the Backup Bidder, as the case may be) and July 1, 2013 (the "**CRO Retention Bonus Carveout**").

27. The Morgan Joseph Carveout and the Estate Carveout will be funded, first, from the net unencumbered cash proceeds of the Sale (cash remaining after payment of closing costs, the Breakup Fee to a Stalking Horse Bidder if any has been designated, and payment of the Lenders' secured claim). If there are insufficient unencumbered cash proceeds from the Sale (after paying closing costs, any Breakup Fee, and the Lenders' secured claims) with which to fully fund the Morgan Joseph Carveout and the Estate Carveout, then in that event the balance necessary to fully fund such amounts, together with the amount necessary to fund payment of the CRO Retention Bonus Carveout, shall be carved out and funded from cash proceeds of the Sale allocable on account of the Lenders' secured claims against the Stock and Assets. If, subsequent to the payment of

the Carveouts, the Debtor recovers cash proceeds from assets of the Debtor unencumbered by the security interests of the Lenders, such cash proceeds shall be used to repay any Morgan Joseph Carveout and Estate Carveout (but not CRO Retention Bonus Carveout) amounts funded by the Lenders from cash proceeds of the Sale allocable on account of the Lenders' secured claims against the Stock and Assets.

28. The Carveouts are in exchange and consideration for a waiver by the Debtor and the estate and any subsequent chapter 11 or chapter 7 trustee that may be appointed in this case of the Debtor's rights to surcharge the Lenders' collateral pursuant to section 506(c) of the Bankruptcy Code or otherwise (the "**Surcharge Waiver**"). The Court having found them fair and reasonable and in the best interests of the estate and its creditors, the Surcharge Waiver and the Carveouts are approved in all respects.

29. Paragraphs 26(b), 27, and 28 of this Order with respect to the Estate Carveout and the Debtor's tax refund from the Department of the Treasury / Internal Revenue Service (the "**IRS**"), as described in the pending *Agreed Order Granting BankUnited's Motion to Prohibit Use of Cash Collateral*, are intended to assure the Debtor and its estate the availability of a $500,000 sum free and clear of the liens and secured claims of the Lenders (as provided in paragraph 26(b) above) should a sale under section 363 occur. Should a section 363 sale occur and the Debtor prevail in asserting a senior interest in an IRS tax refund in an amount of at least $500,000 free and clear of the liens and secured claims of the Lenders, this Court may reconsider the Estate Carveout based upon the totality of the circumstances upon request of a party in interest. If such a request for reconsideration is made, a portion of the IRS tax refund equal to the Estate

Carveout shall be placed into escrow pending the Court's determination on the request for reconsideration. No portion of the Estate Carveout may be used by the Debtor, any trustee, or other estate representative or professional retained in the Debtor's bankruptcy case to challenge the security interests of the Lenders against the Stock or Assets or to assert any action against the Lenders or their officers, directors, employees, or agents.

30. For purposes of this Order, the use of the singular shall include the plural, and vice versa, and references to a "Bidder" shall include multiple Bidders if the Debtor, in consultation with its professionals and BankUnited, determines to sell the stock of separate subsidiaries to more than one Bidder.

31. Following the entry of this Order, the Debtor shall cause copies of the form Purchase Agreement and this Order to be served by electronic mail transmission to each entity that has expressed to Morgan Joseph an interest in purchasing the Stock and Assets. The Court approves notice as provided by this Order as being adequate and sufficient notice of the Bid Procedures, the proposed sale of the Stock and Assets, and the objection deadlines set forth in this Order. The Court finds that notice as provided in this Order complies with the Bankruptcy Code, the Federal Rules of Bankruptcy Procedure, and the Local Rules of this Court.

DONE AND ORDERED in Chambers at Tampa, Florida, on _____.

_____
K. RODNEY MAY
United States Bankruptcy Judge

MESCH, CLARK & ROTHSCHILD, P.C.
259 North Meyer Avenue
Tucson, Arizona 85701
Phone: (520) 624-8886
Fax: (520) 798-1037
Email: mmcgrath@mcrazlaw.com
knye@mcrazlaw.com
By: Michael McGrath, #6019
Kasey C. Nye, #20610

BROWNSTEIN HYATT FARBER SCHRECK, LLP
410 Seventeenth Street, Suite 2200
Denver, CO 80202-4432
Phone: (303) 223-1100
Fax: (303) 223-1111
Email: mpankow@bhfs.com
jhantman@bhfs.com
By: Michael J. Pankow (Pro Hac Vice)
Joshua M. Hantman (Pro Hac Vice)

Attorneys for Debtors

UNITED STATES BANKRUPTCY COURT

FOR THE DISTRICT OF ARIZONA

In re: REGIONAL CARE SERVICES CORP., CASA GRANDE COMMUNITY HOSPITAL REGIONAL CARE PHYSICIAN'S GROUP, INC., and CASA GRANDE REGIONAL RETIREMENT Debtors.	Chapter 11 Proceedings Case Nos. 4:14-bk-01383-EWH 4:14-bk-01384-EWH 4:14-bk-01385-EWH 4:14-bk-01386-EWH (Joint Administration)
This Filing Applies to: ☒ All Debtors ☐ Specified Debtor(s)	Hearing Date: March 17, 2014 Hearing Time: 1:30 p.m. Location: , Courtroom #329, U.S. Bankruptcy Court, 38 S. Scott Avenue, Tucson, AZ

DISCLOSURE STATEMENT FOR DEBTORS' SECOND AMENDED JOINT CHAPTER 11 PLAN OF REORGANIZATION

Dated: March 28, 2014

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TABLE OF CONTENTS

TABLE OF CONTENTS
(continued)

I. INTRODUCTION

A. Overview

1. The Purpose of the Disclosure Statement

Regional Care Services Corp. ("RCSC"), Casa Grande Community Hospital d/b/a Casa Grande Regional Medical Center ("CGRMC"), Regional Care Physician's Group, Inc. ("RCPG"), and Casa Grande Regional Retirement Community ("CGRRC") (collectively, the "Debtors") hereby submit this disclosure statement (the "Disclosure Statement") pursuant to 11 U.S.C. § 1125.

The purpose of this Disclosure Statement is to provide Creditors[1] and interested parties in this proceeding with such information as is sufficient to allow Creditors and interested parties to make an informed decision regarding the Debtors' Amended Joint Chapter 11 Plan of Reorganization, attached hereto as Exhibit A (the "Plan"). The Disclosure Statement describes the Plan and explains the Debtors' pre-bankruptcy operations; debt obligations; financial history; and events leading up to the commencement of their chapter 11 cases (the "Chapter 11 Cases" or "Cases").

2. Source of Information

Substantially all of the factual information utilized in this Disclosure Statement, including but not limited to the amount of claims, was obtained from information provided by the Debtors' books and records, the knowledge of their officers, including Rona Curphy as Chief Executive officer and Karen Francis as Chief Financial Officer, and the advisory services of Grant Thornton LLP, the court-appointed Financial Advisor to the Debtors. The financial information, including the value of assets, is based on information provided by the Debtors' officers to their professionals and was prepared for the purposes of this Disclosure Statement. Certain materials contained in this Disclosure Statement are taken directly from other readily accessible documents or are summaries of other documents. While every effort has been made to retain the meaning of

[1] See Section (I)(C)(1).

such documents, creditors and other parties in interest are urged to rely upon the contents of such documents only after a thorough review of the documents themselves.

3. Proposed Sale Transaction Under the Plan

The Debtors filed these Cases to effectuate a sale of substantially all of their assets to Banner Health ("Banner") (the "Sale"). Assets will be transferred to Banner in exchange for up to $87 million in cash (subject to adjustments) and forgiveness of loans that Banner has extended or is expected to extend to maintain hospital operations. Cash proceeds received upon the Sale Closing (the "Sale Proceeds") will pay the Debtors' bond indebtedness, in the aggregate principal amount of $63,785,000 plus accrued interest and fees, in full in exchange for subordination of the $1.3 million prepayment fee to all other claims. The remainder of the Sale Proceeds will be placed in a trust for the benefit of Creditors (the "Creditor Trust"). Administrative expenses, priority claims, and secured claims will be paid in full from the Creditor Trust. Remaining funds will be distributed to general unsecured creditors followed by payment of the Allowed Bond Redemption Premium Claim. The Debtors project there will be sufficient funds to pay all creditors in full upon closing of the Sale; any surplus would be returned to Banner. Following final distributions, the Debtors' estates will be wound down.

With the Sale, and by bringing the hospital the Debtors own and operate under the Banner umbrella, the Debtors expect to be able to (1) ensure continued availability of outstanding medical care to the Casa Grande community, (2) preserve jobs for the Debtors' approximately 800 employees, and (3) generate cash in an amount that, by current projections, should be sufficient to pay creditors in full or close to full.

The Sale is proposed in response to significant financial challenges facing this and other hospitals, and comes after a considerable effort in searching for purchasers or strategic partners conducted for the benefit of Creditors and the community the Debtors serve.

4. Brief Explanation of Chapter 11

Debtors filed a petition for Chapter 11 relief on February 4, 2014 (the "Petition Date"). In Chapter 11, a debtor may reorganize its business or liquidate its assets under the protection of the Bankruptcy Court. To facilitate this process, all efforts to collect prepetition claims from a debtor

and any secured creditor's attempt to foreclose on or seize property of the debtor are stayed during the pendency of the proceeding. A debtor in Chapter 11 is authorized to maintain possession of its assets as a "debtor-in-possession" and operate its business in the ordinary course. Among powers that a debtor-in-possession may exercise subject to Bankruptcy Court approval, a debtor may sell assets free and clear of liens, it may borrow money on terms approved by Bankruptcy Court, and it may assume or reject leases and executory contracts.

B. Disclaimers and Limitations

The information contained in this Disclosure Statement is included for purposes of soliciting acceptances of, and obtaining confirmation of, the Plan and may not be relied upon for any other purpose.

Creditors should note that amendments beneficial to one or more classes of claims without further impairment of other classes may be made to the Plan prior to confirmation. Amendments of that nature may be approved by the Bankruptcy Court at the confirmation hearing without re-solicitation of Creditors and membership interest holders.

The descriptions of the Plan contained in this Disclosure Statement are summaries and are qualified in their entirety by reference to the Plan. Each Creditor is encouraged to analyze the terms of the Plan carefully.

The statements contained in this Disclosure Statement are believed to be accurate as of the date of its filing unless another time is specified in the Disclosure Statement. They should not be construed as implying that there has been no change in the facts set forth since the date the Disclosure Statement was prepared and the materials relied upon in preparation of the Disclosure Statement were compiled. Counsel for the Debtors makes no representation as to the accuracy of the information contained in this Disclosure Statement.

This Disclosure Statement has been neither approved nor disapproved by the Securities and Exchange Commission or any state securities regulator, and neither the Securities and Exchange Commission nor any state securities regulator has passed upon the accuracy or adequacy of the statements contained in this Disclosure Statement.

C. Definitions

1. Defined Terms In the Plan

Various terms are defined in Article II of the Plan. These defined terms are also used in the Disclosure Statement and have the same meaning in this Disclosure Statement as set forth in the Plan.

2. Other Terms

The words "herein," "hereof," "hereto," "hereunder," and others of similar inference refer to the Disclosure Statement as a whole and not to any particular section, subsection, or clauses contained in the Disclosure Statement unless otherwise specified herein. A term used herein or elsewhere in the Disclosure Statement that is not defined herein or in the Plan shall have the meaning ascribed to that term, if any, in the Bankruptcy Code or the Bankruptcy Rules. The headings in the Plan are only for convenience of reference and shall not limit or otherwise affect the provisions of the Plan.

3. Exhibits

All exhibits to the Plan and Disclosure Statement are incorporated into and are a part of the Plan and Disclosure Statement as if set forth in full herein.

D. Classification and Treatment of Claims

Class	Status	Treatment Under Plan	Estimated Distribution
Class 1 (Allowed Bond-Related Claims)	Impaired	The Allowed Bondholder Claim will be allowed in the principal amount of $63,785,000 plus accrued interest, fees and expenses. After application of reserves, the Allowed Bondholder Claim will be paid in full in Cash at Sale Closing or as soon as reasonably practicable thereafter. In exchange, the Allowed Bond Redemption Premium Claim will be subordinated to Class 4 General Unsecured Claims.	100%

Class	Status	Treatment Under Plan	Estimated Distribution
Class 2 (Banner Assumed Liabilities)	Unimpaired	The rights of the holders of Class 2 Claims shall not be affected by the Plan or Confirmation Order. Banner has agreed to assume these liabilities pursuant to the APA.	100%
Class 3A (Allowed Cardinal Claim)	Impaired	The Allowed Cardinal Claim shall be paid in full as soon as practicable after the Effective Date.	100%
Class 3B (Allowed Siemens Claim)	Impaired	The Allowed Siemens Claim shall be paid in full as soon as practicable after the Effective Date.	100%
Class 3C (Allowed Baxter Claim)	Impaired	The Allowed Baxter Claim shall be paid in full as soon as practicable after the Effective Date.	100%
Class 3D (Allowed Morgan Stanley Secured Claim)	Impaired	The Allowed Morgan Stanley Secured Claim shall receive the collateral securing the claim, *i.e.*, the Morgan Stanley Collateral, on the Effective Date.	100%
Class 3E (Allowed Great Western Claim (Pavilion))	Impaired	The Allowed Great Western Claim (Pavilion) shall be paid in full as soon as practicable after the Effective Date.	100%
Class 3F (Allowed Great Western Claim (Urgent Care Center))	Impaired	The Allowed Great Western Claim (Urgent Care Center) shall be paid in full as soon as practicable after the Effective Date.	100%
Class 3G (Allowed First Financial Corporate Claim)	Impaired	The Allowed First Financial Corporate Claim shall be paid in full as soon as practicable after the Effective Date.	100%
Class 4A (General Unsecured Claims Against CGRMC)	Impaired	Commencing on the Initial Distribution Date, Holders of Allowed Claims in Classes 4A, 4B, 4C and 4D will receive a *pro*	100%

Class	Status	Treatment Under Plan	Estimated Distribution
		rata distribution of funds available for distribution from the Creditor Trust after (a) the Reserves, (b) payment of Administrative Expenses, Priority Claims, and Tax Claims not otherwise contained in the Reserve, and (c) payment on account of Allowed Class 1 and Allowed Class 3 Claims.	
Class 4B (General Unsecured Claims Against RCSC)	Impaired	*See* Treatment of Class 4A above.	100%
Class 4C (General Unsecured Claims Against RCPG)	Impaired	*See* Treatment of Class 4A above.	100%
Class 4D (General Unsecured Claims Against CGRRC)	Impaired	*See* Treatment of Class 4A above.	100%
Class 5 (Membership Interests)	Impaired	Class 5 Membership Interests shall be cancelled and shall not receive anything under the Plan.	0%

The estimated Distributions set forth above are based upon the Debtors' estimates of the Allowed Claims in each class. There is no guaranty that each Class will receive the distribution estimate above.

E. Parties Entitled to Vote on the Plan

Under the provisions of the Bankruptcy Code, not all parties in interest are entitled to vote on the Chapter 11 Plan. Creditors whose Claims are not impaired by the Plan are deemed to accept the Plan under Bankruptcy Code § 1126(f) and are not entitled to vote. Further, a Holder of Claim or Interest that does not receive or retain any property under the Plan on account of such Claims or Interests is deemed to reject the Plan under Bankruptcy Code § 1126(g). Accordingly,

Classes 1, 3 and 4 are entitled to vote on the Plan. Class 2 (Banner Assumed Liabilities) is deemed to accept the Plan. Class 5 is deemed to reject the Plan.

F. Voting Procedures, Confirmation Hearing, and Cramdown

1. Classified Claims and Interests

After approval of the Disclosure Statement by the Bankruptcy Court, certain Creditors will have an opportunity to vote on the Plan. Voting will be by class as set forth in the Plan and described later in this Disclosure Statement. For classes containing more than one Claim or Interest, a class is deemed to have accepted the Plan if at least one-half of the Creditors in number holding at least two-thirds of the aggregate amount of Claims voting elect to accept the Plan.

If you are entitled to vote to accept or reject the Plan, a Ballot is enclosed for the purpose of voting on the Plan. After carefully reviewing the Plan, this Disclosure Statement, and the detailed instructions accompanying your Ballot, please indicate your acceptance or rejection of the Plan by voting in favor of or against the Plan. **For your vote to be counted, you must complete and sign your original Ballot and return it by 5:00 p.m. on _____, 2014, which is the last date set by the Court to vote on the Plan.**

2. Confirmation Hearing

The Bankruptcy Court has set a hearing on Confirmation of the Plan and to consider objections to Confirmation, if any, for _____, 2014 at _:__ _.m. The Confirmation hearing will be held in Courtroom _____, Tucson, Arizona. At the hearing, the Bankruptcy Court will consider whether the Plan satisfies the requirements of the Bankruptcy Code.

3. Cramdown

If any class of Claims or Interests fails to accept the Plan, the Bankruptcy Court may confirm the Plan in accordance with Bankruptcy Code § 1129(b) on the basis that the Plan is fair and equitable and does not discriminate unfairly with respect to any nonaccepting, Impaired Class. Because Class 5 Membership Interests are deemed to reject the Plan under Bankruptcy Code § 1126(f), the Debtors are seeking confirmation of the Plan pursuant to Bankruptcy Code § 1129(b).

G. Effect of Confirmation of the Plan

Confirmation of the Plan makes the Plan and its provisions binding on the Debtors, all Creditors, and other parties in interest, regardless of whether they have accepted or rejected the Plan. As a result, Creditors may receive payment on their claims only in accordance with the Plan. If confirmed, the estimated Effective Date of the Plan will be 15 days after the Bankruptcy Court enters the Confirmation Order, unless such order is the subject of a stay by the Bankruptcy Court.

H. Approval of the Disclosure Statement

A decision by the Bankruptcy Court to approve this Disclosure Statement under Bankruptcy Code § 1125 is a finding that the Disclosure Statement contains information of a kind and in sufficient detail to enable a reasonable, hypothetical investor typical of holders of impaired claims to make an informed judgment about the Plan and is not a recommendation by the Bankruptcy Court either for or against the Plan.

II. HISTORY AND ORGANIZATION OF THE DEBTORS

A. CGRMC

1. Operations of the Hospital

CGRMC is an Arizona non-profit corporation that is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. CGRMC was incorporated in November 1981 and is sponsored by RCSC.

CGRMC operates a 177-licensed bed, general acute care hospital located in Casa Grande, Arizona (the "Hospital"). CGRMC's medical center campus includes the Hospital building, Desert Reflections Outpatient Imaging Center, four medical office buildings, and the Pavilion. CGRMC also operates a 12,500 square foot urgent care center (the "Urgent Care Center") at a site near the main campus.

CGRMC offers a broad range of services for acute care and ancillary services in both inpatient and outpatient settings, with a significant amount of outpatient services provided at the Urgent Care Center. CGRMC, in conjunction with RCPG, provides a wide range of medical

specialty services including cardiology, gastroenterology, gynecology, neurology, pediatrics, surgery, intensive care and urology.

CGRMC is licensed by the Arizona Department of Health Services through June 2015 and accredited by various organizations. CGRMC is accredited by Det Norske Veritas Healthcare, Inc. (DNV) through April 2014. CGRMC's mammographic imaging and ultrasound services are accredited by the American College of Radiology through September 2014 and October 2015, respectively. CGRMC's laboratory has been accredited by the College of American Pathologists through February 2014 and its sleep lab is accredited by the American Academy of Sleep Medicine.

CGRMC had net revenues of $98,748,100 in 2013 and $108,822,332 in 2012.

2. Mission

The Debtors' mission, as set forth in CGRMC's Articles of Incorporation, dated November 25, as amended, is as follows:

> The Corporation is organized and shall be operated exclusively for charitable, educational, and scientific purposes. The general nature of the business of the corporation and the character of the affairs which the corporation initially intends to conduct in the State of Arizona, shall be the care and nursing of the sick, providing means for their sustenance, alleviation of their distress and to preserve and restore health, to seek the cause and cure of diseases and to educate those who would serve humanity. In furtherance and not in limitation of the purposes for which the corporation is organized, solely for the above purposes and without otherwise limiting its powers, the corporation is empowered to exercise all rights and powers by the laws of Arizona upon nonprofit corporations.

In addition, CGRMC's mission and vision statements are as follows:

> *Mission Statement*: We exist to make a positive difference in the lives of those we serve through compassion and excellence in patient care.

> *Vision Statement*: To be the healthcare system of choice for the communities we serve.

3. Overview of Employees

CGRMC has approximately 800 employees, consisting of physicians, nurses and finance, IT, billing, collections, accounting, administrative, and technical personnel. The medical staff

includes approximately 165 physicians, 81% of whom are board certified in their specialty. The medical staff includes 11 hospitalists that are contracted through a third-party. CGRMC employs one anesthesiologist and its affiliate, RCPG, employs six physicians: two general surgeons, one general and vascular surgeon, one OB/GYN physician, one GYN physician and one neurologist. CGRMC also has contracts with five independent anesthesiologists and a group of five Certified Registered Nurse Anesthetists (CRNAs).

4. Senior Management

Senior management consists of Rona Curphy as Chief Executive Officer and President with an approximate annual base salary in the amount of $365,000 and Karen Francis as Chief Financial Officer with an approximate annual base salary in the amount of $300,000.

B. Background on Other Debtor Entities

RCSC is an Arizona non-profit corporation that is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. RCSC was incorporated in 1997 for charitable and educational purposes, and has the purpose of benefiting, performing the functions of, and carrying out the purposes of the medical care in the community. RCSC is the sole member and sponsor of CGRMC, RCPG and CGRRC. The RCSC board of directors consists of five members (four independent members and one physician). As of the Petition Date, RCSC's management consists of Rona Curphy as President , Karen Francis as Chief Financial Officer, Cherie McGlynn as Chairman, David Fitzgibbons as Vice Chairman, and John Robert McEvoy as Secretary/Treasurer.

CGRRC is an Arizona non-profit corporation that is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. CGRRC was incorporated in 1989 with the purpose of, among other things, providing elderly and handicapped persons housing facilities and services specially designed to meet specific physical, social, and psychological needs. The organization's central purpose also included support for charitable, educational, and other exempt activities of CGRMC. CGRRC is the borrower on the loan for the Urgent Care Center utilized under Hospital operations but there has been no activity in this organization since 2005. As of the Petition Date, CGRRC's management consists of Rona Curphy

as President/CEO, Cherie McGlynn as Chairman, David Fitzgibbons as Vice Chairman, and John Robert McEvoy as Secretary/Treasurer.

RCPG is an Arizona non-profit corporation that is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. RCPG was incorporated in 2008 with the purpose of providing medical services, medical programs and health care for the benefit of patients in the service area of Casa Grande, and to manage the operations of employed physicians that had formerly been under CGRMC operations. As of the Petition Date, RCPG's management consists of Rona Curphy as President/Chief Executive Officer and Karen Francis as Chief Financial Officer.

