AMERICAN BANKRUPTCY INSTITUTE

2019 Caribbean Insolvency Symposium

CONCURRENT SESSION

U.S. Track

Issues Facing Community and Critical-Access Hospitals: What Is the Answer, and When Is It Too Good to Be True?

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2019

Critical Access Hospitals Background and the Fight to Stay Alive

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CAH Eligibility

- Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized States to establish a State Flex Program under which certain facilities participating in Medicare can become Critical Access Hospitals ("CAHs").
- The following providers may be eligible to become CAHs:
  1. Currently participating Medicare Hospitals,
  2. Hospitals that ceased operation after November 29, 1989 and
  3. Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.

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CAH Designation Criteria

- Generally, a hospital that participates in Medicare must meet the following criteria to be certified and remain certified as a CAH:
  1. Be located in a State that established a State rural health plan for the State Flex Program,
  2. Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural;
  3. Furnish 24/7 emergency care services;
  4. Maintain no more than 25 inpatient beds that may also be used for swing beds. Under CMS, a CAH may use beds to provide acute care or SNF (skilled nursing) care;

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CAH Designation Criteria (continued)

5. Have an average length of stay (ALOS) for acute care of 96 hours or less;
6. Be located more than a 35-mile drive from any hospital or other CAH or located more than a 15-mile drive from any hospital or other CAH in an area with mountainous terrain or only secondary roads.

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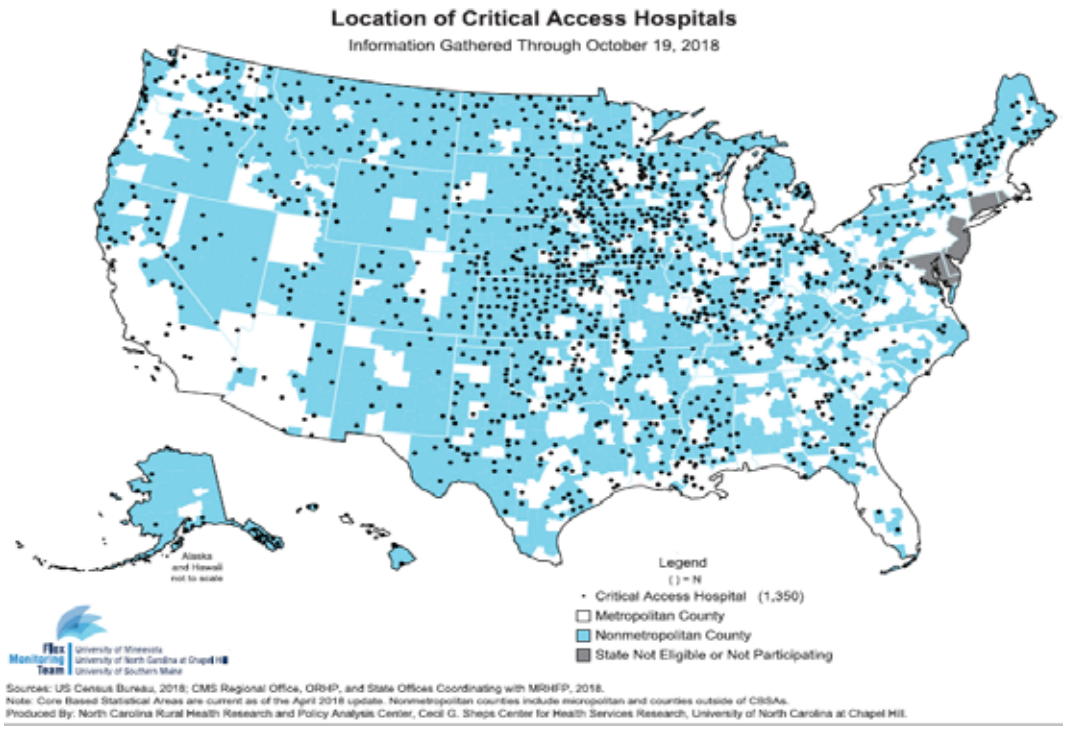

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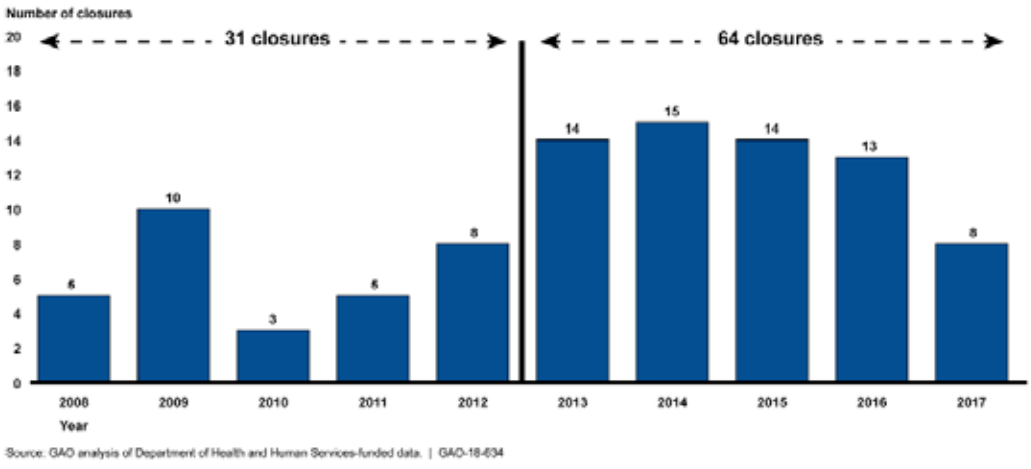
Rural Hospital Closures – 2008 through 2017



As illustrated above, 64 rural hospitals closed from 2013 through 2017. Forty-seven (47%) of these closures ceased operations.