C. Description of the Non-Debtor Affiliates

Casa Grande Community Hospital Foundation, Inc. (the "Foundation") was formed solely and exclusively for the promotion of fundraising, charitable programs and to receive donations for the benefit of the CGRMC and its affiliates. The Foundation ensures that donors' intent is carried out in use of the funds. The Foundation raises and provides funds for, among other things, breast mammograms and diagnostics to uninsured women, pediatric clinic services, and medications. Officers of the Foundation are David Fitzgibbons as Chairman, Robert McEvoy as Secretary and Cherie McGlynn as Treasurer.

Regional Health Care Ventures, Inc. ("RHCV") was formed for the purpose of holding a minority interest in the joint venture for providing cancer treatment services for Arizona. There are no operations at this entity. Officers of RHCV are Cherie McGlynn as Chairman and Rona Curphy as President.

D. Outstanding Debts

1. Bond Debt

CGRMC issued certain Hospital Revenue Refunding Bonds (Casa Grande Regional Medical Center), Series 2001A, pursuant to the Bond Documents (as defined in the Plan) in the aggregate principal amount of $41,485,000. CGRMC further issued certain Hospital Revenue Refunding Bonds (Casa Grande Regional Medical Center), Series 2001B pursuant to the same Bond Documents in the aggregate principal amount of $4,645,000. Finally, CGRMC issued

certain Hospital Revenue Bonds (Casa Grande Regional Medical Center) Series 2002A pursuant to the same Bond Documents in the aggregate principal amount $25,475,000. The outstanding principal due and owing on the bond obligations totals approximately $63,785,000.

To secure repayment of the Bonds, CGRMC granted liens on its interest in the "Casa Grande Hospital Site," all "Buildings and Improvements" thereon, all "Collateral," and all "Fixtures" as defined in the Bond Documents, which liens collectively may cover substantially all of CGRMC's assets, including real estate. The grant of liens on rights to payment from Medicare and similar programs which provide 70 percent of the Debtors' revenues, however, is subject to the federal Anti-Assignment Act. In addition, due to the nature of the Debtors' operating bank accounts, the lien on the Debtors' cash may be limited to identifiable proceeds of other collateral, reducing the scope of the lien. On November 18, 2013, the Bond Trustee with respect to the Bonds filed an amended UCC financing statement. To the extent that this financing statement was necessary to perfect security interests in CGRMC's personal property, the filing could be subject to review pursuant to Bankruptcy Code section 547.

The Plan provides that the Allowed Bondholder Claim, but not the Allowed Bond Redemption Premium Claim, will be paid in full on or about the Effective Date, notwithstanding any questions or issues regarding the full extent of the collateral securing the Bonds or whether any grants of security are subject to preference or other avoidance challenge. In consideration, the Allowed Bond Redemption Premium Claim shall be subordinate in payment to Class 4 General Unsecured Claims and shall be paid to the extent funds are available for distribution from the Creditor Trust after (a) the Reserves, (b) payment of Administrative Expenses, Priority Claims, and Tax Claims provided in Article IV of the Plan not otherwise contained in the Reserve, and (c) payment on account of Allowed Claims in Classes 1 (except for the Allowed Bond Redemption Premium Claim), 3, and 4.

2. Morgan Stanley Debt

In May 2005, CGRMC entered into several derivative financial agreements and transactions (collectively, and together with the Term Sheet (defined below), the "Morgan Stanley Documents and Transactions") with Morgan Stanley Capital Services LLC (f/k/a Morgan

Stanley Capital Services, Inc.) and/or Morgan Stanley & Co. LLC (f/k/a Morgan Stanley & Co. Incorporated) (collectively, "Morgan Stanley"), consisting of the ISDA Master Agreement, dated as of May 26, 2005, between CGRMC and Morgan Stanley Capital Services LLC (f/k/a Morgan Stanley Capital Services Inc.) (as subsequently amended and together with any schedules and exhibits thereto and confirmation thereunder), the Credit Support Annex to the schedule to the Master Agreement, dated as of May 26, 2005, between CGRMC and Morgan Stanley Capital Services LLC (f/k/a Morgan Stanley Capital Services Inc.) (as amended on April 1, 2010 and as subsequently amended and together with any schedules and exhibits thereto), the transactions entered into between CGRMC and Morgan Stanley under the ISDA Master Agreement, including those evidenced by the confirmations dated May 26, 2005 and bearing Morgan Stanley Reference Numbers AUD5K, AUD5J, AUD5M, AUD5N and AUD5P, the Debt Service Fund (Principal Account) Forward Delivery Agreement, dated as of May 26, 2005, by and among CGRMC, Wells Fargo Bank, National Association, as trustee, Morgan Stanley Capital Services LLC (f/k/a Morgan Stanley Capital Services, Inc.), and Morgan Stanley & Co. LLC (f/k/a Morgan Stanley & Co. Incorporated), the Debt Service Reserve Fund Forward Delivery Agreement, dated as of May 26, 2005, by and among CGRMC, Wells Fargo Bank, National Association, as trustee, Morgan Stanley Capital Services LLC (f/k/a Morgan Stanley Capital Services, Inc.), and Morgan Stanley & Co. LLC (f/k/a Morgan Stanley & Co. Incorporated), and the Debt Service Fund (Interest Account) Forward Delivery Agreement, dated as of May 26, 2005, by and among CGRMC, Wells Fargo Bank, National Association, as trustee, Morgan Stanley Capital Services, LLC (f/k/a Morgan Stanley Capital Services, Inc.), and Morgan Stanley & Co. LLC (f/k/a Morgan Stanley & Co. Incorporated).

As collateral under the Morgan Stanley Documents and Transactions, Morgan Stanley maintained a bank account in its name (the "Collateral Account," with funds in the Collateral Account that CGRMC was obligated to fund from time to time in accordance with the Morgan Stanley Documents and Transactions, the "Morgan Stanley Collateral"). The Debtors' books and records indicate that $752,372 is currently on deposit in the Collateral Account. CGRMC's obligations under the Morgan Stanley Documents and Transactions were otherwise unsecured.

On April 1, 2010, CGRMC and Morgan Stanley Capital Services LLC (f/k/a Morgan Stanley Capital Services Inc.) entered into that certain Term Sheet, which, among other things, (i) resolved the parties' disagreement as to CGRMC's obligations to post eligible collateral pursuant to the Morgan Stanley Documents and Transactions, and (ii) terminated transactions evidenced by the confirmations bearing Reference Numbers AUD5N and AUD5P (the "Term Sheet").

On February 7, 2014, Morgan Stanley delivered notices to CGRMC that events of default had occurred and were continuing under the Morgan Stanley Documents and Transactions and that Morgan Stanley was exercising its right to immediately terminate the remaining Morgan Stanley Documents and Transactions in accordance with their respective terms. On February 21, 2014, Morgan Stanley delivered to CGRMC a settlement statement (the "Morgan Stanley Settlement Statement") setting forth the amounts Morgan Stanley alleges are due and owing by the Debtors to Morgan Stanley under the Morgan Stanley Documents and Transactions.

Morgan Stanley's claims against the Debtors pursuant to the Morgan Stanley Documents and Transactions include: (i) a secured claim secured by and to the extent of the Morgan Stanley Collateral (the "Allowed Morgan Stanley Secured Claim") and (ii) a General Unsecured Claim for the remainder of the Debtors' outstanding obligations under the Morgan Stanley Documents and Transactions not secured by the Morgan Stanley Collateral, which Claim shall be Allowed in the amount of $3,877,640[2] (the "Allowed Morgan Stanley Unsecured Claim").

3. Equipment Lease Obligations

The Debtors have certain debt obligations on account of medical equipment leases by and between CGRMC and various medical equipment and equipment service providers including, but not limited to, Siemens Financial Services, Inc. and First Financial Corporate Leasing. As of the Petition Date, capital lease obligations in the aggregate are estimated to be $303,532. The Debtors intend to exercise a buyout with respect to all equipment as set forth in the respective leases under the Allowed Siemens Claim and the Allowed First Financial Corporate Claim, and sell the

[2] Pursuant to the Morgan Stanley Settlement Statement, Morgan Stanley asserted that it is owed $4,029,307 on account of the Allowed Morgan Stanley Unsecured Claim. The Debtors calculations indicate that Morgan Stanley is owed $3,877,640 on account of the Allowed Morgan Stanley Unsecured Claim. Morgan Stanley has consented to the Debtors' calculated amount.

equipment free and clear of liens to Banner. Based on the Debtors' books and records, the buyout costs with respect to Siemens Financial Services, Inc. total approximately $180,000, and the buyout costs with respect to First Financial Corporate Leasing total approximately $83,000.

4. Trade Debt

The Debtors' trade debt consists of unsecured vendor liabilities that, in the aggregate, approximate $6.0 million as of the Petition Date. The Debtors' trade debt is typical for that of a hospital -- debts for medical supplies and other goods and services necessary to provide patient care and maintain the hospital.

5. Bank Loans

The Debtors have two bank loans pursuant to a certain bank loan agreement, dated June 25, 2004, by and between RCSC and Sunstate Bank in the principal amount of $1,500,000 relating to the Pavilion; and a certain bank loan agreement, dated September 15, 2005, by and between CGRRC and Sunstate Bank in the principal amount of $1,440,000 relating to the Urgent Care Center. Great Western Bank now holds the beneficial interest with respect to these bank loans.

E. <u>Major Assets</u>

The Debtors operate the Urgent Care Center located at 1676 E. McMurray Blvd. Casa Grande, AZ (Tax Parcel No. 505-66-002, 505-66-001). The bank loan agreement dated September 15, 2005 by and between Sunstate Bank and CGRRC provides a security interest against this real property for the benefit of Great Western Bank, the Holder of the Claim.

In addition to the Urgent Care Center, the Debtors own real property located at 950 N. Arizola Rd., Casa Grande, AZ 85122 ((Tax Parcel Nos. 505-22-0200, 505-22-0210, 505-84-0020, 505-84-0030, 505-84-0040, 505-84-0050). The bank loan agreement dated June 25, 2004 by and between Sunstate Bank and Regional Care Services Corp. provides a security interest against this real property for the benefit of Great Western Bank, the Holder of the Claim.

The Debtors own real estate, including property located at 1780 E. Florence Blvd. and 1800 E. Florence Blvd. The property located at 1800 E. Florence Blvd. (505-22-022C, 505-22-022D505-22-0230, 505-22-0190, and 505-22-022B) is encumbered by two deeds of trust,

including one held by Wells Fargo and another held by Republic Bank. The property located at 1780 E. Florence Blvd. (Tax Parcel Nos. 505-22-0730, 505-22-0700, and 505-22-0750) is comprised of three units (Unit 1, Unit 4, and Unit 6). Unit 4 is encumbered by a deed of trust originally held by Sunstate Bank.

Finally, the Debtors also own the following real properties: (i) property located at 1828 E. Florence Blvd. (Tax Parcel No. 505-22-0240), and (ii) raw land (Tax Parcel Nos. 505-22-0130 and 505-22-012C).[3]

The Debtors have nineteen bank accounts including twelve operating accounts, two savings accounts, and five collateral accounts. The Debtors' obligations under the Bond Documents are secured by cash in the Collateral Account at Wells Fargo & Company. The Debtors' obligations under the Morgan Stanley Documents and Transactions are secured only by and to the extent of the cash in the Morgan Stanley Collateral Account.

The Debtors' assets also include intercompany receivables and non-intercompany receivables. The four non-intercompany receivables include: (1) patient receivables; (2) rent receivables ; (3) receivable by Oasis Pavilion Nursing & Rehabilitation; and (4) pharmacy receivables. The Debtors anticipate full collection on the four non-intercompany receivables because the amounts are based on net estimated collectible amounts. The Allowed Cardinal Claim and the Allowed Bondholder Claim are secured by these accounts.

The Debtors also own building fixtures and equipment. Schedule 3.3 to the APA provides a list of encumbrances on the Debtors' building fixtures and equipment.

The Debtors hold inventory with an estimated value of $2,640,981. The Allowed Cardinal Claim and the Allowed Bondholder Claim are secured by inventory.

The Debtors' prepaid assets are comprised of the following: (i) prepaid insurance, (ii) prepaid service agreements, (iii) prepaid dues and subscriptions, (iv) prepaid accounts payable, and (v) prepaid software licensing and support. These prepaid assets are not likely to be recovered in a liquidation scenario.

[3] Property located at 2111 Sweetwater Drive (Tax Parcel No. 504-51-0190) is owned by Casa Grande Community Hospital Foundation, Inc., a non-Debtor entity.

Finally, the Debtors expect an estimated potential recovery in the amount of $480,505.95 (plus costs and interest) from a pending litigation matter in front of the Ninth Circuit Court of Appeals titled Regional Care Services Corporation Health and Welfare Employee Benefit Plan v. Companion Life Insurance Company, United States District Court No. CV10-2597-PHX-LOA, Ninth Circuit No. 12-16538. The basis of the lawsuit was to recover on a denied claim under a stop loss policy. RCSC prevailed on its claim in district court and the matter has been fully briefed at the Ninth Circuit, awaiting arguments.

F. Other Litigation

The Debtors have a pending lawsuit brought by InterTech Computer Products, Inc. against Casa Grande Regional MedicalCenter ("CGRMC") and Bret Huth. In 2009, CGRMC entered into an IT Managed Services Agreement with InterTech to provide remote helpdesk and vendor management of CGRMC's computer systems. In May 2010, Huth, an InterTech employee, was assigned to be the primary InterTech technical support contact for CGRMC. Because the proposed renewal rates were excessive, CGRMC terminated the InterTech contract on April 30, 2012 and posted an opening for the position to bring the services in house. Huth applied for the position in June 2012 and was offered the position. Before he commenced work, InterTech intervened claiming that CGRMC's employment of Huth violated their Agreement. Without admitting fault, CGRMC withdrew the employment offer to Huth. Notwithstanding, InterTech filed suit on July 27, 2012 alleging that CGRMC breached the terms of its Agreement, which caused immediate and irreparable harm and monetary damages. InterTech also alleged causes for breach of the implied covenant of good faith and fair dealing and aiding and abetting. It is CGRMC's position that the Agreement only prohibits solicitation of InterTech employees and the posting of a job opening is not a solicitation, therefore it did not breach the terms of the contract and the case has no merit. In addition, CGRMC did not ultimately hire Huth. The parties participated in a court ordered mediation on October 28, 2013. InterTech's demand for $138,000 to settle was rejected by CGRMC.

G. Events Leading to Chapter 11 Filing

1. Financial Challenges

The Arizona Health Care Cost Containment System ("AHCCCS") is Arizona's Medicaid program. AHCCCS oversees contracted health plans in the delivery of health care to individuals and families who qualify for Medicaid and other medical assistance programs. AHCCCS, through its contracted health plans, pays hospitals and other health care providers for inpatient and outpatient services provided to AHCCCS members. Additionally, AHCCCS makes supplemental payments to hospitals for different purposes and activities.

In 2011, AHCCCS's per diem reimbursement rates were reduced by more than ten percent. Effective October 1, 2011, AHCCCS eliminated reimbursement for AHCCCS-eligible patients after the twenty-fifth day of any inpatient treatment at a hospital or long-term acute care facility during the federal fiscal year from October 1st through September 30th. AHCCCS also eliminated coverage for otherwise eligible patients who do not have dependent children. These changes resulted in a dramatic decrease in the Hospital's AHCCCS reimbursement for the medical services it provides to these indigent patients.

CGRMC estimates that these changes resulted in a decline of its revenue in excess of $10 million from 2011 to 2013. These AHCCCS changes also resulted in decreases in supplemental federal reimbursements linked to treatment of Medicaid-eligible patients of an additional $1 million annually.

Other external factors have also led to declining revenues including the industry-wide migration of treatment from inpatient to outpatient settings (which are reimbursed at significantly lower rates) and the 2% across the board reduction in Medicare reimbursement rates due to the federal budget sequestration. For the fiscal year ended June 30, 2013, the Hospital's net patient service revenue declined by over 11% from 2011 levels. In the first six months of the current fiscal year, inpatient admissions have declined by approximately 15%, compared to the same period in the prior year resulting in a further reduction in revenue. These changing dynamics have substantially impacted CGRMC's operating margins and liquidity over the last two and one-half years.

The Debtors have significant debt obligations, including its obligations under Bond Documents in the aggregate principal amount of $63,785,000. As a result of these financial challenges, the Debtors violated certain bond covenants beginning on June 30, 2013.

The Debtors' business is very seasonal with patient volumes ramping up in the late Fall and Winter and dropping off in the Spring, mirroring the population of the community. As a result of this seasonality, CGRMC's working capital needs increase significantly as it increases its staffing levels, purchased supplies and services to provide care for patients well in advance of receiving reimbursement from Medicare, AHCCCS, commercial insurers and other payers.

Notwithstanding the financial challenges that CGRMC faces, the local community's need for its medical services is critical. CGRMC is the primary medical service provider in its service area, with an overall market share of approximately 59% in 2012. For the 12 months ended June 30, 2013, CGRMC admitted over 7,600 patients and had over 58,000 emergency room and urgent care visits.

2. Review of Strategic Options

In the summer of 2013, CGRMC commenced an intensive review of strategic options that would ensure that CGRMC could continue providing quality health care to the Casa Grande community and surrounding areas and that the Debtors' creditor obligations would be satisfied.

CGRMC and other hospitals who had been negatively impacted by the 2011 changes in AHCCCS applied to the federal government for a provider tax assessment program that was expected to generate an incremental $11,756,252 of net income to the Hospital for the last three quarters of fiscal year 2013 and first two quarters in fiscal year 2014. This application was not approved by the appropriate government agencies.

CGRMC pursued a refinancing of its bonds through a federal program that would have reduced its financing costs by over $2.5 million annually predicated on a successful implementation of the provider tax assessment program. This refinancing effort ultimately failed when the provider tax was not approved.

CGRMC also pursued a strategic partnership with a for-profit hospital system based in Brentwood, Tennessee. This effort ultimately failed.

In May 2013, CGRMC retained Hammond Hanlon Camp ("H2C"), a leading financial advisor and investment banker for hospital and health systems, to assess CGRMC's strategic and restructuring options. CGRMC concluded that it would have inadequate cash to continue operations and was forced to evaluate all strategic options, including filing for bankruptcy. Nevertheless, CGRMC continued to search for other strategic partners and options that would avoid insolvency.

In October 2013, on behalf of CGRMC, H2C contacted twenty potential strategic partners, fifteen of which received CGRMC's confidential information memorandum describing CGRMC, its operations, the Casa Grande market, and the Hospital's financial condition. Six of the recipients submitted an indication of interest in CGRMC, including Banner, another potential not-for-profit strategic partner, and four for-profit health systems. Ultimately, Banner and three other potential strategic partners, including Dignity Health, a California non-profit public benefit corporation, submitted proposed term sheets for a potential partnership.

The CGRMC Board considered numerous factors in choosing a strategic partner, including the likelihood of satisfying creditor claims, execution risk, transition of the assets from the Debtors as a non-profit to Banner as a non-profit, and CGRMC's mission, and determined that Banner presented the best option to satisfy the Debtors' creditor obligations and continue CGRMC's mission to provide and expand quality health care to the Casa Grande community and surrounding areas in a caring and compassionate environment. The CGRMC Board concluded that the terms proposed by Dignity Health were inferior to those proposed by Banner because of, among other reasons, the significant execution risk and the determination that the Banner transaction was more likely to continue CGRMC's mission to provide quality health care to the Casa Grande community. Moreover, Banner played a greater role in understanding and facilitating the federal review process under Hart-Scott Rodino.

3. About Banner

Banner is a non-profit health system headquartered in Phoenix, Arizona that operates 24 hospitals and health care facilities in Alaska, Arizona, California, Colorado, Nebraska, Nevada and Wyoming, in addition to the Banner Health Network and Banner Medical Group. It currently

employs approximately 36,000 individuals. Banner provides a strong financial option for CGRMC, with operating revenue of $5.0 billion, operating earnings before interest, taxes, depreciation and amortization of $683 million, cash and investments of $3.6 billion, almost 300 days cash on hand, and an Aa3/AA- rating. Significantly, the substantial capital of reserves on hand shows financial strength and ability to make needed capital investments. As important, Banner's non-profit mission of making a difference in people's lives through excellent patient care, and reinvesting all of its earnings back into improving patient care, aligns directly with CGRMC's mission.

4. Debtors' Current Financial Status

According to the Debtors' books and records, as of February 28, 2014, CGRMC continues to demonstrate the severe financial stress the Hospital is operating under. The eight month fiscal year operating loss equals $12.25 million, which is more than twice the loss from a year ago of $5.8 million. The current year loss also includes a one-time transfer from its Foundation of $1.45 million and an additional $1.47 million from Medicare Meaningful Use reimbursement. There will be no additional funds received from either of these sources the remainder of the fiscal year. Without these two sources of funding this year, the Hospital's loss year to date would be $15.16 million.

The Hospital has written off $27 million in bad debts and charity. Medicaid (AHCCCS) expansion began in Arizona on January 1st, but will continue to be a very slow process as the state AHCCCS program more than doubles its enrolled members over the next eighteen months. As payments lag at least 60-90 days behind providing the services to patients, the Debtors do not anticipate seeing any significant positive impact to their cash position for several months. In addition, the expansion does not eliminate the reimbursement cuts put into place in 2011 by AHCCCS. Those cuts reduced the payment rate by over 10% and limited inpatient Hospital coverage payments to 25 days per year.

The Hospital had total unrestricted cash in the amount of $6.464 million available for use on February 28th. This includes $4.82 million of cash funding provided from Banner Health since January. Without the additional funding beginning in January, the Hospital would not have

been able to pay its payroll and would be completely insolvent at this time. The Hospital began delaying payments to its vendors last May. Prior to the bankruptcy filing many vendors began demanding payment for back invoices before they would deliver any more product or services. Since the filing, many additional vendors have now gone to COD or require a wire payment on the day of delivery to continue to provide goods. Even with the funding from Banner, trade accounts payable have still increased $3.8 million over the prior year.

The Hospital has not funded its mandatory Bond sinking fund payments of approximately $540,000 per month to preserve its cash since September 2013. This is a default under the Bond covenants as are its ongoing failure to meets its debt coverage ratio and required days of cash on hand ratio.

The Hospital has only expended $1.5 million for its capital needs the past nineteen months. The industry standard for capital expenditures in Hospitals is to spend at least as much as current year depreciation to prevent the aging of the plant and equipment. This would have required total capital expenditures during this same nineteen month period of $9.5 million. As a result, the Hospital's plant and equipment is rapidly aging. During this time, capital dollars have only been expended for two primary purposes: (1) when a piece of existing equipment breaks and cannot be repaired because the item is so old it is unserviceable, or the repair costs don't make sense in relation to the new purchase cost; and (2) additional investment has been required in information technology to enable the Hospital to continue to qualify for meaningful use dollars, which substantially exceed the cost of investment. If meaningful use is not met by a Hospital by 2015, Medicare will begin reducing payments.

Were a significant piece of Hospital equipment to break today, there are no dollars available to replace it and there is no financing available due to the current financial situation. This has been the situation for over a year. An example of this is the Hospital's cardiac cathertization laboratory equipment. This equipment is more than fourteen years old, has gone down unexpectedly multiple times the past year with various part failures, and will cost $2 million to replace. This equipment provides a much needed service within the Community and has saved many lives.

III. DESCRIPTION OF PLAN TERMS

A. Description of the Plan and Means of Implementation

The entire text of the Plan has been provided with this Disclosure Statement, and a general overview of the Plan is provided in Article I. The following is a summary of certain provisions of the Plan; however, this summary is not comprehensive. The Plan and not the Disclosure Statement is the legally operative document that controls the relationship between the Debtors and their Creditors. Therefore, the Plan should be read carefully and independently of this Disclosure Statement. Creditors are urged to consult with counsel and other professionals in order to fully resolve any questions concerning the Plan.

B. Plan Summary

The Plan proposes two basic sets of transactions. First, the Debtors would sell substantially all of their assets to Banner. Second, the net sales proceeds would be disbursed out of escrow to pay the Allowed Bondholder Claim in the compromised amount, with the balance placed in a trust for the benefit of creditors and distributed in accordance with their amounts, lien rights or statutory priority. If there are disputes as to claim amounts or other relevant matters, such disputes may be brought before the Bankruptcy Court for determination,

C. Banner Transaction

1. Overview

A copy of the Asset Purchase Agreement, by and between the Debtors, as sellers, and Banner, as purchaser, dated as of February 4, 2014, and as may be amended, modified or supplemented from time to time (the "APA"), is attached as Exhibit A to the Plan. The details of the transaction set forth in the APA and its specific terms control. By way of a general description, however, Banner and the Debtors agreed that Banner would acquire, among other things, substantially all of the Debtors' assets with the exception of certain excluded assets (as more specifically set forth in the APA, the "Transferred Assets") and would assume certain liabilities.

Banner will pay Debtors cash equal to the lesser of (A) the aggregate amount necessary to pay Allowed Claims against the Debtors in full after payment of allowed, unpaid pre-

confirmation expenses of the bankruptcy and post-confirmation bankruptcy expenses approved by Banner or approved by the Court, excluding postpetition interest on unsecured claims and excluding all claims of Banner, or (B) $87,000,000 minus certain paid time off obligations for employees who will work for Banner after the Sale Closing and certain pre-Closing taxes and also certain Cost Report liabilities of the Debtors (the "Purchase Price"). At Closing, Banner will deliver an amount the parties determine under alternative (B) into escrow. The escrow agent will record documents and disburse the funds. The amount necessary to pay the Allowed Bondholder Claim will be paid out of escrow and the balance will be disbursed to the Creditor Trust to be administered and disbursed in accordance with the APA, the Plan, and the Confirmation Order. Upon payment in full of certain bankruptcy expenses and Allowed Claims, the Creditor Trust will return any remaining cash to Banner.

In addition to the cash payment, prepetition and postpetition loans that Banner extended to the Debtors to sustain hospital operations and allow the Chapter 11 Cases to proceed, in a total principal amount up to $9,507,845, will be deemed satisfied upon the Sale Closing.

2. Conditions to Closing

Pursuant to Section 7.1(a)(iii) of the APA, Banner had the right to terminate the APA any time up to and including February 28, 2014 if it determined, based on due diligence or otherwise, that it was no longer commercially reasonable to proceed to Closing. *See* APA at § 7.1(a)(iii). That date has passed and Banner has not exercised its option to terminate. Accordingly, Banner may only terminate the APA, without the consent of the Debtors, under three scenarios: (i) if a condition to Banner's obligation to close, as set forth in Section 6.1 of the APA, is not satisfied; (ii) if an Action (as defined therein) is commenced by a governmental authority under applicable federal or state antitrust law seeking to enjoin, modify or otherwise prohibit the Sale; and (iii) if the Sale does not close by June 30, 2014. *Id*. at § 7.1.

The conditions to Banner's obligation to close, provided under Section 6.1 of the APA, include: (i) the representations and warranties made by the Debtors are true and accurate, and the covenants and obligations of the Debtors have been performed; (ii) there is no stay of the Confirmation Order in effect and no injunction, restraining order proceeding or regulation in

effect that enjoins or prohibits the Sale; (iii) all governmental and third-party approvals necessary for consummation of the Sale have been obtained; (iv) any consents necessary to transfer the Transferred Assets have been obtained; (v) all Encumbrances other than Permitted Encumbrances (as those terms are defined in the APA) on the Transferred Assets have been released; and (vi) the Confirmation Order shall have been entered in a form and substance reasonably acceptable to Banner. The Debtors are confident that each of the conditions to Banner's obligation to close will be met.

3. Purchase and Sale

Subject to the terms and conditions of the APA, and pursuant to the Plan, Banner will purchase, and the Debtors will sell, the Transferred Assets on the Effective Date or at a later date consistent with the terms of the APA. The Plan further provides that (i) Banner and the Debtors shall perform the terms and conditions of the APA, and (ii) upon the Effective Date and subject to the conditions of the APA, the Debtors are authorized and directed to execute, deliver, perform under, consummate and implement the APA, together with all additional instruments and documents reasonably necessary or desirable to implement it.

The Plan provides for a private sale to Banner. The Debtors do not intend to hold a public auction for the Transferred Assets. Dignity Health, an unsuccessful bidder whose proposal the Debtors decided not to pursue, has acquired roughly $950 in claims in order to obtain standing to be heard in these Cases. Dignity Health has argued, among other things, that a private sale to Banner not subject to auction is improper. The Debtors are aware of no statute or rule requiring the Sale be subject to auction, and none have been cited by Dignity. The Debtors believe that a marketing and selection process additional to the one that was conducted prior to the commencement of these Cases would not be in the best interests of creditors nor would it serve to further CGRMC's mission. Several factors inform the Debtors' judgment in that regard. Proceeds from the Sale to Banner are anticipated to pay all Allowed Claims in full. The Debtors have made significant progress with Banner toward closing the transaction, and Banner is prepared to close, assuming all the conditions to closing are satisfied, once the confirmation order becomes final. The Debtors are confident that all conditions to Banner's obligation to close will

be satisfied. And discretionary regulatory approvals necessary to effectuate the Sale have occurred with respect to the Sale to Banner, leaving only non-discretionary actions still to be completed (e.g. issuance of a new hospital license and the like). To reopen the process to other potential purchasers could provide Banner incentive and the legal right to terminate the APA. Moreover, the sale to any party other than Banner would necessarily involve significant continued operating and bankruptcy costs, risk, delay, and incremental (unfunded) costs as those regulatory approval processes would start over, including the 90-day notice requirement under the Day Act, and no other potential purchaser has undertaken material diligence efforts. Accordingly, the Debtors believe that the Sale to Banner, as provided for under the Plan, is in the best interests of creditors and the estates.

4. Privacy Ombudsman

On March 25, 2014, the United States Trustee for the District of Arizona filed a motion seeking appointment of a consumer privacy ombudsman pursuant to section 332 of the Bankruptcy Code. The Debtors conditionally do not oppose the appointment of such an ombudsman. If appointed, the ombudsman would report on whether the Sale to Banner, which includes the sale of "personally identifiable information", complies with the Debtors' privacy policy or non-bankruptcy law. To assist in this process, Banner has filed with the Court a declaration outlining its own privacy policies.

5. Corporate Authority

The Plan and Confirmation Order shall constitute full corporate authorization to execute and perform the APA.

6. Transfer Free and Clear

Pursuant to the Plan and Bankruptcy Code sections 363(f) and 1141(c), the sale and transfer of the Transferred Assets to Banner shall be free and clear of all claims and interests in such Transferred Assets, including liens, claims, interests, obligations and encumbrances whatsoever, held by Creditors or members of the Debtors. Liens shall attach to the Sale Proceeds in the same validity, scope and priority as existed against the Transferred Assets and shall be held in the Secured Claim Reserve pending distribution by the Creditor Trustee.

7. Banner Assumes No Liability

Except for the Assumed Liabilities (as defined in the APA), Banner shall assume no liability to any Creditor of the Debtors by virtue of the transactions provided for in the Plan and the APA under any theory of contract, tort or doctrine of successor liability. Banner shall be deemed not to be a successor to the Debtors for purposes of the doctrine of successor liability. Upon the Effective Date and the closing pursuant to the APA, each and every holder of a claim against the Debtors shall be permanently enjoined from commencing, continuing or otherwise pursuing or enforcing any remedy, claim, cause of action or encumbrance against Banner or the Transferred Assets.

8. Employment Arrangements

As of the date of execution of the APA, and except to the extent provided under Section 5.8(e) of the APA, no member of the senior management team had received any promise by Banner regarding future employment or future compensation. As of March 12, 2014, Banner informed Ms. Curphy of its intent to continue her role under the same position, with the same responsibilities, and the same compensation structure with the exception of her transition into the benefits plan that Banner maintains for employees.

9. Purchase Price

(i) **Cash Purchase Price.** As generally described in the Overview above and set forth in detail in the APA, the Cash Purchase Price payable subject to the terms of the APA shall be paid to an escrow agent, who will pay the Allowed Bondholder Claim and disburse remaining funds to the Creditor Trust established pursuant to Section 9.01 of the Plan. Upon resolution of all Allowed and Disputed Claims, completion of distributions thereon and payment of the expenses of the Creditor Trust, all Professional Fees, and any fees due to the United States Trustee under 28 U.S.C. § 1930, and the Allowed Bond Redemption Premium Claim, any remaining funds shall be returned to Banner.

(ii) **Loan Forgiveness.** Pursuant to the Plan and in accordance with the APA, any and all obligations under the Prepetition Bridge Loan and the DIP Loan shall be deemed forgiven upon the Sale Closing.

10. Professional Fees Reserve

As provided in and subject to the terms of the DIP Loan, on the Effective Date Banner shall advance DIP Loan funds as part of the Carve-Out in an amount equal to the difference of (i) the cumulative amounts appearing in the Budget for professional fees and disbursements as of the Effective Date less (ii) the cumulative amounts actually funded for payment of Professional Fees and disbursements as of such date. The DIP Loan advance shall be deposited into a separate account maintained by the Creditor Trustee (the "Professional Fees Reserve Account") and used exclusively for payment of allowed professional fees and disbursements incurred by Borrower or any committee appointed pursuant to 11 U.S.C. § 1102 prior to the Effective Date. In the event any balance remains in the Professional Fee Reserve Account after full payment of all such allowed professional fees and disbursements, such balance shall be returned to Banner.

D. Treatment of Claims

The Plan provides claims will be treated based upon their type, as follows:

1. Administrative Expense Claims

The deadline for filing an administrative expense claim (other than post-petition operating expenses or professional fees) (an "Administrative Expense Claim") shall be 30 days after the Effective Date. Except to the extent any entity entitled to payment of an Allowed Administrative Expense Claim has received payment on account of such Claim prior to the Effective Date, each Holder of an Allowed Administrative Expense Claim shall receive, in full and final satisfaction of its Allowed Administrative Expense Claim, Cash in an amount equal to the amount of such Allowed Administrative Expense Claim, by the later of (i) the date that is 14 days after the Effective Date or (ii) the date that is 14 days after the Administrative Expense Claim is Allowed. Notwithstanding the foregoing, the Debtors are permitted to pay administrative expense claims arising from the ordinary course of business without the need for application or court order.

The estimated administrative expenses and fees to be paid for professionals are provided in further detail in the budget attached hereto as Exhibit B (the "Budget"). Based on the progress of these Cases, the Debtors currently estimate that the Plan Effective Date may occur on or around May 30, 2014. Assuming a May 30, 2014 Effective Date, the Budget provides for roughly $3.7 million in administrative expenses and fees to be paid for professionals for the entire duration of these Cases, *i.e.*, the Petition Date through the Effective Date. That amount does not include a success fee payable to H2C, which is the greater of $800,000 or 2% of the consideration received upon completion of the Sale closing. The $3.7 million does include roughly $250,000 for fees of a creditors' committee, although one has not yet (and may not be) appointed. To the extent the Effective Date is delayed beyond May 30, 2014, administrative expenses and fees would increase, as set forth in the Budget. The Debtors believe that these administrative expenses and fees are commensurate with those that would be incurred if the Sale were to occur outside of bankruptcy.

2. Tax Claims

Except to the extent any entity entitled to payment of any Allowed Tax Claim has received payment on account of such Claim prior to the Effective Date, each Holder of an Allowed Tax Claim shall receive, in full and final satisfaction of its Allowed Tax Claim, Cash in an amount equal to the amount of such Tax Claim within 14 days after the Effective Date.

3. Professional Fees

Professionals retained by the Debtors or the Committee under §§ 327 of the Bankruptcy Code and to be compensated pursuant to §§ 327, 328, 330, 331, or 503(b)(2) or (4) of the Bankruptcy Code ("Professionals") seeking payment of professional fees or reimbursement of expenses incurred through and including the Effective Date under §§ 330(a) and 503(b)(2), of the Bankruptcy Code ("Professional Fees") shall file their respective final applications on or before the date that is 60 days after the Effective Date, unless otherwise directed by the Court.

Professionals include, but are not limited to: (i) Brownstein Hyatt Farber Schreck, LLP, the Debtors' bankruptcy counsel; (ii) Mesch Clark & Rothschild, P.C., local bankruptcy counsel; (iii) Grant Thornton LLP, the Debtors' financial advisor; (iv) Hammond Hanlon Camp LLP, the

Debtors' investment banker; (v) antitrust counsel; (vi) Epiq Bankruptcy Solutions, Inc., the Debtors' claims agent; and (vi) any Professionals retained by the Committee, if one is appointed. The Debtors estimate that the fees of the Professionals through the Effective Date of the Plan will not exceed the amounts budgeted by the Debtors.

4. Priority Claims

Each holder of a Priority Claim, if any, shall receive, in full and final satisfaction of its Priority Claim, Cash in an amount equal to the Allowed Amount of such Priority Claim within 14 days after the Effective Date.

5. Statutory Fees

On or before 30 days after the Effective Date, the Creditor Trustee shall make all payments required to be paid the U.S. Trustee pursuant to § 1930 of Title 28 of the United States Code. All fees payable pursuant to § 1930 of Title 28 of the United States Code after the Effective Date shall be paid by the Creditor Trustee on a quarterly basis until these Cases are closed, converted, or dismissed.

6. Classified Claims

The remaining Claims and Interests are divided into 5 Classes.

(i) Class 1: Allowed Bond-Related Claims

As of the Effective Date, the Allowed Bondholder Claim shall be deemed Allowed for all purposes in the aggregate principal amount of $63,785,000, plus (ii) accrued interest thereon under the Bond Documents through the Confirmation Date, plus (iii) the reasonable fees and expenses of the Master Trustee and Bond Trustee, respectively, and their respective counsel and advisors in the amounts set forth in the Confirmation Order. By agreement, the Allowed Bondholder Claim does not include the Allowed Bond Redemption Premium Claim.

Also as of the Effective Date, the Master Trustee and the Bond Trustee shall be deemed to have applied all cash and cash equivalents held by each to reduce the aggregate amount of Allowed Bondholder Claim. According to the Debtors' books and records, this amount is estimated to be $6.1 million. The remaining amount of the Allowed Bondholder Claim shall be paid through escrow at Sale Closing or as soon thereafter as reasonably practicable. The Allowed

Bond Redemption Premium Claim shall be subordinated to the Class 4 General Unsecured Claims and shall be paid if, and after, Allowed Claims in Classes 1 (except for the Allowed Bond Redemption Premium Claim), 3, and 4 are paid in full. This treatment of the Allowed Bondholder Claim and the Allowed Bond Redemption Premium Claim shall be in full and final satisfaction of the Allowed Bondholder Claim, the Allowed Bond Redemption Premium Claim, any and all Claims of the Bond Trustee, the Master Trustee, and all Holders of the Bonds, and all Claims in respect of, arising out of, or related to the Bond Documents.

(ii) Class 2: Banner Assumed Liabilities

The rights of the Holders of Class 2 Claims shall not be affected by the Plan or Confirmation Order. Banner has agreed to assume these liabilities pursuant to the APA.

(iii) Class 3: Secured Claims

Class 3A. Class 3A consists of the Secured Claim of Cardinal Health. According to the Debtors' books and records, this Claim totals approximately $1.2 million. The Allowed Cardinal Claim shall be paid in full as soon as practicable after the Effective Date.

Class 3B. Class 3B consists of the Secured Claim of Siemens Financial Services, Inc. According to the Debtors' books and records, this Claim totals approximately $434,000, which Secured Claim consists of total amounts due, and the fair market value buyout amount for all equipment as set forth in, the aforementioned leases. The Allowed Siemens Claim shall be paid in full as soon as practicable after the Effective Date.

Class 3C. Class 3C consists of the Secured Claim of Baxter Healthcare Corp. According to the Debtors' books and records, this Claim totals approximately $1,000. The Allowed Baxter Claim shall be paid in full as soon as practicable after the Effective Date.

Class 3D. Class 3D consists of the Allowed Morgan Stanley Secured Claim. Morgan Stanley has two claims in these Cases: (i) the Allowed Morgan Stanley Secured Claim, which is secured by and to the extent of the Morgan Stanley Collateral, and (ii) the Allowed Morgan Stanley Unsecured Claim, which represents the unsecured remainder of the Debtors' outstanding obligations to Morgan Stanley under the Morgan Stanley Documents and Transactions. On the Effective Date, Morgan Stanley shall receive, in full satisfaction of the

Allowed Morgan Stanley Secured Claim, the Morgan Stanley Collateral. The Allowed Morgan Stanley Unsecured Claim shall be treated as an Allowed Class 4A General Unsecured Claim under the Plan. This treatment of the Allowed Morgan Stanley Secured Claim and the Allowed Morgan Stanley Unsecured Claim shall be in full and final satisfaction of (i) the Allowed Morgan Stanley Secured Claim, (ii) the Allowed Morgan Stanley Unsecured Claim, and (iii) any and all Claims in respect of, arising out of, or related to the Morgan Stanley Documents and Transactions.

Class 3E. Class 3E consists of the Secured Claim of Great Western Bank. According to the Debtors' books and records, this Claim totals approximately $700,000. The Allowed Great Western Claim (Pavilion) shall be paid in full as soon as practicable after the Effective Date.

Class 3F. Class 3F consists of the Secured Claim of Great Western Bank. According to the Debtors' books and records, this Claim totals approximately $700,000. The Allowed Great Western Claim (Urgent Care Center) shall be paid in full as soon as practicable after the Effective Date.

Class 3G. Class 3G consists of the Secured Claim of First Financial Corporate Leasing. According to the Debtors' books and records, this Claim totals approximately $149,000, which Secured Claim consists of total amounts due under, and the fair market value buyout amount of the equipment as set forth in, the aforementioned lease. The Allowed First Financial Corporate Claim will be paid in full as soon as practicable after the Effective Date.

(iv) Class 4: General Unsecured Claims

Commencing on the Initial Distribution date, Holders of Allowed Claims in Classes 4A, 4B, 4C, and 4D will receive a *pro rata* distribution of funds available for distribution from the Creditor Trust after (a) the Reserves, (b) payment of Administrative Expenses, Priority Claims, and Tax Claims not otherwise contained in the Reserve, and (c) payment on account of Allowed Class 1 and Allowed Class 3 Claims. According to the Debtors' books and records, Debtors

anticipate the Allowed Class 4 Claims total roughly $16.1 million.[4] The Debtors anticipate that Allowed Class 4 Claims shall be paid in full under the Plan. Disputed claims will be paid on a *pro rata* basis from the Reserve held back to account for such Disputed Claim to the extent ultimately Allowed. If Holders of Allowed Claims are not paid in full on the Initial Distribution Date or upon Allowance of their Claims, and cash remains after all Claims are Allowed or Disallowed, and all remaining costs to wind down the bankruptcy estates are paid or arranged to be paid, an additional *pro rata* distribution will be made to Holders of Allowed Claims in Classes 4A, 4B, 4C, and 4D up to the full amount of their Allowed Claims, without postpetition interest.

Pursuant to the APA, the cap on the Purchase Price described in Section III.C.1 of this Disclosure Statement is projected to provide for payment of Allowed Class 4 Claims in full but does not provide for payment of interest accruing on such Claims after the Petition Date. Section 502(b) of the Bankruptcy Code, which governs allowance of claims in bankruptcy cases, generally disallows claims for post-petition interest. Thus, while the Plan is expected to provide for payment of Allowed Claims in full, the Plan does not provide for payment of post-petition interest to unsecured creditors.

Bankruptcy Courts have, in limited circumstances, required payment of post-petition interest in Chapter 11 cases. Pursuant to Bankruptcy Code section 726(a)(5), when a bankruptcy estate administered pursuant to Chapter 7 of the Bankruptcy Code has assets available after payment of expenses of administration and payment of allowed claims in full, among other things, then unsecured creditors would receive payment of post-petition interest "at the legal rate" to the extent funds are available. In this case, the unsecured Allowed Bond Redemption Premium Claim will be paid after payment of unsecured creditors without interest and other costs and expenses, because of the subordination provisions of the settlement described in Section VI.D. of

[4] The estimated total Allowed Claims for Class 4 is (i) derived from the Schedules filed with the Court, and (ii) also includes, among other things, anticipated damages arising from rejection of executory contracts and/or unexpired leases. Based on the Debtors' books and records, the Debtors do not believe any unsecured claims exist in Class 4D (General Unsecured Claims Against CGRRC). CGRRC simply owns real estate and does not otherwise generate separate revenue or debts. However, to the extent there are unsecured claims in Class 4D, they will receive distributions on par with Classes 4A, 4B, and 4C.

this Disclosure Statement. It is possible that there would be no remaining funds thereafter to pay interest to holders of unsecured claims in any event.

The provision for payment of post-petition interest has been incorporated into requirements for Chapter 11 plan confirmation pursuant to the "best interest" test in section 1129(a)(7), which requires that a plan of reorganization provide a return to creditors who have not voted in favor of the plan at least as much return on account of their claims as such creditor would receive in a hypothetical liquidation under Chapter 7 of the Bankruptcy Code. In the present case, the liquidation analysis attached as Exhibit D shows that creditors would receive substantially less than their Allowed Claim amounts in a Chapter 7 liquidation. Therefore, on the facts of these Chapter 11 Cases, the Debtors do not believe that section 726(a)(5) would provide for post-petition interest on Allowed Claims. In any event, the "legal rate" of interest accrual provided in section 726(a)(5) has been interpreted to refer to the federal judgment rate. *See Onink v. Cardelucci (In re Cardelucci)*, 285 F.3d 1231, 1235-36 (9th Cir. 2002). The federal judgment rate is currently 0.12% per annum. At that rate, post-petition interest would amount to less than 0.05% of a creditors Allowed Claim.