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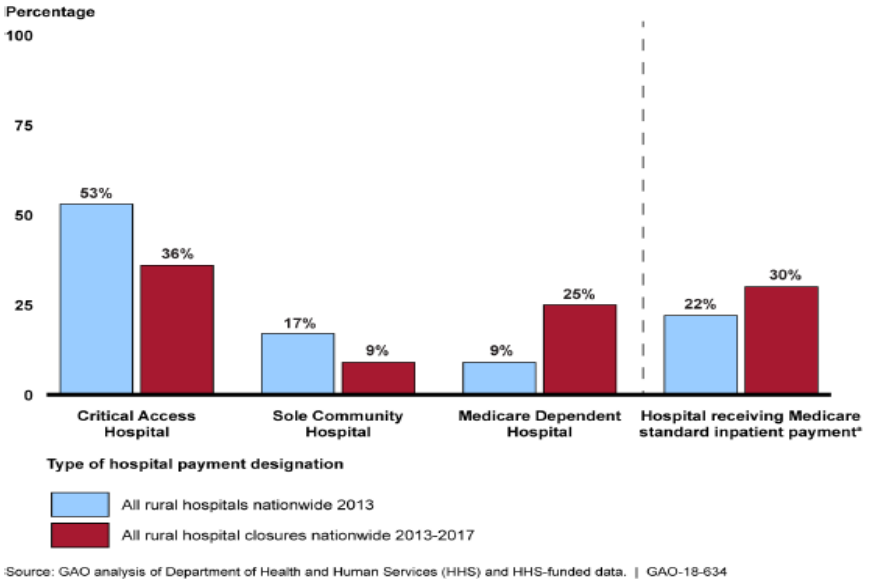
Percentage of Rural Hospitals in 2013 Compared to Rural Hospital Closures From 2013 through 2017



Source: GAO analysis of Department of Health and Human Services (HHS) and HHS-funded data. | GAO-18-634

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Rural Hospital Closures – Contributing Factors

- Not surprisingly, according to a 2016 study operating margin proved to be consistent predictor of CAH closures. CAHs that closed had a median operating margin of (7.56%) while those that continued to operate had a slightly better than breakeven margin of 0.46%.
- Other factors contributing to the closure of rural hospitals include:

1. Increased competition for the small number of rural residents.
2. Declining rural population.
3. Reductions in nearly all Medicare reimbursements. Currently, CAHs are reimbursed at 101% of Medicare allowable cost subject to 2% sequestration.
4. Reductions in Medicare Bad Debt Payments

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CRITICALLY CHALLENGED:

A CHECKLIST FOR INCREASING PROFITABILITY IN CRITICAL ACCESS HOSPITALS

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Critically Challenged

- The economic deterioration and current failure rate of rural and CAHs demonstrates quite clearly that America's rural healthcare infrastructure is facing very real and very significant challenges.
- While the cost-based reimbursement system enjoyed by CAHs is designed to provide a revenue-driven advantage over their larger counterparts, elements of scale, size, staffing, and treatment options remain barriers to economic viability for many rural operators.
- In these more remote locations, size seems to matter more now than ever, and margins for error have appeared to narrow tremendously in the current fiscal landscape.
- Intelligent examination, cohesive analysis, and critical data-driven planning are more important than ever in leveling the playing field between CAHs and their more established, larger, and more urban-centered "competitors."

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From Critical to Stable…..
Operational, Service Line, Facility and Staffing Enhancements to Profitability

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Operational Initiatives

- **Improve the revenue cycle**
  - Much of this can be handled by gathering appropriate data at the patient intake level and rationalizing the billing process
  - Send bills early and systematically, and maintain oversight of the collection process.
- **Align services with community needs**
  - Look at gathering and harvesting local population data to square services with community needs
- **Swing beds**
  - In addition to increasing profits a swing bed program can improve patient outcomes and allows a continuity of care between the patient and the patient's original treatment team.

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Operational Initiatives (continued)

- **Group purchasing**
  - CAHs need to search for appropriate group-purchasing organizations that may be able to generate more competitive pricing on behalf of a collective group.
  - This may mean taking control of purchasing decisions away from clinicians and putting them in the hands of a more centralized materials purchasing group.
- **Think big**
  - Best practices developed at larger hospitals can be effectively employed in more rural settings and yield positive results on the operational side.

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Service Enhancements

- **Collaborate** with rural health clinics to improve access and continuity of care, improve efficiency of care and decrease duplication of services.
- **Evaluate** current skill set. Collaborate with professional organizations to ensure maximum use of these professionals' skills in hospital and clinic settings.
- **Assess** and grow outpatient offerings and other services consistent with community needs and appropriate analysis and mapping.
- **Increase** the adoption of technology and internet access by rural residents as a means of monitoring, slowing and preventing the progression of illness, especially those patients with chronic diseases who do not need inpatient care.
- **Identify** the role of CAHs in community-wide efforts to control the onset of chronic diseases among rural residents.

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Facilities and Staffing

- Identify opportunities and designated programs for **capital projects**. To this end, CAHs can enhance their credit positions by improving receivable management (Medicare and Medicaid, especially), and reduce discounts and write-downs to allow for better access to such funding.
- Promote the use of evidence-based design to build facilities that support **improved patient safety and outcomes**, and better meet staff needs.
- Identify, recommend, and encourage **CAH-centric training** opportunities for physicians, nurses, and other health profession students.
- Tap into the relevant state's medical schools and residency programs to identify the best approaches to **provide medical students and residents with increased information about provider-to-CAH relationships.**

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Facilities and Staffing (continued)

- Work with health professions education programs to include **telemedicine** experiences in the curricula.
- Develop models for **sharing of highly skilled staff** among multiple CAHs as a mechanism to overcome workforce challenges and to offer competitive salaries and work environments.
- Develop new **employment and volunteer models** for emergency medical services staff that overcome the challenges associated with recruiting in rural communities.

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Increasing Profitability Through Outreach Programs

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Clinical Lab

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Clinical Lab Outreach Program

- Allows a hospital to market its laboratory services to local area physician practices who would otherwise rely on an independent reference laboratory
  - Non-patients: neither an inpatient nor outpatient of the hospital
- May create a revenue stream for the hospital allowing it to further support operating costs through leveraging economies of scale
- CMS and commercial payer guidelines permit the hospital to bill the laboratory services it performs internally at the request of these independent physician orders

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Lab Outreach Program Reimbursement

- CAHs are reimbursed more than standard hospital rates
  - Paid based on 101 percent of reasonable cost
- Non-patient testing performed in a CAH/hospital outreach program is reimbursed at professional fee schedule rates (i.e. CLFS) which are lower than the reimbursement for standard CAH, outpatient or inpatient payment models
- Billing is submitted on a hospital claim form (UB-04/837I)
- A bill type of 14X is reported to indicate a non-patient specimen
  - Should serve as the trigger for the lower fee schedule

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CAH MIPPA Exception

- Medicare Improvements for Patients and Providers Act (MIPPA), Section 148:
  - Effective for services furnished on or after July 1, 2009, the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected in order for the CAH to be paid based on 101 percent of reasonable cost. However, the beneficiary must be an outpatient of the CAH, as defined at 42 CFR §410.2 and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH if he/she is not present in the CAH when the specimen is collected, the beneficiary must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or of a facility provider-based to the CAH.

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Lab Outreach Program Limitations

- When operating under the taxonomy of the CAH, pass through billing is prohibited for non-patient specimens by CMS and most private payers
- Pass through billing occurs when:
  - The CAH refers a specimen to an outside reference laboratory for analysis;
  - The reference (performing) laboratory client bills the CAH; and
  - The CAH bills the patient and/or insurance for the referred test

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CMS Permitted Pass Through Billing

- A hospital outreach laboratory that wishes to pass through bill for referred testing must meet exception criteria AND follow specific claim requirements
  - Medicare Claims Processing Manual, Chapter 16, Section 40
- CAHs qualify for CMS' exception as a rural hospital
- Additional requirements
  - Must obtain a secondary taxonomy for specialty code 69 Independent Clinical Laboratory, 291U00000X Laboratories/Clinical Medical Laboratory (via NPI registry);
  - CPT/HCPCS billed shall be appended with modifier 90 to identify all referred laboratory services;
  - Name, address, and CLIA number of both the referring laboratory and reference laboratory shall be reported on the claim; and
  - Billing submitted on a professional claim form (CMS1500/837P)

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Additional Considerations

- Private payer payment policies may vary from those of CMS – many prohibit pass through billing for non-patient specimens
  - Mandate direct billing of non-patient referred tests by the performing laboratory
- Many states have anti-markup, direct billing and/or disclosure laws that impact pass through billing

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Abuse of Lab Outreach Programs

- Higher CAH reimbursement has led to a hot bed for abuse
- Payers have grown increasingly stringent with requirements for labs to become "in network"
- Marketing companies are preying on CAHs for lab outreach programs that serve as a pass through for out of network reference lab billing
  - Sell a false pretense that the practice is accepted
  - Misinterpret the 14X bill type to represent a referred test as opposed to a non-patient
  - Disguise referred tests as those that are performed by the CAH
  - Collect higher CAH reimbursement and share the wealth with marketers and referring laboratories – violating Patient Brokering and Anti-Kickback Provisions

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Telemedicine

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Telemedicine Requirements § 410.78

- Requires, at a minimum, audio AND video:
  - Asynchronous store and forward technologies means the transmission of a patient's medical information from an originating site to the physician or practitioner at the distant site
  - The physician or practitioner at the distant site can review the medical case without the patient being present
  - An asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail)
  - Photographs visualized by a telecommunications system must be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis and or treatment plan
  - Dermatological photographs, for example, a photograph of a skin lesion, may be considered to meet the requirement of a single media format under this provision

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Telemedicine Requirements § 410.78

- Must be interactive
  - Interactive telecommunications system means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner
  - Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system

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12

When Filing For Bankruptcy is the Best Medicine

1

Bankruptcy Considerations in Healthcare Cases

- Appeals process – Medicare and bankruptcy courts
- Recoupment
- Regulatory approvals
- Sales process
- Healthcare Fraud
  - False claims - 31 USC 3729-33 (criminal law)
  - Stark Law (aka Physician Self-Referral Act) - 42 U.S.C. § 1395nn (civil penalties)
  - Anti-Kickback Statue - 42 U.S.C. § 1320a–7b (criminal law)
- Criminal forfeiture

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Bankruptcy Considerations in Healthcare Cases

Article I of the Constitution assigns to Congress the "Power * * * [t]o establish * * * uniform Laws on the subject of Bankruptcies throughout the United States." U.S. Const. art. I, § 8, cl. 4. Pursuant to that authority, Congress has granted federal courts "original and exclusive jurisdiction of all cases under title 11." 28 U.S.C. 1334(a). A "critical feature" of every bankruptcy [case] is the bankruptcy court's "exercise of exclusive jurisdiction over all the debtor's property." *Cent. Va. Cmty. Coll. v. Katz*, 546 U.S. 356, 363-64 (2006); *see also* 28 U.S.C. 1334(e)(1). Congress provided this comprehensive grant of jurisdiction "to ensure adjudication of all claims in a single forum and to avoid the delay and expense of jurisdictional disputes." *N. Pipeline Constr. Co. v. Marathon Pipe Line Co.*, 458 U.S. 50, 87 n.40 (1982) (citing H.R. Rep. No. 95-595, at 43-48 (1977); S. Rep. No. 95-989, at 17 (1978)).

The bankruptcy system includes several provisions in furtherance of those goals. The automatic stay prohibits commencement or continuation of certain actions against the debtor, 11 U.S.C. 362(a); a debtor may assume its executory contracts after curing any default, 11 U.S.C. 365; bankruptcy courts may issue all relief "necessary or appropriate" to carry out the bankruptcy process, 11 U.S.C. 105(a); and bankruptcy courts may confirm a debtor's plan of reorganization, vesting all property of the estate in the debtor, free and clear of all claims, 11 U.S.C. 1141. In 11 U.S.C. 106, Congress abrogated the federal government's sovereign immunity with respect to the foregoing provisions, submitting the United States to the jurisdiction of the bankruptcy courts.

In 2005, Congress passed BAPCPA, which incorporated specific provisions into the Bankruptcy Code relating to health care businesses.[1] BAPCPA granted a special administrative priority to the winding-up of health care businesses, 11 U.S.C. 503(b)(8), and authorized the compensation of a patient care ombudsman from property of the estate, 11 U.S.C. 330(a). Congress also provided that HHS need not seek relief from the automatic stay to "exclude" (as distinguishable from "terminate") a bankrupt health care business from participation in Medicare.