(v) Class 5: Membership Interests

Class 5 Membership Interests shall be cancelled and shall not receive anything under the Plan.

E. Executory Contracts and Unexpired Leases

1. Executory Contracts and Unexpired Leases Assigned to Banner

(i) **Contracts and Leases to be Assigned**

Upon the Sale Closing, the executory contracts and unexpired leases listed on Exhibit B to the Plan (to be updated prior to the Confirmation Hearing with respect to any contracts or leases entered into by the Debtors after the Petition Date) shall be assumed and assigned to Banner (the "Banner Assigned Contracts)."

(ii) **Defaults**

The cure amounts under each Banner Assigned Contract shall be the amount set forth in Exhibit B to the Plan. Final cure amounts under each Banner Assigned Contract shall be the

amount set forth in the Confirmation Order after such notice to counterparties and opportunity for hearing as ordered by the Court. To the extent such default is monetary, the counterparty to the applicable Banner Assigned Contract shall receive payment in Cash as soon as practicable after the Effective Date from the Creditor Trustee or as otherwise agreed between Banner and the counterparty to the contract, in an amount equal to the final cure amount less any payments made during these Chapter 11 Cases on account thereof in accordance with Bankruptcy Court approval. Upon assignment, Banner shall have no liability in respect of any default that occurred prior to the assignment.

(iii) **No Further Liability**

After assignment, neither any of the Debtors, nor the Creditor Trust, shall have any liability in respect of the Banner Assigned Contracts.

2. Assumption or Rejection of Executory Contracts and Unexpired Leases

Pursuant to §§ 365(a) and 1123(b)(2) of the Bankruptcy Code, all executory contracts and unexpired leases that exist between the Debtors and any party that have not been previously assumed pursuant to an order of the Bankruptcy Court or are not a Banner Assigned Contract, shall be deemed rejected on the Effective Date.

3. Claims Based on Rejection of Executory Contracts or Unexpired Leases

With respect to Claims arising from the rejection of executory contracts or unexpired leases pursuant to the Plan, the bar date to file Proofs of Claim shall be 15 days after the Effective Date and all such Proofs of Claim must be filed during that time so that appropriate Reserves may be calculated. Any Claim arising from the rejection of an executory contract or unexpired lease pursuant to the Plan for which a Proof of Claim is not timely filed within that time period shall be forever barred from assertion against the Debtors officers, directors or agents of the Debtors, the Estates, its successors and assigns, or its assets and properties, unless otherwise ordered by the Bankruptcy Court or as otherwise provided herein.

F. Anticipated Litigation; Waiver of Avoidance Claims

The Debtors do not anticipate any litigation. Pursuant to the Plan, upon the Effective Date and conditioned upon the Sale Closing, all Avoidance Claims shall be deemed waived. All other Causes of Action shall be assigned to the Creditor Trustee (discussed below) as the representative of the Estates. Pursuant to the terms of the Plan and as discussed in more detail below, various parties associated with these Cases, *i.e.*, the Released Parties (defined below), will receive releases from all Causes of Action other than those related to criminal conduct, willful negligence or gross misconduct.

Among potential Avoidance Claims that would not be pursued would be possible challenges to the security interests in the Debtors' personal property securing repayment of the Bonds and in the Debtors' cash. Pursuit of Avoidance Claims would result in a net reduction of recoveries to unsecured creditors, even if the elements under the particular claim exist, simply due to potential defenses and legal fees associated with litigating such claims.

Further, the Debtors made payments of approximately $24,000,000 during the ninety days prior to the Petition Date. The vast majority of these transfers were made in the ordinary course of business. Any other transfers made during this period likely have other defenses under 11 U.S.C. §547. However, the Debtors have not conducted an exhaustive review.

The Debtors believe that waiver of avoidance claims is appropriate given the extremely high payouts proposed in the Plan; pursuit of such claims would create unnecessary delay and expense, and could reduce ultimate recoveries.

G. Feasibility and Distributions to Creditors

The Bankruptcy Code requires that a debtor demonstrate that confirmation of a plan is not likely to be followed by liquidation or the need for further financial reorganization unless the plan calls for liquidation. The Plan calls for (i) the sale of substantially all of the Debtors' assets to Banner pursuant to the terms of the executed APA, and (ii) subsequent wind-down of the Estates by the Creditor Trustee. The Debtors have analyzed their ability to meet their obligations under the Plan. The APA has already been executed and there has been significant progress towards a Sale closing. As of March 12, 2014, all regulatory approval and waiting periods have been

satisfied. The parties have also received premerger clearance under Hart-Scott Rodino. The Debtors expect to get to closing two weeks after the Confirmation Date. Banner has agreed, pursuant to the DIP Loan, to provide the Debtors with sufficient debtor-in-possession financing to operate their businesses until the estimated Sale Closing date. The Purchase Price is anticipated to be sufficient to pay all Allowed Claims in these Cases in full. Therefore, the Debtors anticipate being able to make all payments required under the Plan. Accordingly, the Debtors believe the Plan satisfies the feasibility requirement of the Bankruptcy Code. Moreover, the Plan calls for an orderly wind-down of the Estates after the Sale Closing, which, by definition, satisfies the feasibility requirement.

H. Federal Income Tax Consequences to Creditors

Any tax advice contained in this Disclosure Statement is not intended or written to be used, and cannot be used, by any taxpayer for the purpose of avoiding tax-related penalties under the Internal Revenue Code of 1986, as amended. Any tax advice contained in this Disclosure Statement was written to support the promotion of the transactions described in this Disclosure Statement.

The following discussion is not intended as a substitute for professional tax advice, including the evaluation of recently enacted and pending legislation, since recent changes in the federal income taxation of reorganizations under the Bankruptcy Code are complex and lack authoritative interpretation. The Debtors have not received, nor will they request, a ruling from the IRS as to any of the tax consequences of the Plan with respect to Holders of Claims. The Debtors assume no responsibility for the tax effect that Confirmation and receipt of any distribution under the Plan may have on any given creditor or other party in interest. The brevity of the following discussion requires omission of matters that might affect one or more Holders of Claims against the Debtors depending upon their circumstances. **Accordingly, the Debtors recommend that Creditors and other parties in interest consult with their own tax advisors concerning the federal, state and local tax consequences of the Plan**.

Creditors may be required to report income or may be entitled to a deduction as a result of implementation of the Plan.

To the extent a Creditor receives, or expects to receive, less pursuant to the Plan than the Creditor's basis in the claim to which such amount relates, the Creditor may be permitted to claim a bad debt deduction. The amount, timing and character of the deduction will depend, among other things, upon the Creditor's tax accounting method for bad debts, the Creditor's tax status, the nature of the Creditor's claim, whether the creditor receives consideration in more than one year, and whether the creditor has previously taken a bad debt deduction or worthless security deduction with respect to the Creditor's claim. If the debt is not business related, a deduction is only available if the debt is worthless. A cash basis taxpayer can deduct a bad debt only if an actual cash loss has been sustained or if the amount deducted was included in income. All accrual-basis taxpayers must use the specific charge-off method to deduct business bad debts.

To the extent that a Creditor receives payment pursuant to the Plan in an amount in excess of the Creditor's adjusted tax basis in the claim to which payment relates, the excess will be treated as income or gain to the Creditor. A Creditor not previously required to include in its taxable income any accrued but unpaid interest on a claim may be treated as receiving taxable interest, to the extent the amount it receives pursuant to the Plan is allocable to such accrued but unpaid interest. A Creditor previously required to include in its taxable income any accrued but unpaid interest on a claim may be entitled to recognize a deductible loss, to the extent the amount of interest actually received by the Creditor is less than the amount of interest taken into income by the Creditor.

IV. THE CREDITOR TRUST

A. Creditor Trust Agreement

The Plan provides for the formation of a Creditor Trust as of the Effective Date, which shall be governed by the Creditor Trust Agreement substantially in the form filed with a Plan Supplement. The Creditor Trust shall receive all assets of the Debtors' Estates, excluding Transferred Assets, but including the Sale Proceeds, net of payment of the Allowed Bondholder Claim, and any Excluded Assets under the APA. The Creditor Trustee shall receive the Sale Proceeds free and clear of liens, claims and encumbrances except for funds to be held in the Secured Claims Reserve.

B. Appointment of Creditor Trustee

Scott Davis, a Partner at Grant Thornton LLP, shall be appointed as the Creditor Trustee. Mr. Davis' professional bio is attached as Exhibit C to this Disclosure Statement.

C. Powers and Duties of the Disbursing Agent

The Plan provides that the Creditor Trustee shall have the following powers and duties:

1. To take control of, preserve, and convert to Cash property of the Estates, subject to the terms of the Plan;

2. To investigate, prosecute and/or abandon all Causes of Action belonging to or assertible by the Estates, excluding all Avoidance Claims (it being expected that the Creditor Trustee would only bring a claim or Cause of Action after careful consideration of the costs and benefits, in light of the distributions otherwise to be made under the Plan);

3. To review and object to Claims filed against the Debtors;

4. To compromise all disputes, including all Causes of Action and Objections to Claims;

5. To make distributions on account of all Allowed Claims consistent with the terms of the Plan, and if funds remain after treatment of all Allowed Claims in accordance with the Plan and satisfaction or reservation for all wind-down expenses, return the excess funds to Banner in accordance with the APA;

6. To retain Persons and professionals to assist in carrying out the powers and duties enumerated pursuant to the Plan;

7. To enter into contracts as necessary to assist in carrying out the powers and duties enumerated pursuant to the Plan;

8. To hire employees and/or terminate current employees of the Debtors;

9. To pay expenses incurred in carrying out the powers and duties enumerated pursuant to the Plan, including Professional Fees incurred after the Effective Date;

10. To take all necessary actions to ensure that the corporate existence of the Debtors remains in good standing until entry of a final decree closing the Chapter 11 Cases;

11. To open and maintain bank accounts and deposit funds and draw checks and make disbursements in accordance with the Plan;

12. In general, without in any manner limiting any of the foregoing, to deal with the assets of the Estates or any part or parts thereof in all other ways as would be lawful for any Person owning the same to deal therewith; provided, however, that the investment powers of the Debtors, other than those reasonably necessary to maintain the value of the Debtors' assets and to further the liquidating purpose, are limited to the power to invest in demand and time deposits, such as short term certificates of deposit, in banks and other savings institutions, or other temporary, liquid investments, such as United States Treasury Bills; and

13. At the appropriate time, to ask the Bankruptcy Court to enter the final decree.

D. Corporate Authority

Under the Plan, from and after the Sale Closing, the Creditor Trustee will have all corporate authority for each of the Debtors entities to execute any documents or instruments necessary or appropriate post-Sale Closing and to take any other corporate action to wind up and dissolve the corporate entities.

E. Compensation of Creditor Trustee and Professionals Retained by Him

Under the Plan, the Creditor Trustee and any professionals retained by the Creditor Trustee are entitled to reasonable compensation at their standard rates. When seeking payment, the Creditor Trustee or the relevant professional shall provide a copy of the statement to Banner and the Master Trustee (if any amounts remain outstanding on the Bonds). If no written objection to the payment request is received within 10 days, then the sum requested shall be promptly paid. Any objection shall specify the amount objected to and reasons. If an objection is made, the undisputed amount shall be promptly paid. If the parties are unable to resolve any remaining disputes, the Bankruptcy Court shall resolve the dispute upon notice and a hearing.

F. Post-Effective Date Statutory Fees

All fees payable pursuant to 28 U.S.C. § 1930 incurred after the Effective Date shall be paid in accordance with applicable law.

G. Post Confirmation Reports

The Creditor Trustee shall submit post-confirmation reports in accordance with applicable law.

H. Exculpation

The Plan provides that neither the Creditor Trustee nor its designees, retained professionals or any duly designated agent or representative shall be liable for anything other than such Person's own acts as shall constitute willful misconduct or gross negligence in the performance (or nonperformance) of its duties, or acts contrary to the express terms of the Plan. The Creditor Trustee may, in connection with the performance of its functions, consult with counsel, accountants and its agents, and may reasonably rely upon advice or opinions received in the course of such consultation. If the Creditor Trustee determines not to consult with counsel, accountants or its agents, such determination shall not in itself be deemed to impose any liability on the Creditor Trustee, or its members and/or its designees. The Creditor Trust shall indemnify the Creditor Trustee for any and all damages, fees and expenses incurred in connection with these Cases or the Plan; except that the Creditor Trustee shall not be indemnified from damages, fees or expenses arising from its gross negligence or willful misconduct.

V. PROCEDURES FOR RESOLVING AND TREATING CONTESTED CLAIMS

A. Term of the Automatic Stay

The automatic stay provided for under section 362 of the Bankruptcy Code shall remain in full force and effect until the earliest of the time these Cases are closed or dismissed, as provided under section 362(c)(2) of the Bankruptcy Code.

B. Objections to Claims and Settlements

After the Effective Date, Objections to Claims may be made, and Objections to Claims made previous thereto shall be pursued, only by the Creditor Trustee at his sole discretion. After the Effective Date, the Creditor Trustee may settle any Disputed Claim where the proposed Allowed Claim is to be less than $25,000 without notice and a hearing and without an order of the Bankruptcy Court. All other settlements shall be subject to notice and a hearing pursuant to §

102(1) of the Bankruptcy Code and a Final Order of the Bankruptcy Court approving the settlement.

C. Reserves for Disputed Claims

If any Claim is a Disputed Claim, no distribution shall be made on account of such Claim unless and until said Disputed Claim becomes an Allowed Claim. In the event a Distribution is made while there is a Disputed Claim, the Distribution that would be paid on account of the Disputed Claim shall be withheld and remain in the a bank account maintained in compliance with Article VII of the Plan until the Claim is Allowed or Disallowed. If the Claim is Allowed, the Holder of the Allowed Claim will receive its withheld Distribution.

D. Other Provisions

Additional provisions concerning Objections to Claims are described further in Article VII of the Plan.

VI. MISCELLANEOUS PLAN PROVISIONS

A. Waiver of Avoidance Claims

The Plan provides that, upon the Effective Date and conditioned upon Sale Closing, Avoidance Claims shall be deemed waived and abandoned.

B. Committee Dissolved

The Committee, if one is appointed, shall be dissolved automatically and its members shall be deemed released of all their duties, responsibilities and obligations in connection with these Cases and the Plan.

C. Discharge

Except as otherwise provided in the Plan, and irrespective of any prior orders of the Bankruptcy Court or any other court of competent jurisdiction, effective as of the Confirmation Date: (1) the rights afforded in the Plan and the treatment of all Claims and Membership Interests in the Plan shall be in exchange for and in complete satisfaction, discharge and release of all Claims and Membership Interests of any nature whatsoever, including any interest accrued on such Claims from and after the Petition Date, or any of its assets, property or its Estates; (2) the Plan shall bind all Holders of Claims and Membership Interests, regardless of whether any such

Holders failed to vote to accept or to reject the Plan or voted to reject the Plan; and (3) all Claims against and Membership Interests in the Debtors, and the Debtors in its capacity as debtor-in-possession, shall be satisfied, discharged and released in full, and the Debtors' liability with respect thereto shall be extinguished completely, including, without limitation, any liability of the kind specified under § 502(g) of the Bankruptcy Code; *provided, however*, that nothing in the Plan shall discharge any liabilities of the Debtors arising after the Confirmation Date or that is not otherwise a Claim within the meaning of § 101(5) of the Bankruptcy Code.

D. Approval of Settlements and Releases

In consideration of the subordination of the Allowed Bond Redemption Premium Claim and other consideration and benefits provided in the Chapter 11 Cases and under the Plan, the treatment of the Class 1 Allowed Bond-Related Claims, including releases and exculpations provided under the Plan, constitute a good-faith compromise and settlement of the Estates' Causes of Action and any and all Claims and Liens of the Bond Trustee, the Master Trustee, and the beneficial Holders of the Bonds, respectively. Entry of the Confirmation Order would constitute the Bankruptcy Court's approval of such compromise and settlement of all Causes of Action, and any and all Claims and Liens of the Bond Trustee, the Master Trustee, and the beneficial Holders of the Bonds pursuant to the Plan as well as a finding that such settlement is fair, reasonable and in the best interest of the Debtors and their Estates.

E. Exculpation

The Plan provides for the exculpation of the following parties (collectively, the "Exculpated Parties"): (i) the Debtors; (ii) the Master Trustee in any capacity; (iii) the Bond Trustee in any capacity; (iv) the beneficial Holders of the Bonds; (v) the members of the Committee, if one is appointed; (vi) Banner; and (vii) the current and former officers, directors, members, managers, employees, attorneys, advisors and any other Professionals, each in their respective capacities as such, of each of the foregoing.

Section 13.04 of the Plan provides that none of the Exculpated Parties shall have or incur any liability to any Person for any act or omission in connection with, related to, or arising out of these Cases, including, without limitation, the preparation, formulation or consummation of the

Plan, the Disclosure Statement, or any contract, instrument, release or other agreement or document entered into during the Chapter 11 Cases or otherwise created in connection with the Plan, the pursuit of confirmation of the Plan, or the administration of the Plan or the property to be distributed under the Plan, except for willful misconduct or gross negligence, and, in all respects, the Exculpated Parties shall be entitled to rely upon the advice of counsel with respect to their duties and responsibilities under the Plan.

Exculpation provisions, such as this one, are relatively common in Chapter 11 plans and have been approved by the Bankruptcy Court and others in the Ninth Circuit. *See, e.g., In re Transwest Resort Prop., Inc.*, Case No. 10-37134 (Bankr. D. Ariz. Dec. 30, 2011); *In re W. Asbestos Co.*, 313 B.R. 832, 846-47 (Bankr. N.D. Cal. 2003); *see also In re PWS Holding Corp.*, 228 F.3d 224, 245-46 (3d Cir. 2000) (affirming order confirming plan that contained provisions, similar to those in the Plan, exculpating and releasing claims against the debtors, the reorganized debtors, the creditors' committee, the creditors' representative and their respective members, directors, officers and professionals, finding such release provisions permissible, and stating that such release provisions are "***a commonplace provision in Chapter 11 plans***") (emphasis added).

The Debtors propose the exculpation provision because it furthers the purpose of finality and reducing variability of outcomes to creditors. Each of the Exculpated Parties made significant contributions prior to and during these Cases to achieve a Plan that provides for creditors to likely be paid in full or very close. The exculpation provision takes effect only if the Plan is confirmed and is consistent with acceptance and approval of the general Plan. Moreover, the exculpation provision benefits the estate and creditors because many of the Exculpated Parties may have rights of indemnification against the Debtors' estates in the event such actions were permitted and brought.

F. Releases

The Plan provides for the release of claims by the Debtors against the following parties (collectively, the "Released Parties"): (i) the Master Trustee in any capacity; (ii) the Bond Trustee in any capacity; (iii) the beneficial Holders of the Bonds; (iv) the members of the Committee, if one is appointed; (v) Banner; and (vi) the current and former officers, directors, members,

managers, employees, attorneys, advisors and any other Professionals, each in their respective capacities as such. The specific release in the Plan is as follows:

> **RELEASES BY THE DEBTORS.** ON THE EFFECTIVE DATE, FOR GOOD AND VALUABLE CONSIDERATION AND IN RETURN FOR THE COMPROMISES EMBODIED IN THE PLAN, THE RECEIPT AND ADEQUACY OF WHICH ARE HEREBY CONFIRMED, THE DEBTORS, ON BEHALF OF THEMSELVES AND THEIR ESTATES, THE REORGANIZED DEBTORS, AND THE CREDITOR TRUSTEE, SHALL BE DEEMED TO HAVE IRREVOCABLY RELEASED ANY AND ALL CLAIMS AND CAUSES OF ACTION, INCLUDING AVOIDANCE CLAIMS, AGAINST THE RELEASED PARTIES ARISING PRIOR TO THE EFFECTIVE DATE.

The Debtors believe that this release of claims against the Released Parties is necessary and appropriate, especially given the unique facts of these Cases. The causes of action being released are property of the Debtors' estates under section 541 of the Bankruptcy and their release is authorized under section 1123(b)(3)(A) of the Bankruptcy Code. Here, the Released Parties made significant contributions to these Cases and to a Plan that is anticipated to pay creditors in full. Released were a negotiated deal point for many of the Released Parties. *See, e.g.*, Disclosure Statement § VI.D.

Moreover, it is the Debtors' business judgment that there would be nominal, if any, benefit to creditors and the estates in preserving and pursuing causes of action against the Released Parties. Among other reasons, that is why Article X of the Plan provides that Avoidance Actions are deemed waived and abandoned as of the Effective Date. Moreover, because the Plan is anticipated to pay creditors in full, creditors would unlikely receive any benefit from the pursuit of such causes of action. To the contrary, the Debtors believe that investigating and pursuing these causes of action could distract from the goal of a quick sale and distribution to creditors and would lead to increased administrative expense claims, which, in turn, could actually reduce overall recoveries for creditors. Moreover, the Released Parties might assert counterclaims or indemnification claims in response to such litigation, which could further deplete funds otherwise available for distribution to creditors.

G. Other Provisions

Creditors and other parties in interest are directed to the Plan with respect to the provisions that are not specifically discussed in this Disclosure Statement.

VII. RISK FACTORS

As with any plan or other financial transaction, there are certain risk factors which must be considered. It should be noted that all risk factors cannot be anticipated, that some events will develop in ways that were not foreseen and that many or all of the assumptions that have been used in connection with this Disclosure Statement and the Plan will not be realized exactly as assumed. Some or all of such variations may be material. While every effort has been made to be reasonable in this regard, there can be no assurance that subsequent events will bear out the analysis set forth herein. Not all possible risks can be, or are discussed in this Disclosure Statement. Under the Plan, some of the principal risk that Holders of Claims should be aware of, in the Debtors' view, are as follows:

- Risk Related to the Sale Closing. Banner's right to terminate the APA based upon results of due diligence expired on February 28, 2014, and Banner is proceeding towards the Sale closing under the APA. Banner's commitment to purchase is subject to, among other things, state and federal regulatory approval. The Federal Trade Commission has completed its review of the parties' required submission under the Hart-Scott-Rodino Act and has determined not to challenge the sale. The Arizona Attorney General has also completed and closed its premerger investigation. The Day Act hearing, which provided for a state regulatory review process, was completed on March 13, 2014 and the required report from the hearing was issued March 17, 2014. The Arizona Corporate Commission has confirmed receipt of the summary report of the public hearing, thus satisfying A.R.S. §10-11253. Banner is financially strong and its ability to perform is not considered to be a material risk.
- Dilution of Distributions Based on Allowed Claims The Claims Bar Date has not yet passed and to the extent there are additional claims filed before the Bar Date,

the amount of Allowed Claims may increase, subjecting the Holders of Allowed Claims to the risk of dilution. Additionally, no final determination has been made as to which Claims will be Disputed Claims, and it is possible that the number of Disputed Claims may be material and that the amounts allowed in respect of such Disputed Claims may be materially in excess of the estimates of Allowed Claims used to develop the Plan and this Disclosure Statement. The Holders of Allowed Claims are subject to the risk of dilution if the amount of actual Allowed Claims exceeds such estimates. Accordingly, distributions to the Holders of Allowed Claims are at risk of being adversely affected by the total amount of Allowed Claims. Factors that may cause Allowed Claims to exceed projected amounts include claims arising from contract rejections, unknown claims and liabilities, or differences in books and records between the Debtor and the relevant Creditor.

- Costs of Administering the Estate The disbursement of the proceeds of any litigation recoveries will require certain administrative costs that may vary based on a variety of factors. Such administrative costs cannot be predicted with certainty and will be paid from cash on hand. Accordingly, such expenses may affect recoveries under the Plan, in particular if the Creditor Trustee elects to pursue any litigation.

- Hospital Operations. The estimated payouts on Allowed Claims assumes that the Debtors will operate the hospital at certain levels of profit and loss. If the Debtors' performance is below those projections, return to Creditors could be diminished.
- Adjustments to Purchase Price. The APA provides for certain adjustments to the Purchase Price. If these adjustments reduce cash proceeds of sale, payouts to Creditors would be affected accordingly.

VIII. ALTERNATIVES AND POTENTIAL PLAN RECOVERY

A. Chapter 7 Liquidation

An alternative to confirmation of the Plan would be liquidation of the Debtors' assets by a trustee appointed in a case under Chapter 7 of the Bankruptcy Code. In that event, a trustee would be appointed to liquidate the assets of the Debtors for distribution to holders of Claims and Membership Interests in accordance with the priorities established by the Bankruptcy Code. The Chapter 7 trustee would make all of his or her own decisions with respect to the liquidation of the Estate, the hiring of professionals, the pursuit of any claims or litigation, and the payment or objection to Claims. If a Chapter 7 trustee were appointed, the Chapter 7 trustee would be paid pursuant to the provisions of § 326(a) of the Bankruptcy Code, which would add an additional Administrative Expense Claim.

Under § 1129(a)(7), a debtor's plan must provide that creditors receive no less under the plan that they would in a liquidation scenario under Chapter 7. Such analysis is unusually hypothetical in these Cases because the Debtors are non-profit entities and not "moneyed, business, or commercial corporation[s]" and, as such, their Cases cannot be converted to Chapter 7 without their consent. 11 U.S.C. §1112(c). *See also In re Hyperion Foundation, Inc.*, 2009 WL 2477392 (holding that 11 U.S.C. § 1112(c) bars conversion of non-profit debtor with the charitable purpose of operating nursing homes and related healthcare facilities); *In re Hospital de Damas, Inc.*, 2012 WL 1190651 at n.1 (noting that a non-profit hospital is not eligible to be converted to Chapter 7 under 11 U.S.C. § 1112(c)).

Nevertheless, Debtors have included a hypothetical liquidation analysis attached hereto as Exhibit D (the "Liquidation Analysis"). As more fully demonstrated in the Liquidation Analysis, the Debtors believe that Confirmation of the Plan will provide each holder of a Claim entitled to receive a distribution under the Plan with a recovery that is not less than it would receive if the

Debtors were liquidated under Chapter 7 of the Bankruptcy Code. For instance, the average recovery for Secured Claims under the Plan is 100%, whereas under a liquidation scenario Secured Claims are estimated to recover anywhere from 13.3% to 39.2%. Similarly, Unsecured Claims are estimated to recover on average 100% under the Plan and 0% under a liquidation scenario.

The Debtors submit that the Banner Transaction pursuant to the terms of the Plan is in the best interest of Creditors. A Chapter 7 trustee would not be able to operate a hospital. As a result, the Banner Transaction would be unavailable and assets would be sold at liquidation values. The Banner Transaction provides value far in excess of liquidation values.

B. Alternative Plan

If the Plan is not confirmed as to one or more Debtors, one or more Debtors (or if the Debtors' exclusive period in which to file a plan or plan of reorganization has expired, any other party in interest) may be entitled to file a different plan. However, the Debtors believe that the proposed Plan provides holders of Claims and Interests with the greatest value possible under the circumstances. The Debtors believe that any subsequently-proposed plan would likely provide a less favorable treatment than the Plan by further delaying distribution, resulting in additional expense. Moreover, the Debtors do not believe that they can propose an alternative plan without additional capital, no known source of which is available, and for other reasons believe that a sale is in the best interests of creditors and the community the Debtors serve. A sale pursuant to an alternative plan would be subject to the risks described in Section VII of the Disclosure Statement under "Risks Related to Sale Closing."

C. Dismissal of Bankruptcy Case

The Debtors do not believe that dismissal of the Bankruptcy Case would be to the advantage of parties in interest.

March 28, 2014

Debtors and Debtors-in-Possession

By: s/ Rona Cuyler
Title: Chief Executive Officer

APPROVED AS TO FORM:

Michael McGrath Az. #6019
Kasey C. Nye Az. #20610
MESCH, CLARK & ROTHSCHILD, P.C.
259 North Meyer Avenue
Tucson, Arizona 85701
Telephone: 520.624.8886
Facsimile: 520.798.1037
Email: mmcgrath@mcrazlaw.com
knye@mcrazlaw.com

AND

Michael J. Pankow (Co. # 21212)
Joshua M. Hantman (Co. # 42010)
BROWNSTEIN HYATT FARBER SCHRECK, LLP
410 Seventeenth Street, Suite 2200
Denver, CO 80202-4432
Telephone: 303.223.1100
Facsimile: 303.223.1111
Email: mpankow@bhfs.com
jhantman@bhfs.com

Attorneys for Debtors-In-Possession

ATTACHMENTS TO AMENDED DISCLOSURE STATEMENT

EXHIBIT A: The Plan

EXHIBIT B: The Budget

EXHIBIT C: Professional Bio of Scott Davis

EXHIBIT D: Liquidation Analysis

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re:	**Case No.: 8:14-bk-09521-MGW**
BAYOU SHORES SNF LLC,	**Chapter 11**
Debtor.	**Telephonic Hearing Set for Friday, August 22, 2014 at 1:30 p.m.**

_____/

DEBTOR'S EMERGENCY MOTION TO ENFORCE THE AUTOMATIC STAY AND/OR FOR AN ORDER, PURSUANT TO 11 U.S.C. § 105, PROHIBITING ANY ACTION TO TERMINATE DEBTOR'S MEDICAID AND MEDICARE PROVIDER AGREEMENTS, TO DENY PAYMENT OF CLAIMS, AND/OR TO RELOCATE RESIDENTS

AND

CERTIFICATE OF NECESSITY OF REQUEST FOR HEARING

Bayou Shores SNF LLC ("Bayou Shores" or "Debtor"), by and through its undersigned counsel, hereby files its Emergency Motion to Enforce the Automatic Stay and/or for an Order, Pursuant to 11 U.S.C. § 105, Prohibiting Any Action to Terminate Debtor's Medicaid and Medicare Provider Agreement, to Deny Payment of Claims, and/or to Relocate Residents and Certificate of Necessity of Request for Hearing (the "Motion") and states as follows:

1. On August 15, 2014 Bayou Shores SNF, LLC, filed a petition for protection under Chapter 11 of Title 11 of the U.S. Code.

2. Bayou Shores is a Florida limited liability company that operates a skilled nursing facility known as the Rehabilitation Center of St. Petersburg (the "Nursing Home"). The Nursing Home has a total of one hundred fifty-nine (159) licensed beds. Many of the Nursing Home's residents have Alzheimer's and other dementias, and/or serious psychiatric conditions such as depression, bipolar affective disorder and schizophrenia.

3. The Nursing Home participates in the Medicare program pursuant to a provider agreement with the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS"), and the Medicaid program pursuant to an agreement with State of Florida Agency for Healthcare Administration ("ACHA"). Additionally, the Nursing Home has four (4) managed Medicaid Provider Agreements with United Healthcare Insurance Company, Molina, American Eldercare, and Sunshine Healthcare Services, Inc. Of the one hundred eight (108) residents currently living in the Nursing Home, ninety-eight (98) are on Medicaid, eight (8) are on Medicare and three (3) are private pay or other.

4. The majority of courts have held that provider agreements are executory contracts that may be assumed or rejected in bankruptcy cases. *See*, *In re University Medical Center*, 973 F.2d 1065, 1077 (3d Cir. 1992) (finding Medicare provider agreement was executory contract subject to assumption under Section 365); *Matter of Visiting Nurse Ass'n of Tampa Bay, Inc.*, 121 B.R. 114, 116 (Bankr. M.D. Fla. 1990) (same); *In re Slater Health Center, Inc.*, 294 B.R. 423, 432 (Bankr. R.I. 2003) (same).

5. On July 22, 2014 CMS sent a letter to the Debtor stating that "your Medicare provider agreement will be terminated at 11:59 pm on August 3, 2014". (*A true and correct copy of the Notice of Involuntary Termination is attached hereto as* ***Exhibit "A"***). This letter was sent after a finding of immediate jeopardy after a patient wandered from the facility for a very short period of time. Normally, after such a finding, the Nursing Home would remedy the issue and would ask for a survey in order to determine that it was in substantial compliance.

6. In order to ensure that the Nursing Home was in substantial compliance Bayou Shores retained the services of Hoffman and Associates ("Hoffman"), a firm that has worked as a federal monitor, and Hoffman certified to Bayou Shores that it was in substantial

compliance on July 28, 2014. However, despite Bayou Shore's request for a survey one was not undertaken. (*A true and correct copy of the Declaration of David Hoffman, Esq. is attached hereto as* ***Exhibit "B"***).

7. On July 31, 2014, the Debtor filed a lawsuit in the District Court for the Middle District of Florida, Tampa Division, seeking injunctive relief against both CMS and ACHA seeking to prohibit the termination of both the Medicaid and Medicare provider agreements and mandamus.

8. On August 1, 2014 the District Court entered a TRO prohibiting the termination of both the Medicare and Medicaid provider agreements until August 15, 2014 at 3:00 pm.

9. On August 15, 2014 the District Court entered an order denying an extension of the TRO and dissolving the TRO finding that it lacked subject matter jurisdiction.

10. Immediately thereafter, at 1:52 pm the Debtor filed the instant bankruptcy case and sent suggestions of bankruptcy to ACHA and CMS, and on August 18 filed a suggestion of bankruptcy in the District Court case in which ACHA and CMS are parties.

11. No further notice of termination of the Medicare agreement was sent to Bayou Shores by CMS and no public notice was provided to indicate that the termination of the Medicare agreement would occur as required by 42 C.F.R. § 488.456(c).[1] Consequently, the Medicare provider agreement was in effect on the Petition Date.

---

[1] As relevant, 42 C.F.R. § 488.456(c) governs termination of provider agreements and provides as follows:

(c) ***Notice of termination.*** Before terminating a provider agreement, CMS does and the State must notify the facility and the public—

(1) At least 2 calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

(2) At least 15 calendar days before the effective date of termination for a facility with non-immediate jeopardy deficiencies that constitute noncompliance.

12. At no time prior to the petition date did ACHA take any action to terminate or attempt to terminate the Medicaid provider agreement. Moreover, the Debtor received no notice of any termination of the Medicaid provider agreement. Consequently, the Medicaid provider agreement was in effect on the Petition Date.

13. On August 21, 2014, seven days after the filing of the petition and after notice of the bankruptcy case was provided to ACHA, ACHA arrived at the Debtor's facility with approximately fourteen (14) people and hand-delivered notices to residents stating that Federal law requires the State of Florida to terminate the Medicaid provider agreement, and that as of September 15, 2014 Medicaid will not pay for the services provided to a resident of the facility (the "Notice"). The Notice specifically provides that "it is your choice as to whether or not to remain a resident of the facility". (*A true and correct copy of the Notice is attached hereto as* ***Exhibit "C"***).

14. The action by ACHA to attempt to terminate the Medicaid provider agreement on September 15, 2014 and to suggest to the residents that they relocate violates the automatic stay.

15. On the morning of August 21, 2014 one of the Debtor's attorneys informed one of ACHA's attorneys, Andrew Sheeran, that the bankruptcy case had been filed. In response, Mr. Sheeran indicated that ACHA was exercising its police powers to protect health, welfare and public safety under 11 U.S.C. § 362(d)(4). ACHA's actions to attempt to terminate the Medicaid provider agreement post petition cannot be an exercise of police powers because the notice to residents clearly permits the residents to choose to stay at the Debtor's facility if they desired. Clearly, ACHA cannot be concerned with health, welfare and public safety and the

residents are not in danger or ACHA would not allow them to remain at the facility[2]. Further, even if ACHA is attempting to exercise its police powers, the court may enjoin such action under 11 U.S.C. §105. *See, In re King Memorial Hospital, Inc.*, 4 B.R. 704, 709 (Bankr. M.D. Fla. 1980; *United States v. Commonwealth Cos.*, 913 F.2d 518, 527 (8th Cir. 1990).

16. Here, the residents are not in danger and the Medicaid provider agreements were in place as of the Petition Date. As ACHA encourages residents to leave, the facility will be unable to pay its post-petition obligations and would be forced to close. All of the approximately one hundred seventy-five (175) employees of the facility would lose their jobs. The harm to the Debtor is clearly irreparable. By contrast, no harm to ACHA will occur if an injunction issues or if delay otherwise ensues.

17. In addition, the harm to the residents is clearly irreparable. More than fifty percent (50%) of the residents have psychiatric conditions in addition to dementia. These patients are difficult to place and there are simply no nearby beds to accommodate the patients. The patients will suffer transfer trauma if they are forced to move, or even consider moving (*A true and correct copy of the Declarations of Charles Crecelius, MD, PhD, FACP, CMD and Barbara Ziv, M.D are attached hereto as* ***Exhibit "E"*** *and* ***Exhibit "F"***). In fact, the concern is so great that the patients sought and obtained an injunction from a state court judge prohibiting their transfer. (*A true and correct copy of the state court injunction is attached hereto as* ***Exhibit "G"***). ACHA is essentially requiring the transfer of the patients by intimidation and non-payment under the provider agreement.

Wherefore, Bayou Shores SNF, LLC requests that this court enforce the provisions of 11 U.S.C §362 against ACHA and CMS, or alternatively issue an order under 11 U.S.C. §105

[2] Likewise CMS is also not acting to protect health, safety and welfare, in that CMS filed an affidavit in the district court action stating that the patients would not be required to move from the facility. (*A true and correct copy of the Declaration of Polly Weaver is attached hereto as* ***Exhibit "D"***)

prohibiting ACHA from terminating the Medicaid provider agreement, ceasing payments under the provider agreement, prohibiting ACHA from soliciting the transfer of patients and to prohibit CMS from terminating the Medicare provider agreement and such other relief as is just and proper.

CERTIFICATE OF NECESSITY
OF REQUESTED EXPEDITED CONSIDERATION

I HEREBY CERTIFY, as a member of the Bar of the Court, that I have carefully examined the matter under consideration and to the best of my knowledge, information and belief formed after reasonable inquiry, all allegations are well grounded in fact and all contentions are warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law can be made, that the matter under consideration is not interposed for any improper purpose, such as to harass, to cause delay, or to increase the cost of litigation, and there is just cause to request a consideration of the matter on an emergency basis.

I CERTIFY FURTHER that there is a true necessity for expedited consideration, specifically to prevent harm to the Debtor's 108 residents, the Debtor's approximately 180 employees, and damage to the Debtor as a going concern. A team of 14 people from ACHA arrived at the Debtor's nursing home facility today and hand-delivered to "Each Medicaid Eligible Resident" of the nursing home a letter informing them that as of September 15, 2014, Medicaid will no longer pay for services provided to them by the Debtor. More than fifty percent of the Debtor's residents have psychiatric conditions in addition to dementia. These patients are difficult to place and there are simply no nearby beds to accommodate the patients. The patients will suffer transfer trauma if they are forced to physically move and some may have already been traumatized by ACHA's letter informing them they would stop receiving Medicaid for any of the Debtor's services after September 15, 2015. An injunction is necessary to prevent any further harm to the Debtor's residents, the Debtor, and its employees.

I CERTIFY FURTHER that the necessity of this expedited consideration request has not been caused by a lack of due diligence on my part, but has been brought about only by circumstances beyond my control or that of my client. I further certify that this Emergency Motion is filed with full understanding of Federal Rule of Bankruptcy Procedure 9011 and the consequences of noncompliance with same.

RESPECTFULLY SUBMITTED this 21st day of August, 2014.

/s/ Elizabeth A. Green
Tiffany D. Payne, Esq.
Florida Bar No.: 0421448
tpayne@bakerlaw.com
Elizabeth A. Green, Esq.
Florida Bar No.: 0600547

egreen@bakerlaw.com
Andrew V. Layden, Esq.
Florida Bar No.: 86070
alayden@bakerlaw.com
BAKER & HOSTETLER LLP
200 South Orange Ave. SunTrust Center, Suite 2300
Orlando, Florida 32801-3432
Tel: (407) 649-4000
Fax: (407) 841-0168
Attorneys for Debtor

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on August 21, 2014, a true and correct copy of the foregoing **DEBTOR'S EMERGENCY MOTION TO ENFORCE THE AUTOMATIC STAY AND/OR FOR AN ORDER, PURSUANT TO 11 U.S.C. § 105, PROHIBITING ANY ACTION TO TERMINATE DEBTOR'S MEDICAID AND MEDICARE PROVIDER AGREEMENTS, TO DENY PAYMENT OF CLAIMS, AND/OR TO RELOCATE RESIDENTS AND CERTIFICATE OF NECESSITY OF REQUEST FOR HEARING,** was filed with the Court using the CM/ECF System which provided electronic notice to those parties requesting such notice and via facsimile at (850) 488-2520 to Justin M. Senior, Deputy Secretary for Medicaid, Florida Agency for Healthcare Administration.

Additionally, on August 21, 2014, this Motion was provided via email to the following:

- Andrew T. Sheeran, Esq. (via email at sheerana@ahca.myflorida.com)
- Leslei G. Street, Esq. (via email at leslei.street@ahca.myflorida.com)
- Kenneth Wilson (AG) (via email at kenneth.wilson@myfloridalegal.com)
- Sean Flynn (US Attorney) (via email at sean.flynn2@usdoj.gov)
- Kirk S. Davis, Esq. (via email at Kirk.Davis@akerman.com)
- Tim Lupinacci, Esq. (via email at tlupinacci@bakerdonaldson.com)

*/s/ Elizabeth A. Green*_____
Elizabeth A. Green, Esq.

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CENTERS FOR MEDICARE & MEDICAID SERVICES

Refer to: 10-5772.Invol.Term.07.22.14.docx

IMPORTANT NOTICE – PLEASE READ CAREFULLY
NOTICE OF INVOLUNTARY TERMINATION
(Receipt of this Notice is Presumed to be July 22, 2014 - Date Notice E-mailed)
Via Federal Express, Regular Mail & E-mail

July 22, 2014

Ms. Tracy Johnson, Administrator
Rehabilitation Center of Saint Petersburg
435 42nd Avenue South
Saint Petersburg, Florida 33705

Re: Involuntary Termination Notice
CMS Certification Number (CCN #): 10-5772

Dear Ms. Johnson,

A facility must meet the pertinent provisions of Sections 1819 and 1919 of the Social Security Act, and be in substantial compliance with each of the requirements for long term care facilities, established by the Secretary of Health and Human Services in 42 C.F.R. section 483.1 et seq., in order to qualify to participate as a skilled nursing facility (SNF) in the Medicare program, and as a nursing facility (NF) in the Medicaid program.

On July 11, 2014, a recertification and complaint investigation survey was completed at Rehabilitation Center of Saint Petersburg, Inc. by the Florida Agency for Healthcare Administration to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid program. **This survey found that your facility was not in substantial compliance with the participation requirements, and that conditions in your facility also constituted immediate jeopardy to residents' health and safety and substandard quality of care that was determined to exist on June 21, 2014, and is considered ongoing.** A statement of the deficiencies (CMS-2567) will be furnished to you by the Florida State Survey Agency.

All regulatory requirements referenced in this letter are found in Title 42, Code of Federal Regulations.

Remedies imposed Based on the July 11, 2014 Recertification and Complaint Survey

Based on the July 11, 2014 survey findings, CMS is imposing the following remedies:

Involuntary Termination

Your Medicare provider agreement will be terminated at 11:59 pm on August 3, 2014, in accordance with 42 C.F.R. 488.456(b) (i) and 42 C.F.R. 489.53. We are required to provide the general public with a notice of impending termination and we published a notice in your local newspaper, *The Tampa Bay Times*, prior to the effective date of the termination. Medicare and Medicaid payments for services rendered to those residents admitted to Rehabilitation Center of Saint Petersburg, before August 3, 2014, will continue to be made up to a 30-day period in order to facilitate the orderly transfer/relocation of residents. The 30-day time interval for payment is from August 3, 2014 through September 2, 2014.

Discretionary Denial of Payment for New Admissions (DPNA)

Denial of Payment for new admissions is effective as of July 24, 2014.

Please note that any filing of Medicare or Medicaid claims for new admissions after the denial of payment for new admissions (DPNA) is in effect could result in such claims being considered "false" claims under applicable federal statutes and thus potentially subjecting the filing entity to a referral to the appropriate authorities and possibly to the penalties prescribed under such statutes. An exception possibly applies where a timely appeal of the controlling certification/finding of non-compliance is filed (and remains pending) under 42 C.F.R. Part 498, and where your facility has made arrangements acceptable to your Medicare and Medicaid fiscal intermediaries to submit the claim (or claims) with prominent flagging clearly indicating that the claim(s) is/are being filed not for current payment, but "under protest" and for the sole purpose of preserving a timely filing should the facility prevail on its administrative appeal under 42 C.F.R. Part 498.

Civil Money Penalty (CMP)

As a result of your facility's noncompliance as evidenced by the findings of the July 11, 2014 survey, and in accordance with sections 1819 (h) and 1919 (h) of the Social Security Act and the enforcement regulations specified at 42 C.F.R. Part 488, **we are imposing a Federal Civil Money Penalty in the amount of $3050.00 per day effective June 21, 2014.** We considered factors identified at 42 C.F.R. 488.438 (f) in setting the amount of the CMP being imposed for each day of noncompliance.

NOTICE OF INTENT TO HOLD YOUR FACILITY'S CMP IN ESCROW

In accordance with federal law at 42 C.F.R. 488.431 and based on the scope/severity of noncompliance identified during your facility's survey, we have decided to collect your facility's CMP and place it in an escrow account.

If you wish to dispute the findings of noncompliance upon which we have made this decision, you may request an Independent Informal Dispute Resolution (Independent IDR) proceeding in accordance with 42 C.F.R. sections 488.331 and 488.431. **If you would like to request an Independent IDR, you must do so in writing within ten (10) days of receiving this notice.**

Your written request should identify the specific findings of noncompliance you are disputing, as well as an explanation of why you are disputing them (and/or why you are disputing the scope/severity of noncompliance constituting immediate jeopardy or substandard quality of care). Your request for an Independent IDR should be sent to the following address:

Carol Higgins, IIDR Coordinator
Agency for Health Care Administration, Field Operations
2727 Mahan Drive, Building 2, Third Floor
Tallahassee, Florida 32308
Email: IDRcoordinator@ahca.myflorida.com
Telephone: (850) 412-3942

Please note that an incomplete Independent IDR process will not delay the effective date of any enforcement remedy imposed on your facility, and it will not delay our collection of your facility's CMP for more than ninety (90) days. We are authorized by federal law at 42 CFR 488.431(b) to collect your CMP in 90 days and place it in escrow, or to do so when a decision is issued from an Independent IDR proceeding, whichever is earlier.