Although bankruptcy courts have comprehensive jurisdiction to deal with all matters connected with a debtor's estate, and possess "exclusive jurisdiction" over "all cases under title 11" and "all property of the estate," 28 U.S.C. 1334(a), (e)(1), the Medicare Act limits a party's ability to pursue claims arising under the Act in federal court. In 42 U.S.C. 405(g), Congress provided for judicial review following a final decision by the agency. Congress then limited review of the agency's decision as follows:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], 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.
>
> 42 U.S.C. 405(h).

Section 405 was enacted in 1939 as part of the Social Security Act. As originally drafted, it barred actions brought "under section 41 of Title 28 to recover

[1] The term "health care business" is broadly defined in 11 U.S.C. § 101(27)(A) and includes hospitals, ambulatory care facilities, hospices, home health agencies, long-term care facilities like nursing homes and assisted-living facilities.

on any claim arising under sections 401-09 of this chapter." 42 U.S.C. 405(h) (1939). At the time, "§ 41 contained all of that title's grants of jurisdiction to United States district courts," *Weinberger v. Salfi*, 422 U.S. 749, 756 n.3 (1975), including "all matters and proceedings in bankruptcy," 28 U.S.C. 41(19) (1934). In 1948, however, Congress revised the U.S. Code, extracting the various jurisdictional grants from Section 41 and re-codifying some of them as 28 U.S.C. 1331 to 1348 (1948). When Congress rewrote Section 41, it did not update Section 405(h), which continued to refer to then-defunct 28 U.S.C. 41, not the new 28 U.S.C. 1334.

The Supreme Court noted this in *Salfi*, 422 U.S. at 756 n.3. The next year, the Office of Law Revision Counsel[2] removed the reference to Section 41 and replaced it with references to 28 U.S.C. 1331 and 1346—the jurisdictional grants for federal questions and suits against the United States, respectively. A codification note acknowledged that the amended statute no longer referenced all of the jurisdictional provisions that formerly comprised Section 41. *See* 42 U.S.C.A. 405 (West 1982).

Eight years later, Congress enacted the Law Revision Counsel's changes. *See* Deficit Reduction Act of 1984 ("DRA"), Pub. L. No. 98-369, § 2663(a)(4)(D), 98 Stat. 494, 1162 ("Section 205(h) of such Act is amended by striking out 'section 24 of the Judicial Code of the United States' and inserting in lieu thereof 'section 1331 or 1346 of title 28, United States Code . . . ."). In enacting the DRA, Congress stated that its amendments should not "be construed as changing or affecting any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date." *Id.*, § 2664(b), 98 Stat. at 1171-72.

The omission of any mention of Section 1334—the federal subject-matter statute governing bankruptcy claims—from Section 405(h) has become increasingly

[2] The Office of the Law Revision Counsel is a body within the U.S. House of Representatives whose purpose is to codify the laws of the U.S. and publish updates to the U.S. Code. *See* 2 U.S.C. 285 et seq.

relevant as the administrative process under the Medicare Act has proven impractical for health care companies facing a financial crisis upon termination of their provider agreements by the government. While facilities terminated from Medicare theoretically have access to expedited administrative review, 42 U.S.C. 1395cc(h)(1)(B), in reality this process is not available to a health care provider facing imminent insolvency. Severe backlogs prevent appeals from being heard in a timely manner. In 2015, the Office of Medicare Hearings and Appeals ("OMHA") reported that the average adjudication took 572 days, and that this time frame "will continue to increase until receipt levels and adjudication capacity are brought into balance." *See Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare: Hearing Before the S. Comm. On Finance*, 114th Cong. 38 (2015) (prepared statement of Nancy J. Griswold, Chief A.L.J., OMHA). "This is a huge problem in healthcare bankruptcy cases because the Medicare program's appeal process is simply broken. Staffed to handle approximately 70,000 appeals annually, it currently has more than 700,000 appeals pending.[3]"

Making these delays more problematic, CMS can institute recoupment against a provider's ongoing payments while the provider's appeal is pending. This loss of revenue creates a very high risk of insolvency. *See* Samuel R. Maizel & Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts*, 32 Emory Bankr. Dev. J. 19, 29 (2015). Against this backdrop, health care businesses have increasingly resorted to bankruptcy courts, with varied success, depending, in part, upon the circuit in which the case is filed, and how the circuit interprets the jurisdictional interplay between 28 U.S.C.

[3] *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183 (D.C. Cir. 2016) (discussing delays in the Medicare appeals process and concluding, among other things, that the delays in Medicare appeals "are having a real impact on 'human health and welfare'").

1334 vs. 42 U.S.C. 405. There is currently a circuit split[4] regarding whether bankruptcy courts are barred by Section 405(h) from adjudicating disputes with CMS. "*Compare Florida Agency For Health Care Admin, et al. v. Bayou Shores, SNF, LLC* (*In re Bayou Shores, SNF, LLC*), 828 F.3d 1297, 1331 (11th Cir. 2016) ("The bankruptcy court was without § 1334 jurisdiction under the § 405(h) bar to issue orders enjoining the termination of the provider agreements and to further order the assumption of the provider agreements.") *with Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1140 n.11 (9th Cir. 2010) (noting the "special status" of bankruptcy court jurisdiction over bankruptcy issues); and *University Medical Center, Inc. v. Sullivan* (*In re Univ. Med. Ctr.*), 973 F.2d 1065, 1072 (3d Cir. 1992) ("Because we agree . . . that the Bankruptcy Code supplies an independent basis for jurisdiction in this case, we reject the Secretary's arguments and find that the district and bankruptcy courts properly had jurisdiction . . . ."); and *Sullivan v. Town & Country Home Nursing Servs., Inc*. (*In re Town & Country Nursing Services, Inc.*), 963 F.2d 1146, 1155 (9th Cir. 1992) ("Section 405(h) only bars actions under 28 U.S.C. §§ 1331 and 1346; it in no way prohibits an assertion of jurisdiction under section 1334."); and *Nurse's Registry & Home Health Corp. v. Burwell* (*In re Nurses' Registry & Home Health Corp.*), 533 B.R. 590, 593 (Bankr. E.D. Ky. 2015) (Court holds that "the statutory bar on federal jurisdiction over unexhausted Medicare Act disputes . . . did not apply to bankruptcy jurisdiction."); *see also* Samuel R. Maizel v. Michael B. Potere, *Killing the Patient to Cure the Disease: Medicare's Jurisdictional Bar Does Not Apply to Bankruptcy Courts,* 32 EMORY BANKR. DEV. J. 1 (2015)."