Please note, furthermore, that an incomplete IDR or Independent IDR process will not delay any deadline listed below under "Appeal Rights" for requesting a hearing, or for requesting a waiver of hearing rights.

NOTICE OF RIGHT TO REQUEST HEARING OR WAIVE HEARING RIGHTS

As explained more fully below under "Appeal Rights," you have the right to request a hearing before the Departmental Appeals Board (DAB) if you wish to dispute the basis and amount of your facility's CMP. You may also decide to waive your right to a hearing, in accordance with regulations at 42 C.F.R. 488.436. **If you would like to waive your right to a hearing, you must do so in writing within sixty (60) days of receiving this notice.** If you waive your right to a hearing, the amount of your CMP will be reduced by thirty-five percent (35%); on the other hand, if you request a hearing or miss the deadline for requesting a waiver, your CMP will not be reduced by 35 percent.

You must submit your waiver request directly to our Atlanta Regional Office by **certified mail** or **via Internet e-mail to the CMP Waiver mail box**. **The Atlanta Regional Office does not accept CMP waivers via facsimile**. Please address correspondence via certified mail to:

Stephanie M. Davis, MS., RD
Chief, LTC Certification & Enforcement Branch
Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMP waivers may also be submitted via Internet e-mail to the CMP Waiver mail box. The Internet e-mail address is:

CMPWaiversATL@cms.hhs.gov

Substandard Quality of Care (SQC)

Your facility's noncompliance with 483.13 cited at tags F224(J), F225(J), and F226(J), and 483.25 cited at tags F323(J), has been determined to constitute substandard quality of care (SQC) as defined at 42 C.F.R. 488.301.sections 1818(g)(5)(C) and 1919 (g)(5)(C) of the Social Security Act, as well as implementing regulations at 42 C.F.R. 488.325(h), require the State Survey Agency to send written notice of your facility's SQC to the attending physician of each resident, as well as the state board responsible for licensing the facility's administrator. In order to satisfy these notification requirements, you are required to provide the State Survey Agency with the name and address of the attending physician for each resident found to have received SQC. The State Survey Agency will advise you of the deadline for providing this information.

Please note that, in accordance federal law at 42 C.F.R. 488.325(g), your failure to provide this information in a timely fashion will result in the termination of your facility's Medicare provider agreement, or the imposition of alternative remedies.

Loss of Nurse Aide Training Program (NATCEP)

Please note that Federal law, as specified in the Social Security Act at sections 1819 (f)(2)(B) and 1919 (f)(2)(B), prohibit approval of nurse aide training and competency evaluation programs offered by or in your facility which within the previous two years has operated under a section 1819 (b)(4)(c)(ii)(II) or section 1919 (b)(4)(ii) waiver; has been subject to an extended or partial extended survey; or has been assessed a civil money penalty of not less than $5,000; or, has been subject to denial of payment, the appointment of a temporary manager, termination or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. As a result of the involuntary termination, this provision is applicable to your facility and you will receive further notification from the State.

Appeal Rights for July 11, 2014 Recertification and Complaint Investigation Survey

If you disagree with CMS determinations that are based on the July 11, 2014, recertification and complaint survey as reflected in this Notice, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in section 498.40, et seq. **A written request for a hearing must be filed no later than sixty days of receipt from the date of this letter.** Such a request should be directed to:

Stephanie M. Davis, MS. RD
Chief, LTC Certification & Enforcement Branch
Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

And

Chief, Civil Remedies Division
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

Application for Readmission Following Involuntary Termination:

Under the Medicare regulation at 42 C.F.R. § 489.57(a) when a provider agreement is terminated by CMS, a new agreement will not be accepted until it has been determined that the reason for the termination of the agreement has been removed and there is a reasonable assurance that it will not recur. Once terminated, therefore, you must demonstrate through a reasonable assurance period that you can maintain substantial compliance for at least 180 consecutive days. Substantial compliance with the applicable participation requirements at 42 C.F.R Part 483 will be verified by surveys conducted at the beginning and end of this period. Additionally, before readmission to the Medicare program, you must demonstrate your ability to comply with all pertinent requirements of Title XVIII of the Social Security Act (including your financial ability to provide services required for Medicare participation). You must also establish that you have fulfilled, or made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of your previous provider agreement (including resolution of all outstanding financial obligations due the Medicare program) 42 C.F.R. § 489.57(b).

Assuming substantial compliance with participation requirements is documented at the beginning and end of the reasonable assurance period, and assuming all other federal requirements are met, Medicare certification and reimbursement will begin following the conclusion of the reasonable assurance period in accordance with the terms of 42 C.F.R. § 489.13.

If you have any questions regarding this matter, please contact Stephanie M. Davis, LTC Enforcement Branch Manager at (404) 562-7471 or Phyllis King at (404) 562-7456.

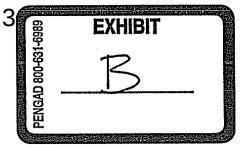
Sincerely,

/s/

Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

cc: State Survey Agency
State Medicaid Agency
Medicare Administrative Contractors
Jackie Glaze, DMCHO, ARA
Stephanie M. Davis, LTCCEB Manager

NOTE TO THE MEDICARE ADMINISTRATIVE CONTRACTORS:
This letter replaces the CMS-2007, Provider Tie-In Notice



IN THE UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF FLORIDA

BAYOU SHORES SNF, LLC Plaintiff, v. SYLVIA MATHEWS BURWELL, Secretary of the United States Department of Health and Human Services, and MARILYN TAVENNER, Administrator of the Centers for Medicare & Medicaid Services, and ELIZABETH DUDEK, Secretary of the Florida Agency for Healthcare Administration, Defendants.	Case No. 8:14-cv-1849-T-33MAP

DECLARATION OF DAVID HOFFMAN, ESQ.

I, David Hoffman, do hereby declare the following to be true and correct to the best of my knowledge, information and belief.

1. I am President of David Hoffman & Associates, a national health care consulting firm located in Philadelphia, Pennsylvania. For the last nine (9) years, my firm has assisted health care providers with patient/resident safety and compliance through clinical and regulatory consulting and has also served as a federal and state monitor of nursing homes on multiple occasions. Prior to starting my firm, I served as an Assistant United States Attorney for the Eastern District of Pennsylvania where I prosecuted health care cases, both criminally and civilly. Before joining the US Attorney's Office I served as Chief Counsel to the Pennsylvania Department of Aging.

2. David Hoffman & Associates has been engaged by Rehabilitation Center of St. Petersburg (RCSP) to evaluate the interventions instituted by RCSP following a July 11, 2014, adverse survey of the facility that focused on issues associated with elopement.

3. I was present at RCSP on July 28 and July 29, 2014, spending a total of 15.5 hours in the facility.

4. In addressing the measures that RCSP has undertaken to address the issues identified in the survey, I have reviewed the following materials:

a. CMS 2567;
b. RCSP revised policies and procedures regarding elopement;
c. RCSP's Plan of Correction;
d. RCSP's revised Elopement Assessment Form;
e. RCSP's elopement prevention audit tools;
f. A sample of elopement prevention audit results and remedial actions to ensure compliance;
g. The Wanderguard system operability logs;
h. The Wanderguard photo book; and
i. All Treatment Administration Records (TARs) for residents located on the secured unit

5. In addition, I interviewed several staff members in order to formulate opinions regarding compliance with regulatory requirements pertaining to the reporting, investigating and addressing of compliance issues associated with elopement.

6. During my time at RCSP and after consultation with my colleague, Dr. Ilene Warner-Maron, all of the current residents of the facility had elopement assessments completed by RCSP personnel. Additionally, I observed that all residents of the second floor had RCSP staff checking the placement of the Wanderguard bracelet every shift as evidenced by the TARs.

7. I observed that important procedural modifications have been implemented pertaining to third-party access to the elevator and the second floor of the facility. Specifically, the following procedural changes have been implemented:

a. No elevator keys are provided to third-parties seeking to visit the secure unit;
b. Visitors must be accompanied by RCSP staff to the secure unit; and
c. RCSP staff surveillance procedures ensure that residents do not gain access to the elevator as the doors are opening or closing.

These actions address the ability of residents to gain access to the elevator from the secured unit.

8. Based upon my review of the CMS 2567, the facility's Plan of Correction, the revised policies and procedures, staff interviews, the documents noted above and my observations of the remedial steps in place at RCSP during my visits, and after consultation with my colleague, Dr. Ilene Warner-Maron, it is my opinion that RCSP has

achieved compliance with the Immediate Jeopardy (IJ) deficiencies cited by the Agency for Health Care Administration during the June 2014 survey as of July 28, 2014.

In accordance with 28 U.S.C. Section 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

8-14-14

David Hoffman, Esq. Date

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

HAND DELIVERED
COPY MAILED TO RESIDENT DESIGNEE

DATE: August 21, 2014

TO: Each Medicaid-eligible Resident of Rehabilitation Center of Saint Petersburg

The Secretary of the United States Department of Health and Human Services ("DHHS") has terminated the Medicare provider agreement of the Rehabilitation Center of Saint Petersburg ("RCSP"). Federal law requires the State of Florida to also terminate RCSP's Medicaid provider agreement. RCSP is appealing DHHS's decision to terminate RCSP's Medicare provider agreement in a federal administrative proceeding.

The purpose of this letter is to let you know that, as of September 15, 2014, Medicaid will no longer pay for services provided to you by RCSP. It is your choice whether or not to remain as a resident of RCSP. However, if you choose to continue to reside at RCSP on or after September 15, 2014, Medicaid will not pay RCSP for the services they provide for you. Also, if you choose to receive services in a nursing facility that is not certified by Medicaid, you will need to contact the Florida Department of Children and Families to find out how that will affect your Medicaid eligibility.

If you decide that you want to find a new residence, staff from the Agency for Health Care Administration and representatives of the Long Term Care Ombudsman Program are available to help you find a new Medicaid approved nursing facility or find some other location that provides medically necessary Medicaid-covered services to meet your needs. If you are enrolled in a Statewide Medicaid Managed Care Long-term Care ("LTC") plan, your LTC plan case manager will contact you and work with you to help you find a new Medicaid approved nursing facility or find some other location that provides medically necessary Medicaid-covered services to meet your needs.

There are two websites that can help you find a new residence:

- The Agency for Health Care Administration's Florida Health Finder website: http://www.floridahealthfinder.gov/
- The Federal Centers for Medicare and Medicaid Services Nursing Home Compare website: http://www.medicare.gov/NHCompare/

You can also call the Long Term Care Ombudsman at 1-888-831-0104.

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

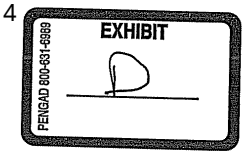
If you have questions, please call Don Fuller, Medicaid Field Office Manager, at (727) 552-1924 during business hours or at (727) 534-5483 during evenings or weekends.

The Agency for Health Care Administration must require nursing facilities to comply with federal requirements. We are sorry for any inconvenience this may cause to you or your family.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JS/tw



IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

BAYOU SHORES SNF, LLC Plaintiff, v. SYLVIA MATHEWS BURWELL, Secretary of the United States Department of Health and Human Services, and MARILYN TAVENNER, Administrator of the Centers for Medicare & Medicaid Services, and Elizabeth Dudek, Secretary of the Florida Agency for Healthcare Administration, Defendants.	Case No. 8: 14-cv-01849

Declaration of Polly Weaver

1. I am the Chief of Field Operations for the Florida Agency for Health Care Administration ("AHCA"), Division of Health Quality Assurance. AHCA administers Florida's Medicaid program. Pursuant to agreement with the Secretary of the United States Department of Health and Human Services, AHCA inspects nursing homes that participate in the Medicare and Medicaid programs and thus receive reimbursement for providing skilled nursing care to the beneficiaries of these programs. The purpose of the inspections (known as "surveys") is to ensure that residents are provided with quality

care and are not abused or neglected in any way. In Florida, the inspections are conducted by AHCA's local field offices. My principal role is, and has been for many years, to oversee and assist those offices. I have been responsible for coordinating with the Secretary on many actions to enforce minimum standards of care for nursing home residents. Individuals who need 24 hour, skilled care in nursing homes are, by definition, infirm and fragile. Many such individuals have behavioral or cognitive problems--some age or dementia-related, some not. Nursing homes that are certified to receive Medicare and Medicaid payments are required by law to provide quality care to all residents, regardless of age, regardless of cognitive or behavioral problems. In Florida, most, probably all, Medicare and Medicaid-certified nursing homes care for residents with problems that could be characterized as behavioral or psychiatric—problems such as wandering, resisting care, or being combative with staff and/or other residents.

2. Based on my extensive experience with oversight of nursing homes, I can unequivocally state that Rehabilitation Center of St. Petersburg ("RCSP") is a substandard nursing home. The nursing home has failed, particularly in the last six months, to provide an acceptable level of care to its residents. RCSP's recent regulatory history demonstrates that it is a particularly problematic facility. On February 10, 2014, my surveyors inspected RCSP and found significant problems that placed residents at risk of death or serious injury. The nursing home was given the opportunity to correct those problems; AHCA and CMS refrained from terminating RCSP's Medicare or Medicaid funding, and AHCA did not revoke the operator's license. The state and federal governments aimed, and hoped, that the nursing home would correct the problems and meet minimum standards of care. Unfortunately, RCSP was unable to maintain compliance. On March

20, 2014, AHCA surveyors returned to RCSP to inspect the facility and again found problems that were of a nature that placed vulnerable residents in serious and immediate danger and which were not uncovered in the prior survey. Once again, however, AHCA and CMS refrained from terminating RCSP's Medicare and Medicaid funding or taking action against its license, hoping that RCSP would make the necessary changes to maintain compliance. Yet, when the surveyors returned on July 11, 2014, they discovered RCSP had allowed a resident with dementia to wander, unnoticed, out of what the facility characterizes as a "secured" unit. The resident was found at a bus stop several blocks away, yet again, placing the resident and others with similar diagnoses in serious and immediate danger.

3. Based on the July events, CMS terminated the Medicare funding (which necessarily involves termination of Medicaid funding as well). Termination of Medicare and Medicaid payments to a nursing home, based on bad care, is not extremely uncommon. When it occurs, AHCA implements its standard procedures to insure that residents the nursing home discharges are counseled, educated, and assisted as to alternative placements in nursing homes that are certified as meeting minimum standards of quality. Both the state and federal governments take this very seriously. In this instance, CMS and AHCA have put in place plans to assist the residents with transfers to qualified nursing homes that meet minimum standards.

4. The St. Petersburg area has an ample number of nursing homes that manage to comply with federal and state regulations designed to protect residents' health and safety. My office has determined that compliant nursing homes in close proximity to RCSP have

more than enough nursing home beds available to accommodate all of RCSP's residents, if necessary.

5. Although RCSP may claim that it is uniquely positioned to care for certain resident populations, RCSP has no specialty designations. It is a skilled nursing facility, like the many other skilled nursing facilities in the St. Petersburg area.

6. In my experience, nursing homes sometimes continue to treat Medicare- and Medicaid-eligible residents following termination of the facilities' Medicare provider agreements pending the outcome of administrative hearings (if a nursing home prevails in its administrative appeal, it receives Medicare and Medicaid reimbursement, retroactively). Nursing homes in these circumstances are not compelled by CMS or AHCA to transfer or discharge residents.

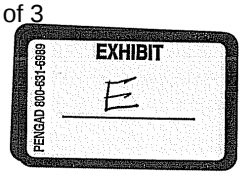
7. In this instance, my understanding is that the nursing home operator intends to discharge all residents, regardless of residents' insurance or payors. In anticipation of this action by the nursing home operator, AHCA has coordinated with CMS to assist residents with transitions to compliant nursing homes (of residents' choosing) in an orderly and safe fashion. I am confident that AHCA can safely effect such transfers for any and all RCSP residents who require it.

In accordance with 28 U.S.C. § 1746, I certify under penalty of perjury that the foregoing is true and correct.

Executed this 7th day of August, 2014.

Polly Weaver

Chief, Bureau of Field Operations



IN THE UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF FLORIDA

BAYOU SHORES SNF, LLC Plaintiff, v. SYLVIA MATHEWS BURWELL, Secretary of the United States Department of Health and Human Services, and MARILYN TAVENNER, Administrator of the Centers for Medicare & Medicaid Services, and Elizabeth Dudek, Secretatry of the Florida Agency for Healthcare Administration, Defendants.	Case No. **VERIFIED COMPLAINT FOR INJUNCTIVE RELIEF AND MANDAMUS**

DECLARATION OF CHARLES CRECELIUS, MD, PhD, FACP, CMD

I, Charles Crecelius, do hereby declare the following to be true and correct to the best of my knowledge, information and belief.

1. My name is Charles Crecelius, MD, PhD, FACP, CMD and I am a physician duly licensed to practice medicine in the State of Missouri (R7F42), and I have been in active, full-time clinical practice in my specialty of geriatrics and internal medicine, in Missouri since 1988. I am an Assistant Clinical Professor of Medicine at Washington University School of Medicine, am board certified in Internal Medicine and Geriatrics by the American Board of Internal Medicine, and am a Certified Medical Director of nursing facilities by the American Medical Directors Association.

2. I have been requested to give an expert opinion as to the effects of transferring residents from one nursing facility to others in the context of adverse survey findings that will result in the mass movement of many residents.

3. In any facility there are some residents who have sufficient cognitive, physical and psychiatric abilities to understand the reasons for such transfer and /or to be able to effectively cope with them. However the vast majority of nursing facilities deal with frail individuals with multiple physical, cognitive and psychiatric conditions that make moving from their current residence highly traumatic. This facility has approximately 150 residents, some who have resided there for many years. One resident (JS) has made this facility his home for over 27 years, arriving there at the age of 46. Many of the residents have Alzheimer's and other dementias, high care needs given by familiar aides and nurses, and/or serious psychiatric conditions such as depression, bipolar affective disorder and schizophrenia.

4. It is well acknowledged in the geriatric and post-acute/long term care literature that such individuals benefit from stable and predictable provision of care including but not limited to nurse aide assignment, person and group focused activity and daily routines, dining experiences and common area and room environments. It is also acknowledged that delirium can occur as a disruption of these routines.

5. Dislocation of vulnerable residents from their home can also cause depression, failure to thrive, and decompensation of medical conditions. Transitions of care are known to be a highly problematic area for frail elders which includes nursing home to nursing home transitions. While medical and nursing information can be put on computer generated forms, they rarely can adequately describe the details and knowledge gained over years of personal interactions that can make dramatic differences in an individual quality of life.

6. The nursing home is called "home" for a good reason – it is the home for many frail persons in their final years. Many demented patients who go out of the facility with friends and family for periods of time will comment that they want to go home – not their old home as younger persons, but the nursing facility that has become another home in their lives.

7. Placement of some of the residents will pose severe logistic problems. Many of these residents have serious psychiatric conditions which will make placement at another facility very problematic. Often such persons are placed miles away – even in different counties. Friends and loved ones may not be able to visit as often if at all in selected cases. Such loss of support can cause catastrophic psychological damage.

8. I have received many letters attesting to the high probability of the consequences outlined above. Statements from the CEO at a local hospital, a VP of Medical Affairs at another hospital, local attending physician and psychiatrists, as well as many other clinicians not affiliated with the SNF state they believe many residents will suffer when forced to find a new home. Other letters, including those from case managers and a court-appointed guardian, indicate that many of the residents will be difficult to place because of their psychiatric conditions.

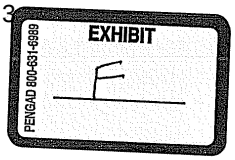
9. There is little doubt that forcing the movement of multiple residents will cause serious psychological and physical damage to many of the residents. Such a matter should only occur as a last resort when there is no other avenue, and when the benefit of causing such a mass

movement which will undoubtable cause harm to vulnerable individuals is clearly outweighed by the immediacy of harm engendered by staying in that facility.

In accordance with 28 U.S.C. Section 1746, I declare under penalty of perjury that the forgoing is true and correct to the best of my knowledge, information and belief.

Charles Crecelius, MD, PhD, FACP, CMD

Date _____



IN THE UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF FLORIDA

BAYOU SHORES SNF, LLC Plaintiff, v. SYLVIA MATHEWS BURWELL, Secretary of the United States Department of Health and Human Services, and MARILYN TAVENNER, Administrator of the Centers for Medicare & Medicaid Services, and Elizabeth Dudek, Secretatry of the Florida Agency for Healthcare Administration, Defendants.	)	Case No. **VERIFIED COMPLAINT FOR INJUNCTIVE RELIEF AND MANDAMUS**

DECLARATION OF BARBARA ZIV, M.D.

I, Barbara Ziv, do hereby declare the following to be true and correct to the best of my knowledge, information and belief.

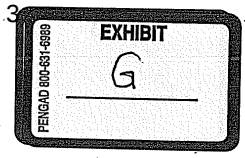
1. My name is Barbara Ziv, M.D. and I am a physician duly licensed to practice medicine in Pennsylvania, New Jersey, Vermont, North Carolina, Maryland and Florida. I have been in active clinical practice in my specialty of psychiatry since 1991. I am an Assistant Clinical Professor of Psychiatry at Temple University School of Medicine, am board certified in Psychiatry by the American Board of Neurology and Psychiatry.
2. I have been requested to give an expert opinion as to the effects of transferring residents from one nursing facility to others in the context of adverse survey findings that will result in the mass movement of many residents.
3. Dementia is an acquired global impairment in memory, personality and intellect in an alert patient that is sufficiently severe to interfere with social and/or occupational functioning.

4. Dementia as a handicap is characterized by: impaired memory, impaired reasoning, impaired ability to learn, high level of stress, and acute sensitivity to the social and the living environment.
5. Patients with dementia commonly have comorbid medical conditions such as depression, cardiovascular and pulmonary diseases, infections, arthritis, sleep disturbances, falls, incontinence and drug-related adverse events, among others. There is a strong association between medical conditions and impaired cognition.
6. People with dementia are at risk of inadequate nutrition and dehydration. Both of these factors can contribute to the development of neuropsychiatric symptoms.
7. Treatment of individuals with dementia is holistic and frequently multidisciplinary. Of necessity, the treatment involves caregivers and family. Patient target symptoms include declining cognition and impairment in daily functioning, among various associated symptoms that manifest during the course of the disorder. Treatment aims at maximizing functional performance and quality of life, while reducing the period of disability.
8. Neuropsychiatric symptoms rather than cognitive decline, prompt entry into long-term care. Over 90% of individuals with dementia will exhibit at least one neuropsychiatric symptom that needs specific management at some point in the course of their illness. These symptoms may wax and wane over time while some symptoms (e.g. visual hallucinations) are more common in some dementias than in others.
9. Environmental factors implicated in triggering neuropsychiatric include excessive noise and stimulation, lack of daily structure and routine, change in daily structure and routine, confusing surroundings, excessive demands, loneliness and boredom.
10. The living environment can have a fundamental effect on a person with dementia: probably greater than on people who are mentally fit. Generally speaking, the environment has the greatest effect on the person with the least capacity. This has been repeatedly documented in scientific literature.
11. The World Health Organization (WHO) has a commitment to holistic views of health, which includes the health-related quality of life. It refers not only to health in its narrow sense of the absence of disease and impairment, but also to health as a state of physical, mental and social well-being. The primary aim of any health intervention is to maximize health and minimize disease, thereby enhancing the person's quality of life.
12. Studying risk factors for falling among elderly persons living in the community, researchers concluded that cognitive impairment, second only to sedative use, is associated with a very high risk of falling.
13. Environmental changes for individuals with dementia have been associated with compromised protective responses and engagement in hazardous activities.
14. Individuals with dementia frequently decompensate medically, cognitively and psychiatrically when they are removed from a reassuring foundation in reality provided by consistency in caregivers, routines and environment.
15. Imprudent or hasty environmental change in demented individuals or others with psychiatric conditions can result in deterioration in behavior, medical status, and psychiatric stability and is associated with increased rates of morbidity and mortality.
16. Transferring residents, such as those at the Rehabilitation Center of Saint Petersburg, especially when there have not been allegations of actual harm to residents, will likely cause more harm than good and be a detriment to the mental health of many residents.

In accordance with 28 U.S.C. Section 1746, I declare under penalty of perjury that the forgoing is true and correct to the best of my knowledge, information and belief.

Barbara Ziv, M.D.

7/30/14
Date



IN THE CIRCUIT COURT IN AND FOR
CIRCUIT COURT OF THE SIXTH JUDICIAL
CIRCUIT IN AND FOR PINELLAS COUNTY
FLORIDA

FERNANDO GUTIERREZ,
as Patient Representative for Fifteen
Nursing Home Residents, and
G. B., D.B., C.C., A.C., D.C.,
M.D., M.G., T. G., B.H., M.H., G.H.,
P.H., K.K., V.M., G.T., D.T., and H.W.,

Case No. 14-5776-CI

Plaintiffs,

v.

ELIZABETH DUDEK,
Secretary of the Florida Agency
for Health Care Administration,

Defendant.

_____/

ORDER GRANTING PLAINTIFF'S AMENDED EMERGENCY MOTION FOR TEMPORARY INJUNCTION

THIS CAUSE is before the Court on the Amended Emergency Motion for Temporary Injunction of Plaintiffs, FERNANDO GUTIERREZ, as Patient Representative for fourteen (14) nursing home patients, and G.B., D.B., B.C., C.C., A.C., D.C., M.D., M.G., T.G., B.H., M.H., G.H., K.K., V.M., G.T., B.C. (erroneously designated in the Amended Motion and Complaint as D.T.) and H.W., collectively referred to as "Plaintiffs" or "Residents", requesting the Court to temporarily enjoin ELIZABETH DUDEK, Secretary of the Florida Agency for Health Care Administration, Defendant, from stopping Medicaid payments to REHABILITATION

AUG 20 2014

CENTER OF ST. PETERSBURG, INC. ("Rehab Center of St. Pete") for care furnished to Plaintiffs, as provided by law, from revoking or suspending the license of Rehab Center of St. Pete, and preventing transfer of Plaintiffs to other facilities.

This second hearing for Plaintiff's Emergency Motion for Temporary Injunction was held before the Court at 11:30 a.m. on Friday, August 15, 2014, where the Court reviewed Plaintiff's now entitled, Amended Emergency Motion for Temporary Injunction and Complaint for Declaratory Judgment, which was served the previous day on Defendant. The Court reviewed the Exhibits submitted by Plaintiffs in their Motion but did not take witness testimony. The Court allowed extensive argument from various counsels. A temporary injunction is based on limited evidence developed at a preliminary stage of the case. Accordingly, the Court made findings of fact concerning: (a) the likelihood that the Plaintiff will suffer irreparable harm; (b) that the Plaintiff has no adequate legal remedy available; (c) that the Plaintiff has a substantial likelihood of prevailing on the merits; and (d) that the considerations of the public interest support the entry of an injunction. *Hasley v. Harrell*, 971 So.2d 149, 152 (Fla. 2d DCA 2009).

After careful consideration of the Motion, its exhibits, arguments, rules, regulations, and based on the finding contained in the transcript of the hearing held on

August 15, 2014, which shall be filed in this case, and which is incorporated by reference herein, and being advised in the premises, the Court temporarily enjoins ELIZABETH DUDEK, Secretary of the Florida Agency for Health Care Administration from transferring or ordering the transfer of any of the Plaintiffs who are parties and the patients represented by Plaintiff, FERNANDO GUTIERREZ.

This Temporary Injunction shall remain in effect until the Court reconvenes on August 22, 2014 at 1:30 to ascertain AHCA's plan regarding the residents' status.

DONE AND ORDERED in Chambers at St. Petersburg, Pinellas County, Florida, this__day of August, 2014.

Original Signed
AUG 19 2014
Pamela A.M. Campbell
Circuit Judge

PAMELA A.M. CAMPBELL
Circuit Court Judge

copies to:

Kirk S. Davis, Esq.
Julie Gallagher, Esq.
Kenneth Wilson, Esq.

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

In re: **Case No.: 8:14-bk-09521-MGW**

BAYOU SHORES SNF LLC, **Chapter 11**

Debtor.
_____/

ORDER GRANTING DEBTOR'S EMERGENCY MOTION TO ENFORCE THE AUTOMATIC STAY AND/OR FOR AN ORDER, PURSUANT TO 11 U.S.C. § 105, PROHIBITING ANY ACTION TO TERMINATE DEBTOR'S MEDICAID AND MEDICARE PROVIDER AGREEMENTS, TO DENY PAYMENT OF CLAIMS, AND/OR TO RELOCATE RESIDENTS

THIS CASE came on for an emergency telephonic hearing on Friday, August 22, 2014 at 1:30pm on the Emergency Motion to Enforce the Automatic Stay and/or for an Order, Pursuant to 11 U.S.C. § 105, Prohibiting Any Action to Terminate Debtor's Medicaid and Medicare Provider Agreements, to Deny Payment of Claims, and/or to Relocate Residents and Certificate of Necessity of Request for Hearing (Doc. No. 25) (the "Motion") filed by Bayou Shores SNF LLC ("Bayou Shores" or "Debtor"). After considering the Motion, the opposition to the Motion, the law, and being otherwise fully advised in the premises, the Court finds as follows:

1. The Court has jurisdiction to consider the Motion pursuant to 28 U.S.C. § 1334 and the Amended Standing Order of Reference (6-12-MC-26-ORL-22) entered on February 22, 2012.

2. The Debtor, the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS") and the State of Florida Agency for Healthcare Administration ("AHCA") dispute whether the Debtor's Medicare and Medicaid

provider agreements were executory on the date the Debtor filed its Chapter 11 petition, August 15, 2014.

3. Executory contracts as contemplated by 11 U.S.C. § 365 are property of the estate as that term is defined in 11 U.S.C. § 541.

4. The Debtor has made a prima facie showing that the Debtor's Medicare and Medicaid provider agreements are property of the estate sufficient to warrant the entry of an order providing that the automatic stay prohibits CMS, AHCA, and/or any managed care provider from taking action to terminate the Debtor's Medicare and/or Medicaid provider agreements.

5. At this time, the Court has made a preliminary finding that the police power exception to the automatic stay provided in 11 U.S.C. § 365(b)(4) does not apply. This finding is subject to review at the evidentiary hearing scheduled for August 26, 2014, at 1:30 p.m.

6. The Debtor has made a sufficient showing that the residents of its facility may suffer harm if relocated.

Accordingly, it is

ORDERED:

7. The Motion (Doc. No. 25) is granted on a temporary basis.

8. The automatic stay provided by 11 U.S.C. § 362(a) applies and prevents any action against the Debtor or property of the Debtor's estate including the Debtor's Medicare and Medicaid provider agreements.

9. Any and all action to remove the residents of the Debtor are enjoined pursuant to 11 U.S.C. § 105(a).

10. CMS, ACHA, and all providers of managed care are prohibited from denying or threatening to deny claims of the Debtor's residents or to terminate the Debtor's Medicare and Medicaid Provider Agreements pursuant to 11 U.S.C. § 105(a).

11. A final evidentiary hearing will be held on the Motion and any responses on **August 26, 2014 at 1:30 p.m**. in Courtroom 8A, Sam Gibbons U.S. Courthouse, 801 N. Florida Avenue, Tampa, Florida.

DONE AND ORDERED:

_____

HONORABLE MICHAEL WILLIAMSON
United States Bankruptcy Judge

Attorney Elizabeth A. Green, Esq. shall serve this Order on all interested parties and file a certificate of service.

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION
www.flmb.uscourts.gov

In re:

Bayou Shores SNF, LLC,

Debtor.
_____/

Case No. 8:14-bk-09521-MGW
Chapter 11

MEMORANDUM OPINION
AND ORDER ON CONFIRMATION

The Court can only confirm a debtor's proposed plan if it is feasible. Here, the Debtor, which operates a skilled nursing facility that derives 90% of its revenue from Medicare and Medicaid patients, has proposed a chapter 11 plan that is funded from its continuing operations. All of the creditors in the case have voted in favor of the plan. But the United States Department of Health & Human Services ("HHS") has objected that the plan is not feasible because it says the Debtor's Medicare provider agreement was terminated prepetition, and as a consequence, so was its Medicaid provider agreement. This Court must now decide whether the Debtor's plan is feasible.

The Court concludes the plan is feasible because the Debtor has the right to assume the Medicare provider agreement under Bankruptcy Code § 365. Although HHS, through the Center for Medicare & Medicaid Services ("CMS"),[1] gave the Debtor notice it was terminating its Medicare provider agreement prepetition, that termination was not complete and irreversible until the appeals process was complete. And the appeals process was not completed prepetition. For that reason, the Medicare provider agreement can be assumed under Bankruptcy Code § 365, which means the Debtor's Medicaid provider agreement does not terminate as a matter of law.

[1] CMS is the operating component of HHS charged with administering the Medicare and Medicaid programs.

Because the Debtor's Medicare and Medicaid provider agreements remain in effect, the Court concludes the Debtor's plan is feasible and should be confirmed.

Background

The Debtor cares for patients with severe psychiatric conditions

The Debtor owns and operates a 159-bed skilled nursing facility known as the Rehabilitation Center in St. Petersburg, Florida.[2] The Debtor currently has 109 patients, most of whom have Alzheimer's, dementia, or other serious psychiatric conditions.[3] The Debtor is one of the few facilities—if not the only one—in the area that is capable of meeting the needs of patients with challenging psychiatric needs.[4]

The Debtor relies on Medicare and Medicaid revenue

All but a handful of the Debtor's patients are on Medicaid or Medicare. Medicare, of course, is a federal program that provides payment for skilled nursing services for aged or disabled individuals. Similarly, Medicaid is a joint federal and state program that provides medical assistance to low-income individuals who are disabled. Over 90% of the Debtor's revenue is derived from Medicare and Medicaid.[5]

CMS and AHCA conduct surveys to ensure providers are complying with the Medicare and Medicaid program requirements

To receive payment under the Medicare and Medicaid programs, a skilled nursing facility such as the Debtor must comply with the requirements set forth in 42 C.F.R. Part 483, Subpart B. Skilled nursing facilities like the Debtor are subject to standard, special, and other surveys by the

[2] Doc. No. 250 at ¶ 4; Doc. No. 266 at ¶ 4.

[3] Doc. No. 250 at ¶ 4; Ex. 20 at 33-34 & 38.

[4] Ex. 20 at 29.

[5] Doc. No. 250 at 2 n.1; Doc. No. 266 at 2 n.1.

State or CMS—depending on whether the facility participates in one or both programs—to certify they are in compliance with applicable federal law.[6] If a skilled nursing facility is certified to be in noncompliance, then CMS may terminate any Medicare provider agreements that are in effect at the time or apply alternative remedies instead of—or in addition to—termination.[7]

In determining which remedies to apply, CMS must determine the seriousness of the deficiency that has caused the facility to be noncompliant.[8] The seriousness of a deficiency generally ranges from "no actual harm with a potential for minimal harm" to "immediate jeopardy to resident health or safety."[9] "Immediate jeopardy" means "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."[10] Regardless of which remedies CMS decides to apply, a skilled nursing facility must complete a "plan of correction" that describes the actions the facility will take to correct any cited deficiencies and the date by which the deficiencies will be corrected.[11]

The Debtor is cited for three deficiencies

Between February 2014 and July 2014, the Debtor was cited for deficiencies—and determined to be in noncompliance—three separate times.[12] The first deficiency had to do with

[6] 42 C.F.R. § 488.308.

[7] 42 C.F.R. § 488.330(b)(2).

[8] 42 C.F.R. § 488.404(a). The possible remedies (instead of or in addition to termination of the provider agreement) include: temporary management, denial of payment, civil monetary penalties, state monitoring, transfer of residents, closure of the facility, and directed plan of correction. 42 C.F.R. § 488.406(a).

[9] 42 C.F.R. § 488.404(b).

[10] *Id.*

[11] 42 C.F.R. § 488.408(f).

[12] Ex. 20 at 19-28.

recordkeeping. A February 2014 survey revealed that, as a result of the facility's transition to electronic medical records, some of the residents' files contained conflicting entries with respect to "Do No Resuscitate Orders."[13] The second deficiency had to do with admissions procedures. In March 2014, an individual with a history of sexual exploitation or abuse was admitted to the Debtor's facility.[14] Staff members, however, failed to identify this threat and placed him in a room with another resident.[15] Fortunately, the patient with the history of abuse—who was in the facility for less than 24 hours—did not touch or otherwise harm the other resident. The third deficiency had to do with facility security. In July 2014, a resident on the Debtor's second-floor secure unit left the facility with visitors and was found unharmed on a nearby street corner fifteen minutes later.[16] Although no resident was hurt in any of the three incidents, the Debtor was nevertheless cited for "immediate jeopardy" on each occasion.[17]

The Debtor is brought back into substantial compliance after the first two deficiencies

The Debtor immediately cured the first two deficiencies.[18] In the case of the "Do Not Resuscitate" orders, the Debtor made sure that the orders for each resident matched.[19] If a patient had a "Do Not Resuscitate Order," the facility made sure the physician order said the patient was not to be resuscitated.[20] As for the admissions procedures, the Debtor wrote a new set of policies

[13] *Id.* at 20-21.

[14] *Id.* at 21.

[15] *Id.* at 21-22.

[16] *Id.* at 24-25.

[17] *Id.* at 19-28.

[18] *Id.* at 20-23.

[19] *Id.* at 21.

[20] *Id.*

and procedures governing abuse of residents.[21] After the Debtor cured the first two deficiencies, CMS revisited the facility and determined the Debtor was in substantial compliance.[22] On May 29, 2014, CMS notified the Debtor it was in substantial compliance with the Medicare and Medicaid requirements as of May 13, 2014.[23]

The Debtor immediately cures the third deficiency

As with the first two deficiencies, the Debtor immediately cured the third deficiency. Specifically, the Debtor implemented an entirely new system for screening and assessing patients for potential elopement issues and changed the procedure for guests and patients to access the facility's secure unit.[24] The Debtor also took the additional step of hiring a third-party consultant—David Hoffman & Associates—to conduct an extensive review of the corrective measures the Debtor had taken and determine whether the Debtor had been brought back into substantial compliance.[25] On July 17, 2014, just one week after the survey that led to the third deficiency, the Debtor provided CMS with a detailed list of the steps it had taken to remove the "immediate jeopardy" and bring its facility back into substantial compliance.[26] Rather than revisit the facility to certify it was in substantial compliance, as is apparently customary where there is no actual harm to residents, CMS instead opted to terminate the Debtor's Medicare provider agreement.[27]

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[21] *Id.* at 22.

[22] *Id.* at 23.

[23] Ex. 2.

[24] Exs. 4 & 5; *see also* Ex. 20 at 23-24.

[25] Doc. No. 250 at ¶¶ 10-11; *see also* Ex. 20 at 25-27.

[26] Exhibit 4; *see also* Ex. 20 at 25. The Debtor had apparently implemented the corrective measures as of July 17, 2014. Hoffman then reviewed those corrective measures on July 29-30, 2014. Doc. No. 250 at ¶¶ 10-11.

[27] Ex. 20 at 27-28, 32 & 48-49; Doc. No. 250 at ¶ 12.

CMS terminates the Debtor's Medicare provider agreement

On July 22, 2014, CMS notified the Debtor that it was terminating the Debtor's Medicare provider agreement effective August 3, 2014, which would also result in termination of the Debtors' Medicaid provider agreement.[28] The Debtor appealed the termination of its Medicare provider agreement and requested an expedited hearing before an administrative law judge. The appeal of the decision to terminate the provider agreement, however, did not prevent CMS from denying payment to the Debtor, which would have set a catastrophic chain of events in motion: denial of payment would have caused the Debtor to default under its lease, default under its lease would have forced the Debtor to close its facility, closure of the facility would have forced the transfer of the Debtor's patients, many of whom would have had no place to go or would have potentially been harmed by the transfer.[29]

The district court temporarily enjoins CMS from terminating the Medicare provider agreement

So on August 1, 2014, two days before the Medicare provider agreement was terminated, the Debtor sought and obtained an ex parte temporary restraining order from district court that enjoined CMS from terminating the agreement through August 15, 2014.[30] HHS then moved to dissolve the temporary restraining order based on the district court's lack of subject-matter jurisdiction.[31] According to HHS, 42 U.S.C. § 405 mandates that the Debtor exhaust all of its administrative remedies before it can bring a claim under the Medicare statute in district court. In particular, 42 U.S.C. § 405(h) precluded the district court from (i) reviewing an agency decision

[28] Ex. 3.

[29] Exhibit 20 at 29-32.

[30] The Debtor filed an action in district court for the Middle District of Florida (Tampa Division) styled *Bayou Shores SNF, LLC v. Sylvia Mathews Burwell*, Case No. 8:14-cv-1849-T-33-MAP.

[31] Dist. Ct. Doc. No. 22.

before all administrative remedies were exhausted; or (ii) taking jurisdiction over a Medicare-related claim against the United States under 28 U.S.C. § 1331, which grants district courts original jurisdiction over all actions arising under the laws of the United States.[32] The district court agreed that it lacked subject-matter jurisdiction over the dispute because the Debtor had not exhausted its administrative remedies, and as a consequence, it dissolved its temporary restraining order on August 15, 2014.[33]

The Debtor files for bankruptcy

Mere hours after the district court dissolved the temporary restraining order, the Debtor filed this chapter 11 case. A week later, the Debtor sought a ruling from this Court that the automatic stay precluded termination of its Medicare provider agreement.[34] At the conclusion of a final evidentiary hearing on the Debtor's motion, this Court enjoined termination of the Medicare provider agreement pending completion of the administrative appeals process. Since then, the Debtor has fast-tracked this case to confirmation, proposing a plan within four months of filing this case.[35]

The Debtor's proposed plan enjoys the support of all of the creditors in the case, including a secured lender holding an $11 million claim and unsecured creditors holding more than $2 million in claims.[36] The plan also satisfies all of the requirements of Bankruptcy Code § 1129(a) with the exception of perhaps one: feasibility. HHS objects that confirmation is not feasible because the Debtor relies almost exclusively on Medicare and Medicaid for revenue, and

[32] *Id.*

[33] Dist. Ct. Doc. No. 35.

[34] Doc. No. 25.

[35] Doc. Nos. 185 & 186.

[36] Doc. No. 249-1.

those agreements have (or will be) terminated.[37] HHS also objects to the Debtor's attempt to assume the Medicare provider agreement based on its purported prepetition termination.[38] This Court must now determine whether the Debtor's proposed plan is feasible in light of that purported termination.

Conclusions of Law

The Court has jurisdiction over the parties' Medicare-related dispute

As a threshold matter, HHS contends that this Court lacks subject-matter jurisdiction over the parties' dispute. According to HHS, "no court has any jurisdiction over any aspect of a Medicare determination, other than to perform a prescribed form of judicial review of a final administrative decision by the Secretary."[39] Because of that, HHS reasons that the Debtor is precluded from raising any challenge to the termination of its Medicare provider agreement before this Court. HHS's argument, however, misses the mark.

It is true that federal courts are generally precluded from exercising federal question jurisdiction over Medicare issues.[40] The statute the district court relied on in dissolving the temporary restraining order—and the statute HHS presumably relies on here—says as much:

> The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social

[37] HHS contends its Medicare provider agreement has already been terminated. And the parties generally agree that AHCA is obligated to terminate its Medicaid provider agreement once the Medicare provider agreement has been terminated. But there is some question whether termination of the Medicaid provider agreement occurs by operation of law or requires some other action by AHCA.

[38] Doc. Nos. 229 & 255.

[39] Doc. No. 277 at 2.

[40] 42 U.S.C. § 405(h).

> Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.[41]

But this Court's jurisdiction is not based on 28 U.S.C. § 1331 or § 1346.

This Court has independent grounds for exercising jurisdiction: 28 U.S.C. § 1334. Under § 1334, this Court has jurisdiction over all civil proceedings arising under title 11, arising in a case under title 11, or related to a proceeding under title 11. This bankruptcy case, of course, arises under title 11.[42] Confirmation is a contested matter that arises in a case under title 11. And any dispute over the Debtor's ability to assume the Medicare provider agreement is "related to" this title 11 case since the outcome of that dispute could conceivably have an effect on the Debtor's bankruptcy estate.[43] Accordingly, this Court has subject matter jurisdiction over this case, confirmation, and the parties' dispute over whether the Debtor has the authority to assume its Medicare provider agreement under 28 U.S.C. § 1334(b).

In fact, the court in *First American Health Care of Georgia, Inc. v. HHS* recognized that bankruptcy courts have jurisdiction over some Medicare-related disputes under 28 U.S.C. § 1334.[44] In *First American*, the Debtor filed an adversary proceeding seeking turnover of certain periodic income payments it claimed it was entitled to under the Medicare program. HHS moved to dismiss the adversary proceeding because 42 U.S.C. § 405(h) expressly precluded federal

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[41] *Id.*

[42] Technically, the district court for this district has subject-matter jurisdiction over these proceedings. The district court is statutorily empowered to refer all of these proceedings to this Court, which it has done by a standing order of reference.