[4] Courts have routinely recognized the circuit split; *Nurses' Registry & Home Health Corp. v. Burwell (In re Nurses' Registry & Home Health Corp.)*, 533 B.R. 590, 595 (Bankr. E.D. Ky. 2015) (noting that its view has been "embraced by two circuits and acquiesced to by Congress for over twenty years," while acknowledging "a number of courts" disagree); *U.S. Dep't of Health & Human Servs. v. James*, 256 B.R. 479, 481-82 (W.D. Ky. 2000) (noting that "courts have split on this issue" and "the arguments for and against jurisdiction have been well developed by circuits' ruling in favor of each").

Nevertheless, when squarely presented with this split of authority, on June 5, 2017, the United States Supreme Court declined to grant certiorari in order to address whether (i) Section 405(h) strips bankruptcy courts of jurisdiction over claims arising under the Medicare Act; and whether (ii) Section 405(h) requires a debtor to exhaust administrative remedies prior to pursuing the relief available under the Bankruptcy Code. With the denial of certiorari by the Supreme Court, the questions of whether Section 405(h) strips bankruptcy courts of jurisdiction over claims arising under the Medicare Act and whether Section 405(h) requires a debtor to exhaust administrative remedies prior to pursuing the relief available under the Bankruptcy Code are unresolved.

The plain language of Section 405(h)[5] supports the argument that the debtor need not exhaust its administrative remedies before a bankruptcy court may take jurisdiction in order to rule on core bankruptcy issues, including whether the debtor can assume and assign an executory contract under section 365 of the Bankruptcy Code[6] and/or sell debtor assets free and clear of liens, claims, and interests under section 363. Regardless, the government has argued with some success that the absence of a reference to section 1334 of title 28 is a "scrivener's error," and therefore, the statute should be read as if a reference to section 1334 were expressly included.[7] In *Bayou Shores*, the government successfully argued (at the District Court and Circuit Court levels) against a plain language interpretation of 405(h) by injecting an ambiguity where none resides by pointing to a proviso directing that

[5] *United States v. Ron Pair Enters., Inc*., 489 U.S. 235, 241 (1989) (stating that statutory interpretation begins "with the language of the statute itself," and that "is also where the inquiry should end," if "the statute's language is plain").

[6] Unless otherwise noted, all references in this chapter to "section" are to the U.S. Bankruptcy Code, 11 U.S.C. §§ 101-1531, as amended.

[7] *See, e.g*., Bayou Shores, 828 F.3d at 1304 ("we conclude that the lack of reference to section 1334 in section 45(h) is the result of a codification error").

amendments, including those to 405(h), should not "be construed" to change or affect any previously existing rights, liabilities, statuses, or interpretations. *See* DRA § 2664(b), 98 Stat. 474, 1171–72). However, courts need not "construe" unambiguous texts. *See United States v. Fisher*, 6 U.S. (2 Cranch) 358, 386 (1805) (where a statute "is plain, nothing is left to construction"). The plain language of 42 U.S.C. 405(h) – "[n]o action against the United States, the [Secretary of Health and Human Services], 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"— does not include a bar on actions brought under Section 1334 of Title 28, which provides "exclusive jurisdiction" to district courts over bankruptcy cases.

Section 405(h) plainly expressly restricts courts from taking jurisdiction under 28 U.S.C. 1331 (diversity) and 1336 (mandamus), but not 1334 (bankruptcy). When Congress amended Section 405(h), it omitted 28 U.S.C. 1334 from the list of affected jurisdictional provisions, knowing that Section 1334 had previously been affected. Yet, the Eleventh Circuit found Congress's intent unclear because Congress did not explain its decision in legislative history. However, courts do not "require Congress to state in committee reports . . . that which is obvious on the face of the statute." *Harrison v. PPG Indus., Inc.*, 446 U.S. 578, 592 (1980) ("In ascertaining the meaning of a statute, a court cannot, in the manner of Sherlock Holmes, pursue the theory of the dog that did not bark.").

Regarding the second question the Supreme Court declined to address – whether Section 405(h) requires a debtor to exhaust administrative remedies prior to pursuing the relief available under the Bankruptcy Code, unlike the Eleventh Circuit, the Third and Ninth Circuits have held that the exhaustion requirements of Section 405(h) do not apply where there is an independent grant of jurisdiction to the federal courts. This makes sense: if one is not invoking the jurisdiction of courts under Section 405(g), one need not fulfill the jurisdictional prerequisites to 405(g) found

in 405(h). The Supreme Court has never reached this question—something the Eleventh Circuit acknowledged. In *Weinberger v. Salfi*, 422 U.S. 749 (1975), the Court considered whether the third sentence of Section 405(h) barred jurisdiction under 28 U.S.C. 1331. Its decision turned on the "sweeping and direct" bar on actions brought under 1331. *Id.* at 757. There is no such bar on 1334 proceedings. That rule was affirmed in *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000), another 1331 case. In *Heckler v. Ringer*, 466 U.S. 602 (1984), the plaintiffs based jurisdiction on Sections 1331, 1361 (mandamus), and 405(g) itself. *Id.* at 609. The Supreme Court found 1331 and 405(g) jurisdiction barred by the third sentence of 405(h), but assumed without deciding that mandamus jurisdiction was *not* foreclosed; Section 1361, unlike 1331 but *like* 1334, does not appear in the third sentence. Ultimately, mandamus was not viable because the plaintiffs had not exhausted *as required by the law governing mandamus*, not pursuant to 405(h). *Id*. at 616-17. But there is no analogous exhaustion requirement for 1334 proceedings. Ergo, the Eleventh Circuit's ruling is inconsistent with the reasoning in *Ringer.*

The issue of an independent grant of jurisdiction does not arise only in the health care context. In *Califano v. Sanders*, 430 U.S. 99 (1977), the plaintiff's claims were brought under the APA, which plaintiff argued was an independent grant to district courts of subject-matter jurisdiction to review agency decisions. *Id*. at 100-101. The Supreme Court could have decided whether 405(h)'s second sentence required exhaustion of claims brought under separate jurisdictional grants, but declined that "shorter route" to decision. *Id.* at 110-11 (Stewart, J., concurring in the judgment). Instead, the Court held the plaintiff was required to exhaust pursuant to 405(h) because the APA did *not* contain an independent jurisdictional grant. *Id*. at 104-06. The Bankruptcy Code *does* contain such a grant, and it contains no corresponding exhaustion requirement. As such, the better ruling, but one the Eleventh Circuit declined to make, is that Section 405(h) does not require exhaustion

in bankruptcy cases because of the independent jurisdictional grant supplied in Section 1334.

Recoupment

Recoupment is a common law doctrine that applies when a party to a contract overpays and has a credit balance that can be applied to the contractual arrangement. Recoupment arises from a single contract and occurs when a party holds a Medicare provider number and has received overpayments. CMS provides payment to a healthcare provider based upon estimated costs of services which can then be recouped based upon actual costs. Recoupment has an impact for both Chapter 11 debtors and buyers of assets because a pre-petition claim may be recouped post-petition based upon the fact that the payments were part of a single contract.

The minority view is that recoupment may only be for a single year under the Medicare contract. *See*, *In re University Medical Center*, 973 F.2d 1065 (3d Cir. 1992). The majority view is that recoupment can be made for the entire time of the contract. *Holyoke Nursing Home, Inc. v. Health Care Financing Administration (In re Holyoke Nursing Home, Inc.)*, 372 F.3d 1 (1st Cir. 2004). *United States v. Consumer Health Services of America, Inc.*, 108 F.3d 390 (D.C. Cir. 1997). *In re TLC Hospitals, Inc.*, 224 F.3d 1008 (9th Cir. 2000).

Recoupment can have a significant impact on cash flow because the debtor's receivables may be subject to recoupment and recoupment, unlike set off is not subject to the automatic stay. *See, University Medical Center* 973 F. 2d at 1079; *Visiting Nurses Association of Tampa Bay Inc.* 121 B.R. 144, 119 (M.D. Fl. 1990), for buyers who are assigned provider agreements there can be successor liability that runs with the agreement. Buyers have attempted to contract around successor liability for recoupment. Courts have held that under applicable law, a buyer becomes primarily liable for recoupment payments when a provider number is

assumed and that the buyer cannot contract around applicable law. *See, U.S. v. Vernon Home Health, Inc.* 21 F. 3rd 693 (5th Cir. 1994); *In re Senior Management Services of Treemont, Inc.* Case No. 07-30230-HDH-11.

Regulatory Approvals

Approvals required depend upon the type of healthcare business. The approvals generally include CMS 855 applications, Medicare Enrollment applications, notification and approval to the state licensure agency, applications to the DEA and state boards of pharmacy for licenses. Note that State licensure may take several months, and that licenses are generally nontransferable. As a result most transactions will include an Operations Transfer Agreement ("OTA") or a Management Agreement. The OTA generally will deal with the transfer of employees, collection and allocation of accounts receivable, regulatory filings, proration of operating costs, cost reports, and bank account issues.

It should be noted that when there is a Change of Ownership (CHOW) the Medicare provider agreement is automatically assigned to the buyer along with all of the obligations and liabilities associated with the agreement. The buyer should consider holdbacks or other protections in order to avoid liabilities. Although it is possible for the Medicare agreement to be terminated it practically is not a solution in most cases because it requires 45 days' notice and the buyer will likely be unable to obtain a new provider number in time to operate.

ISSUES RELATED TO HEALTHCARE FRAUD

31 USC 3729 – 33 False Claims Act (Criminal Liability)

In the healthcare arena, the government has traditionally enforced claims for fraud under the False Claims Act ("FCA"). Such actions are not stayed under 11 U.S.C. 362(b)(4). While the government can continue to prosecute a FCA, it will

not be able to collect its damages under the police and regulatory exception to the Automatic Stay.

The False Claims Act provides:

A. Whoever knowingly presents or causes to be presented a false or fraudulent claim for Payment or approval;

B Knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim;

C. Conspires to commit a violation of A, B, C, D, E, F, or G

In short, the Plaintiff must show the defendant made a claim, to the United States Government, which is false or fraudulent, knowing of its falsity and seeking payment by the Federal Treasury. United States ex rel. *Makes v. Straud* 274 F. 3rd 687 (2nd Cir. 2001). However, it should be noted that "knowingly" requires no actual intent to defraud and includes those who act in deliberate ignorance or reckless disregard. 31 U.S.C. 3239(b)(1).

The consequences of both pre-petition and post-petition FCA claims are significant because damages awarded under the FCA are the damages sustained trebled, plus fines of $10,781 to $21,996 per violation. A healthcare entity could be found liable for obviously fraudulent violations such as billing for services that were never rendered. However, a healthcare entity could also be held liable for providing a service in violation of another law or billing the government for a substandard service or a higher level of service than what was actually provided.

The FCA provides that a private individual known as a Qui Tam Relator (whistleblower) can bring a FCA Claim on behalf of the government. 31 U.S.C. 3730. The action is filed under seal and the Government has sixty days to intervene in the action. However, this time is routinely extended in six month increments for years. The relator will receive between 25 and 30 percent of the recovery plus attorney's fees if the government does not intervene and up to 25 percent if the

government does intervene. The relator can bring the litigation whether or not the individual has actual damages. 31 U.S.C. 3730. Liability under the FCA is for federal claims. In the healthcare area this means billings for Medicare, Medicare Part D and Tricare, and a host of other claims.

What does this mean for a Chapter 11 debtor or buyer of assets?