[43] A bankruptcy court has "related to" jurisdiction if the outcome of a proceeding could conceivably have an effect on the estate being administered. *Miller v. Kemira (In re Lemco Gypsum, Inc.)*, 910 F.2d 784, 788 (11th Cir. 1990) (adopting the test articulated in *Pacor, Inc. v. Higgins*, 743 F.2d 984, 994 (3d Cir. 1984)).

[44] 208 B.R. 985, 988 (Bankr. S.D. Ga. 1996). The Court later vacated its ruling based on a settlement agreement between the parties. *First Am. Health Care of Georgia, Inc. v. HHS*, 1996 WL 282149 (Bankr. S.D. Ga. 1996). But that does not change the bankruptcy court's analysis, which this Court finds persuasive.

courts from exercising federal question jurisdiction over Medicare claims.[45] In denying HHS's motion to dismiss, the *First American* court acknowledged that 42 U.S.C. § 405(h), as originally drafted, precluded bankruptcy jurisdiction over all Medicare disputes. But the Court correctly observed that Congress passed 28 U.S.C. § 1334 in 1984, which conferred bankruptcy jurisdiction on the district court, and nothing in 42 U.S.C. § 405(h) precludes a court from exercising bankruptcy jurisdiction over Medicare disputes under 28 U.S.C. § 1334.[46]

The Court is aware that some courts have held that omission of 28 U.S.C. § 1334 was essentially a scrivener's error.[47] Those courts begin by observing that 42 U.S.C. § 405(h) previously precluded federal courts from exercising all jurisdiction—including bankruptcy jurisdiction—over Medicare-related claims by prohibiting any action under "section 24 of the Judicial Code of the United States."[48] Section 24 previously contained virtually all of the jurisdictional grants to the district court, including bankruptcy jurisdiction.[49] In 1984, Congress replaced the reference to "section 24" with the phrase "section 1331 or 1346." Since the legislative history regarding that amendment provides the amendment was not to be "construed as changing or affecting any right, liability, status, or interpretation which existed" previously, some courts have ruled that Congress intended 42 U.S.C. § 405(h) to preclude the exercise of bankruptcy jurisdiction under 28 U.S.C. § 1334.[50]

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[45] *Id.* at 987.

[46] *Id.* at 988-89.

[47] *See, e.g., In re St. Johns Home Health Agency, Inc.*, 173 B.R. 238, 244 (Bankr. S.D. Fla. 1994).

[48] *Id.* at 244.

[49] *Id.*

[50] *Id.*

There is one problem with that view: This Court is not free to consider the legislative history of a statute when the statute's text is plain and unambiguous.[51] Here, the text of 42 U.S.C. § 405(h) is plain and unambiguous. It plainly provides that federal courts are precluded from exercising jurisdiction on only two bases: 28 U.S.C. §§ 1331 and 1346. Because 42 U.S.C. § 405(h), by its terms, does not preclude this Court from exercising jurisdiction under 28 U.S.C. § 1334, this Court has subject-matter jurisdiction.

The only plausible argument against this Court having subject-matter jurisdiction is the second sentence of 42 U.S.C. § 405(h), which limits the ability of federal courts to review the findings of fact or an agency decision. Of course, that is not what this Court is doing. HHS had made it plain throughout its various filings in this case that CMS's decision to terminate the Debtor's Medicare provider agreement—the central issue in this case—is not subject to appeal.[52] The only properly appealable issue is CMS's determination that the Debtor was in noncompliance with the Medicare program requirements. But this Court, as part of its executory contract analysis discussed below, assumes that the Debtor was, in fact, in noncompliance. Because this Court assumes the Debtor was in noncompliance, it is not reviewing any findings of fact or agency decision, and as a consequence, 42 U.S.C. § 405(h) does not preclude this Court from considering whether the Debtor can assume its Medicare provider agreement under Bankruptcy Code § 365.

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[51] *Circuit City Stores, Inc. v. Adams*, 532 U.S. 105, 118 (2001) (refusing to examine legislative history where the face of the statutory provision was unambiguous); *Garcia v. Vanguard Car Rental USA, Inc.*, 540 F.3d 1242, 1247 (11th Cir. 2008) (explaining that courts "may consult legislative history to elucidate a statute's ambiguous or vague terms, but legislative history cannot be used to contradict unambiguous statutory text or to read an ambiguity into a statute which is otherwise clear on its face"); *CBS Broad., Inc. v. EchoStar Commc'ns Corp.*, 265 F.3d 1193, 1213 (11th Cir. 2000) (explaining that "resort to legislative history is unnecessary, and indeed, improper, where the statute's terms are plain and unambiguous").

[52] Doc. No. 277 at 6.

The Debtor can assume the Medicare provider agreement

Under Bankruptcy Code § 365, a debtor may assume an executory contract. The Bankruptcy Code does not define "executory contract." In the absence of a definition, courts have generally followed two approaches to determining whether a contract is executory. Under the first approach, proposed by Professor Vern Countryman, a contract is executory if it is so far unperformed that the failure of either party to complete performance would constitute a material breach of the contract.[53] Under the second approach, aptly named the "functional approach," courts "abandon the traditional focus on the 'executoriness' of contracts in bankruptcy in favor of a more practical, functional approach."[54] Regardless of which test is applied, though, the majority of courts have concluded that Medicare provider agreements are executory contracts, a proposition HHS does not appear to dispute.[55] What would otherwise be an executory contract, however, cannot be assumed under Bankruptcy Code § 365 if the contract was terminated pre-petition because there is nothing left for the Debtor to assume.

The central issue in this bankruptcy case is whether the Debtor's Medicare provider agreement was terminated prepetition. According to HHS, the Medicare provider agreement was terminated on August 3, 2014—the date specified in HHS's July 22 notice. The Debtor, however, contends the agreement could not have been terminated prepetition because the right to terminate the agreement expired when the Debtor brought its facility back into substantial

[53] *Walton v. Clark & Washington, P.C.*, 454 B.R. 537, 543 (Bankr. M.D. Fla. 2011).

[54] Bankruptcy Law Manual § 9B:3 (5th ed. 2014); *see also Clark & Washington*, 454 B.R. at 543 (explaining that "[u]nder the functional approach, a court looks to the benefits a debtor and its estate would gain if a contract is assumed or rejected.").

[55] *In re University Med. Center*, 973 F.2d 1065, 1075 n.13 (3d Cir. 1992); *In re Monsour Med. Center*, 11 B.R. 1014, 1018 (W.D. Pa. 1981); *In re Vitalsigns Homecare, Inc.*, 396 B.R. 232, 239 (Bankr. D. Mass. 2008); *In re Heffernan Memorial Hosp. Dist.*, 192 B.R. 228, 231 (Bankr. S.D. Cal. 1996).

compliance, which was on July 18, 2014. The Court concludes the Debtor is correct (i.e., the Medicare provider agreement was not terminated) but for the wrong reason.

The Debtor relies on 42 C.F.R. § 488.454, entitled "Duration of Remedies," in support of its argument.[56] That regulation does provide that certain remedies HHS is entitled to invoke do expire when a revisit by CMS confirms that facility has been brought back into substantial compliance.[57] Expiration of certain remedies can even predate a revisit if the facility can supply HHS with acceptable documentation showing the facility was in substantial compliance at some point before the revisit survey.[58] But as HHS correctly points out, the regulation the Debtor relies on deals with "alternative remedies" other than termination.[59]

In the Court's view, the answer is much simpler. In order for a prepetition termination of contract to cut off a debtor's rights under § 365, the termination must be complete and not subject to reversal.[60] Here, the Debtor had a right to appeal termination of the provider agreement. While that appeal may be limited in scope, the fact remains that termination of the provider agreement is not complete—and is, in fact, subject to reversal—until the appeals process is complete. Because the appeals process was not complete before this case was filed, the contract was not "terminated" prepetition for purposes of § 365.

Concluding that a Medicare provider agreement is "terminated"—for purposes of § 365—before the appeals process is complete would lead to absurd results. Consider the

[56] Doc. No. 278 at 18-21.

[57] 42 C.F.R. § 488.454(a)(1)-(2).

[58] 42 C.F.R. § 488.454(e).

[59] Doc. No. 277 at 2-4.

[60] *In re Fontainebleau Hotel Corp.*, 515 F.2d 913, 915 (5th Cir.1975); *see also Moody v. Amoco Oil Co.*, 734 F.2d 1200, 1212 (7th Cir. 1984); *In re Bricker*, 43 B.R. 344, 347 (Bankr. D. Ariz. 1984).

following hypothetical: a debtor that operates a skilled nursing facility has its Medicare provider agreement terminated because it was improperly cited for noncompliance. The debtor immediately appeals the finding of noncompliance. But because CMS stops payment for Medicare residents, the debtor is forced to file for bankruptcy. If the Court were to adopt HHS's view, the debtor in that hypothetical scenario could never assume its Medicare provider agreement since it is highly unlikely the appeals process will be complete before the debtor files for bankruptcy. The only way to preserve a debtor's right to appeal a finding of noncompliance is to consider a Medicare provider agreement terminated—for purposes of § 365—once the appeals process is complete.

Here, the appeals process was not complete prepetition. So termination of the Medicare provider agreement in this case was not complete and irreversible as of the petition date. For that reason, the Medicare provider agreement is subject to being assumed. The only remaining question is whether the Debtor satisfies the requirements for assuming the provider agreement under Bankruptcy Code § 365.

To assume an executory contract that is in default, a debtor must prove that it can promptly cure the default and provide adequate assurance of future performance.[61] Although HHS has challenged the Debtor's right to assume the Medicare provider agreement, it has made no effort to challenge the Debtor's contention that it has cured the existing default and provided adequate assurances of future performance, instead deciding to rely solely on its argument the agreement cannot be assumed because it was terminated prepetition.[62] HHS also appears to be arguing—at least implicitly—that the § 365 requirements do not apply to Medicare provider

[61] 11 U.S.C. § 365(b); *In re Chapin Revenue Cycle Mgmt.*, 343 B.R. 728, 730 (Bankr. M.D. Fla. 2006).

[62] Doc. No. 255.

agreements because a skilled nursing facility or other provider has no right to cure a deficiency. The Court is sympathetic to HHS's argument, but as the Third Circuit Court of Appeal recognized in *In re University Medical Center* over twenty years ago, "Congress' failure to legislate special treatment for the assumption or rejection of Medicare provider agreements indicates that assumption of these agreements, like that of other executory contracts, should be deemed subject to the requirements of section 365, unless and until Congress decides otherwise."[63]

Given the unrefuted evidence at confirmation, the Court easily concludes the Debtor has satisfied the requirements for assuming the Medicare provider agreement. It cannot be disputed—given CMS's notice that the Debtor was in substantial compliance as of May 13, 2014—that the Debtor previously cured the initial two deficiencies in a timely matter. That leaves only the third deficiency. The Debtor offered into evidence the "allegation of compliance" it submitted to CMS on July 17 & 28, 2014 that outlines the steps it took to cure the final deficiency and remove any immediate jeopardy.[64] As part of the corrective measures it took, the Debtor retained a third-party consultant (David Hoffman) who has concluded that the Debtor is currently in substantial compliance with the Medicare program requirements and that the Debtor's patients are being adequately cared for.[65]

Hoffman's conclusions are consistent with the opinions offered by the Patient Care Ombudsman. At the outset of this case, the Court issued an order to show cause to determine whether it was necessary to appoint a patient care ombudsman for the protection of the Debtor's

[63] 973 F.2d 1065, 1077 (3d Cir. 1992).

[64] Exs. 4 & 5.

[65] Doc. No. 250 at ¶¶ 10 & 11; Ex. 20 at 44-49.

patients.[66] Ultimately, the Court directed the U.S. Trustee to appoint a patient care ombudsman to monitor the quality of patient care and represent the interests of patients in this case. The U.S. Trustee appointed Robert Rosenthal, president of Health Care Management Specialist, Inc., as Patient Care Ombudsman.[67] So far, the Patient Care Ombudsman has issued two reports indicating that the Debtor is adequately and satisfactorily providing for the health and welfare of the Debtor's patients.[68] Significantly, HHS opted not to offer any evidence—presumably because it could not—that the Debtor is not currently in substantial compliance with the Medicare program requirements (i.e., that the Debtor has not cured the prepetition default).

And the Court is persuaded that the Debtor has provided adequate assurances of future performance. In part, those assurances are based on the corrective actions the Debtor has taken to cure the previous deficiencies and the fact that the Debtor has been satisfactorily and adequately providing for patients' health and welfare under the watchful eye of the Patient Care Ombudsman since this case was filed. It is also based on the fact that the Debtor has retained Hoffman in an ongoing role to evaluate the Debtor's regulatory compliance and Hoffman's willingness to remain on as an advisor as long as necessary to ensure the Debtor is adequately and satisfactorily protecting its residents and complying with applicable regulations. Not to mention, HHS has again failed to offer any evidence refuting the Debtor's ability to perform in

[66] Doc. No. 36.

[67] Doc. No. 97. Although Rosenthal is not a doctor or nurse, he has extensive experience operating healthcare and assisted living facilities. AHCA has previously recommended Rosenthal as a receiver for a number of assisted living and skilled nursing facilities. And AHCA submitted his name to the U.S. Trustee for consideration in this case, as well. Because Rosenthal is not a medical professional, the Court authorized him to hire healthcare assistants (such as registered nurses and social workers), including RB Health Partners, Inc., to assist him in his review of the Debtor's operations.

[68] Doc. No. 178-1 at 21; Doc. No. 252 at 17.

the future. Accordingly, the Court concludes the Debtor has satisfied the requirements of § 365 and is permitted to assume its Medicare provider agreement.

The Debtor's plan is feasible even though AHCA indicates it intends to deny renewal of the Debtor's license

The only remaining issue that needs to be considered—even though not raised in an objection to confirmation—is whether the Debtor's plan is feasible despite the fact that AHCA has indicated it intends to seek revocation or deny renewal of the Debtor's nursing home license. Back in June, after the second deficiency had been cited and the facility had been brought back into substantial compliance, AHCA filed an administrative complaint seeking to revoke the Debtor's license.[69] That administrative proceeding has since been abated. But in the meantime, the Debtor filed an application to renew its license. AHCA says it intends on denying the Debtor's application to renew its license, and more recently, AHCA asked the Court to modify its injunction to permit AHCA to either deny the Debtor's license renewal application or invoke the administrative process to revoke the Debtor's license since neither action is prohibited by the automatic stay.[70]

AHCA appears to raise two grounds for refusing to renew or seeking to revoke the Debtor's license. First, AHCA says Florida law requires that it deny renewal of or revoke the Debtor's license because its Medicare and Medicaid provider agreements have been terminated. Second, AHCA says the three deficiencies previously discussed are grounds for both refusing to renew and revoking the Debtor's license. It appears AHCA is correct that refusing to renew the Debtor's license on either ground, at least theoretically, does not run afoul of the automatic stay.

[69] Doc. No. 246-3.

[70] Doc. No. 246.

As AHCA contends, Bankruptcy Code § 362(b)(4) does, in fact, except from the automatic stay actions to enforce a state's police or regulatory powers. In determining whether a government's actions qualify as police powers, courts generally apply the "pecuniary" purpose and "public policy" tests.[71] Under those tests, courts consider whether the government action is intended to protect the public safety or welfare or effectuate public policy, on the one hand, or protect the government's pecuniary interest or adjudicate private rights, on the other hand:

> There are two tests for determining whether agency actions fit within the section 362(b)(4) exception: (1) the "pecuniary purpose" test and (2) the "public policy" test. Under the pecuniary purpose test, the court determines whether the government action relates primarily to the protection of the government's pecuniary interest in the debtor's property or to matters of public safety and welfare. If the government action is pursued solely to advance a pecuniary interest of the governmental unit, the stay will be imposed. The public policy test "distinguishes between government actions that effectuate public policy and those that adjudicate private rights."[72]

AHCA says its actions satisfy both tests because it is attempting to protect the public safety and welfare and effectuate public policy by denying the Debtor's license renewal application or seeking to revoke the Debtor's license.

The Court agrees that AHCA's refusal to renew or intent to revoke the Debtor's license is an attempt to protect the public safety and welfare. That is perhaps best illustrated by comparing AHCA's actions to those of HHS. In enjoining HHS from terminating the Debtor's Medicare provider agreements, the Court reasoned, in part, that HHS's actions did not fall within the "police powers" exception to the automatic stay.[73] That was because it was apparent to the Court that HHS was only seeking to protect its pecuniary interest in terminating the Debtor's Medicare

[71] *In re Pollock*, 402 B.R. 534, 536-38 (Bankr. N.D.N.Y. 2009); *In re Allegheny Health, Educ. Research Found.*, 252 B.R. 309, 327 (W.D. Pa. 1999); *In re Selma Apparel Corp.*, 132 B.R. 968, 969-70 (Bankr. S.D. Ala. 1991).

[72] *Universal Life Church, Inc. v. United States*, 128 F.3d 1294, 1297 (9th Cir. 1997) (internal citations omitted).

[73] Ex. 20 at 89-91.

provider agreement. After all, HHS made no attempt to shut down the Debtor's facility. As far as HHS was concerned, the Debtor could continue to operate its facility and provide care for its patients; HHS simply was not going to pay for it. By contrast, by refusing to renew the Debtor's license, AHCA is essentially attempting to shut down the Debtor's facility because it believes the Debtor's operations are jeopardizing the patients' safety and welfare. While it may be an open question whether shutting down the Debtor's facility is in the best interest of its patients, there can be no question the attempt to shut it down is an effort by AHCA to protect what it believes is in the best interests of the patients' safety and welfare.

But the Court concludes that the Debtor's plan is still feasible notwithstanding AHCA's unwillingness to renew the Debtor's license. For starters, AHCA is collaterally estopped from raising the first ground—i.e., termination of the Medicare and Medicaid provider agreements—as a basis for refusing to renew or seeking to revoke the Debtor's license. This Court has ruled that the Debtor has the right to assume the Medicare provider agreement. And the only basis for terminating the Medicaid provider agreement was that the Medicare provider agreement had been terminated. Since that is no longer the case, the Medicaid provider agreement remains in effect. So the only grounds for refusing to renew or seeking to revoke the Debtor's license are the three deficiencies the Debtor has previously been cited for.

Under Florida law, AHCA does have the right to revoke the Debtor's license if the Debtor has been cited for two "class 1 deficiencies" arising from unrelated circumstances during the same survey or from separate surveys during a 30-month period.[74] AHCA contends that the three deficiencies the Debtor has been cited for constitute "class 1 deficiencies" under Florida law. As a result AHCA contends it is required to revoke or deny renewal of the Debtor's license.

[74] § 400.121(3)(c)-(d), Fla. Stat.

But Florida's Medicaid statutes provide additional protections that are not afforded under the Medicare regulations.

Critically, under the Medicare regulations, the Debtor has no right to challenge the termination of a Medicare provider agreement. The Debtor can challenge the underlying finding of noncompliance that gave rise to termination; but once noncompliance has been established, it appears the Debtor cannot challenge termination of the provider agreement. Florida's Medicaid statutes are different. Under section 400.121, Florida Statutes, the Debtor has the right to present factors that mitigate against revocation or nonrenewal of its license.

Although this Court has no say on whether revocation is appropriate under the circumstances—that decision is up to AHCA under section 400.121, Florida Statutes—it is apparent to the Court that there are a number of mitigating factors that could reasonably lead to the conclusion revocation is not appropriate. For one, the three deficiencies were isolated incidents, and each of them was cured immediately. Moreover, the Debtor has been operating its facility for the last five months in apparent substantial compliance with the Medicare and Medicaid requirements and, according to the Patient Care Ombudsman, in a manner that adequately and satisfactorily provides for the patients' health and welfare.[75] Finally, and perhaps most importantly, the Debtor's facility serves a particularly needy population (i.e., patients with severe psychiatric conditions) that may have trouble finding another skilled nursing facility, and to the extent they can find one, the patients may be at a greater risk if they transfer—because of a phenomenon known as transfer trauma—than if they remained at the Debtor's facility. All of this is to say that AHCA's stated intention of refusing to renew—or seeking to revoke—the Debtor's

[75] Doc. No. 178-1 at 21; Doc. No. 252 at 17.

license does not sound the death knell for the Debtor's business, and as such, it is not a basis for concluding the Debtor's plan is not feasible.

The Court recognizes there are cases holding that feasibility is not established when a debtor's prospects hinge on the uncertain outcome of pending litigation.[76] And it is true the Debtor's license renewal or revocation is uncertain. But what is certain is that denial of confirmation—before the Debtor has even had the opportunity to avail itself of its rights under Florida's license revocation statutes—will displace 109 nursing patients, many of whom suffer from severe psychiatric conditions and will have difficulty finding a place to go. And HHS and AHCA would be hard-pressed to argue there is harm to allow the Debtor to go forward under a confirmed plan until the licensure renewal or revocation issue is fully adjudicated considering that HHS has made no attempt to close the Debtor's facility (even though it has that right under the Medicare regulations) and AHCA has abated its efforts to do so (and allowed the Debtor to operate) since July. So while the Debtor's plan does hinge on the uncertain resolution of the pending licensure renewal or revocation action, the Court cannot allow what appears to be a litigation tactic to derail the Debtor's confirmation and displace over 100 nursing home patients.[77]

Conclusion

The sole issue before this Court on confirmation is whether the Debtor's plan is feasible. Because the Debtor has the right to assume its Medicare provider agreement, the Court concludes the plan is feasible. And the fact that AHCA intends to seek revocation or deny

[76] Doc. No. 242, citing *in re Am. Capital Equip.*, 688 F.3d 145, 156 (3d Cir. 2012); *In re Ewald*, 298 B.R. 76, 82 (Bankr. E.D. Va. 2002); *In re Gregory & Parker, Inc.*, 2013 WL 2285671, at *7 (Bankr. E.D.N.C. May 23, 2013).

[77] The Court says that raising the licensure renewal or revocation appears to be a litigation tactic because, although AHCA filed its administrative complaint back in July, it did not raise revocation of the Debtor's license (which is technically separate from licensure renewal) until four months after the Court enjoined CMS from terminating the Medicare provider agreement and shortly before confirmation.

renewal of the Debtor's license does not change this Court's feasibility analysis. Accordingly, it is

ORDERED:

1. The Debtor has satisfied the requirements of Bankruptcy Code § 1129 for confirming its proposed chapter 11 plan.

2. The Debtor shall prepare a confirmation order finding that the specific requirements of Bankruptcy Code § 1129 have been met, incorporating the relevant terms of this Memorandum Opinion, and confirming the Debtor's proposed chapter 11 plan.

3. This order is a nonfinal order and will not become a final order until entry of a confirmation order.

DATED: _____.

_____
Michael G. Williamson
United States Bankruptcy Judge

Attorney Elizabeth A. Green is directed to serve a copy of this order on interested parties and file a proof of service within 3 days of entry of this order.

Elizabeth A. Green, Esq.
Baker & Hostetler LLP
Counsel for Debtor

Andrew Sheeran, Esq.
Counsel for Agency for Health Care Administration

Sean Flynn, Esq.
Office of the United States Attorney
Counsel for U.S. Department of Health & Human Services