It should be noted that FCA claims may be non-dischargeable. 1141 (d)(6)(A) excludes from discharge a debt owed to a person as a result of an action filed under the FCA or similar statute or owed to a governmental unit due to fraud related acts. Debts owed to a relator i.e. Attorney's fees and percent of recovery are likely non-dischargeable under 1141(d)(c)(A). The government's portion is likely not covered under that section because the "person" definition does not include governmental unit See, 11 U.S.C. §101(41) "person" does not include governmental entity. For the government portion of the claim for damages 523(A)(2)(a) will apply and the government will have to meet its burden of proof to demonstrate false pretenses, a false representation or actual fraud in order to establish a non-dischargeable debt.

A buyer should be concerned about successor liability for false claims and or a systemic problem in the operations that they are buying giving rise to FCA liability. In order to deal with successor liability the sale order can provide for a sale specifically free and clear of such liability, however the free and clear order may not be effective if it is not permitted by law. *See*, *U.S. v Vernon Mane Merton, Inc.*, 211 F.3d at 693.

A buyer's other option is to wait until after the governmental bar date has past so that the extent and nature of the government claims are known. The government must file a proof of claim by the governmental claims bar date to recover damages for false claims. In addition, the APA can provide for holdbacks from the purchase price.

Although the False Claims Act is the most common federal statute for the imposition of liability against a healthcare entity there are other statutes to consider.

Stark Law (aka Physician Self-Referral Act)

42 U.S.C. § 1395nn (civil penalties)

As a general proposition, a Physician may not refer Medicare or Medicaid patients for so-called "designated health services" to an entity with which the physician **or** an immediate family member that has a "financial relationship," unless an exception applies. This federal statute is known generally as the Physician Self-Referral Act. Penalties for violation of the Act range from denial of payment or refunds of payments received to civil monetary fines.

Key provisions of the Self-Referral Act are as follows:

> (a) Prohibition of certain referrals
>
> (1) In general
>
> Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—
>
> > (A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and
> >
> > (B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

(2) Financial relationship specified

For purposes of this section, a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in this paragraph is—

(A) except as provided in subsections (c) and (d) of this section, an ownership or investment interest in the entity, or

(B) except as provided in subsection (e) of this section, a compensation arrangement (as defined in subsection (h)(1) of this section) between the physician (or an immediate family member of such physician) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

(b) General exceptions to both ownership and compensation arrangement prohibitions.

Subsection (a)(1) of this section shall not apply in the following cases:

(1) Physicians' services

. . .

(2) In-office ancillary services

. . .

(3) Prepaid plans

. . .

(4) In the case of any other financial relationship, which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(5) Electronic prescribing

. . .

(g) Sanctions

(1) Denial of payment

No payment may be made under this subchapter for a designated health service which is provided in violation of subsection (a)(1) of this section.

(2) Requiring refunds for certain claims

If a person collects any amounts that were billed in violation of subsection (a)(1) of this section, the person shall be liable to the individual for, and shall refund on a timely basis to the individual, any amounts so collected.

(3) Civil money penalty and exclusion for improper claims

Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service. The provisions of section 1320a-7a of this title (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

...

Anti-Kickback Statute – 42 U.S.C. § 1320a–7b (criminal law)

The Anti-Kickback Statute makes it a felony for anyone to knowingly and willfully offer, pay, solicit or receive remuneration (in cash or in kind) to induce, directly or indirectly, the referral, purchasing, ordering or recommending of any goods or services reimbursable with federal money. Key provisions of the statute are as follows:

> (a) Making or causing to be made false statements or representations
>
> Whoever–
>
> > (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),
> >
> > (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
> >
> > (3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized,
> >
> > (4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or

any part thereof to a use other than for the use and benefit of such other person,

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not licensed as a physician, or

(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1396p(c) of this title, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding

any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b) Illegal remunerations

(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind–

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly

or indirectly, overtly or covertly, in cash or in kind to any person to induce such person–

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

…

(c) False statements or representations with respect to condition or operation of institutions.

Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon recertification) as a hospital, critical access hospital, skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including an eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter or a State health care program

(as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Illegal patient admittance and retention practices

Whoever knowingly and willfully–

(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State (or, in the case of services provided to an individual enrolled with a Medicaid managed care organization under subchapter XIX of this chapter under a contract under section 1396b(m) of this title or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract), or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)–

(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(e) Violation of assignment terms

Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u(h)(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

Criminal Forfeiture and the Bankruptcy Code

Criminal forfeiture allows the government to obtain property used in a crime or the proceeds of criminal activity. The issues related to the criminal Medicare or insurance fraud in the bankruptcy context are complex. The bankruptcy court has exclusive jurisdiction over all property of the debtor as of the commencement of the case. 28 U.S.C. 1334(e)(1). Under criminal forfeiture the forfeited property becomes property of the government as of the date of the crime. *See In Re Chapman* 264 B.R. (9th Cir. B.A.P. 2001). However, criminal forfeiture is not determined until there is a conviction. Thus, in the case of healthcare fraud, receivables are property of the estate so long as there is no forfeiture order. Upon the entry of an order of forfeiture the receivables would no longer be property of the estate due to the fact that the forfeiture order relates back to the date of the crime. *Id.* The cloud of a potential forfeiture has implications for the use of cash collateral and for a plan because it is

possible that it could ultimately be determined that assets are not property of the estate.

Further, in some circumstances, criminal forfeiture can defeat the interests of secured creditors, subsequent purchasers, or other entities with an interest in forfeited property. The criminal forfeiture statute only directly sets out two circumstances under which a third party can petition to have their interest in forfeited property protected: (i) if the petitioner's right, title or interest "was superior to any right, title, or interest of the defendant at the time of the commission of the acts which gave rise to the forfeiture of the property" or (ii) if "the petitioner is a bona fide purchaser for value of the right, title, or interest in the property and was at the time of purchase reasonably without cause to believe that the property was subject to forfeiture under this section[.]" 21 U.S.C. § 853(n)(6). The criminal forfeiture statute does not directly include the "innocent owner" defense available to third parties in civil forfeiture proceedings. *See* 21 U.S.C. § 983(d). At least one circuit court has held that lienholders who took their liens for value can be protected under the bona fide purchaser defense. *See United States v. Huntington National Bank*, 682 F.3d 429 (6th Cir. 2012).

UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF TENNESSEE (NASHVILLE)

IN RE:	.	Case No. 16-03296
	.	Chapter 11
VANGUARD HEALTHCARE, LLC,	.	
	.	701 Broadway
	.	Nashville, TN 37203
Debtor.	.	
	.	Monday, June 19, 2017
. . . . .	.	1:36 p.m.

TRANSCRIPT OF EXCERPT OF PROCEEDINGS: ORAL RULING
BEFORE THE HONORABLE RANDAL S. MASHBURN
UNITED STATES BANKRUPTCY COURT JUDGE

APPEARANCES:

For the Official Committee of Unsecured	Bass, Berry & Sims, PLC By: PAUL JENNINGS, ESQ. 150 Third Avenue, South, Suite 2800 Nashville, TN 37201 615-742-6273
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Proceedings recorded by electronic sound recording,
transcript produced by transcription service.

(Excerpt at 1:36 p.m.)

THE COURT: All right. This matter is before the Court in connection with an agreement reached between the debtors and the United States and the State of Tennessee to seek a preliminary and limited determination regarding feasibility of the debtor's Chapter 11 plan. A more typical confirmation hearing is scheduled in these cases for early August, but the parties believe that it would be useful to have a hearing to determine if the potential exposure of the debtors based on False Claim Act allegations be tried eventually in district court is so significant as to make the debtor's plan not feasible regardless of any other issues that would be addressed at the confirmation hearing.

The hearing was conducted over two days on May 31 and June 1 of this year. The parties agreed to limit the time for proof and the number of witnesses. Since the parties have projected that a full-blown trial of the district court litigation could take several weeks, this limited hearing was obviously a very truncated version of the proof relating to the False Claim Act issues. Recognizing the somewhat unusual nature of the hearing and the limited purpose of the hearing, it was agreed by the parties that no determination from the hearing would have any preclusive effect on any other litigation between the parties. Ultimately, each party presented several witnesses and the Court heard -- took into

evidence several dozen exhibits. The parties subsequently submitted post-hearing briefs on the particular issues that I identified as needing additional attention.

The statements by the Court today will later be incorporated by reference into a short order. This oral ruling will constitute the Court's findings and conclusions pursuant to Bankruptcy Rule 7052, as made applicable to this contested matter by Bankruptcy Rule 9014.

I should also note that I decided to make this ruling from the bench as quickly as possible rather than draft a full written opinion with detailed references to the record and case citations. The ruling on this issue has implications for various other matters scheduled in this case in the coming weeks. It may not -- this opinion or ruling may not be as polished as it could be or as I might like, but I thought the parties would likely prefer promptness over eloquence.

As I've said on several occasions since this process started, the whole nature of this hearing is very unusual. It is not the determination of liability of Vanguard to the Government. It is not the allowance or disallowance of the Government's claim. It is not an estimation of a claim for voting purposes. Instead, it is, in some respects, an effort to give -- to make an educated guess about how the False Claim Act litigation may turn out many months down the road in a much

lengthier full-blown trial in district court. And that educated guess is being made solely for purposes of determining if the debtor's plan had a feasibility problem in light of the fact that the plan incorporates an assumption that the debtors will largely prevail in that litigation.

Before getting into any specific findings or conclusions, I need to provide some context about the underlying litigation. The government has filed claims against several of the debtors under the False Claims Act. Unless they are resolved, these claims will ultimately be litigated in district court. There are specific claims against the Manchester, Boulevard, and Glen Oaks -- hold on a second.

One thing I left out, a little bit about terminology. Before proceeding, maybe I should mention that whenever I say "debtors" or "Vanguard" for purposes of the hearing, I'm talking collectively about the debtors who filed a joint Chapter 11 plan. The cases have not been substantively consolidated, but there's a joint plan that involves the holding company, which is Vanguard Healthcare, LLC, and various subsidiaries and related entities. So if I refer to the "holding company," I mean Vanguard Healthcare, LLC. When I refer to the "Government," I'm referring collectively to both the United States of America and the State of Tennessee. Even though they have slightly different interests and their claims relate to different federal and state statutes, they're joined

at the hip for purposes of this hearing, and there's no real need to make a distinction between the two for most purposes. I may, from time to time also, refer to the particular facilities, and I generally will not give the formal name but will just refer to the location.

And in that regard, there are several specific claims in the litigation that are against the Manchester, Boulevard, and Glen Oaks facilities and those are still operating subsidiaries of the holding company. Then there are claims in the $60-million range against the holding company and the management arms of the holding company that deal with -- hold -- the management arms that deal with payroll, financial services, and pharmacy services. The larger claims are based on theories that would make the holding company and the management-level entities of Vanguard liable for any of the debt to the Government owed by the individual facility-level subsidiaries that would have liability. That would include the debt from the three subsidiaries that still operate, as well as three others that have since been closed or sold. The primary purpose of the False Claim Act is to indemnify the Government through restitution and penalty provisions against losses caused by a defendant's fraud, in this case, a provider of nursing home services paid with Government funds. To establish a prima facie case under the False Claims Act, the Government must prove first that claims were presented for payment;

second, that the claims were false or fraudulent; and third, that the defendants knew the claim was false or fraudulent.

The Government claims that the Vanguard nursing homes are liable for two types of misconduct. First, the largest part of the claims, which is about 90percent of the alleged total, is based on the allegation that six nursing home provided grossly substandard care making the value of those services worthless. The second part of the claims relate to what can be called signature or certification issues involving those nursing homes. That second part, essentially, has two subparts. One subpart involves the alleged unauthorized use of a nurse's signature on certain admission certification forms at Imperial Gardens and Crestview, and the other subpart relates to use of, at the other nursing homes, photocopied signatures of doctors on another part of the same type of form required to certify that patients qualified for care.

The, quote, "worthless services," unquote, theory of the False Claims Act liability is premised on the single -- on the simple theory that the defendant received reimbursement for services that were so bad as to be deemed worthless. But for that to apply, most courts say that the performance of the service must be so deficient that for all practical purposes, it is the equivalent of no performance at all. It is generally not enough to offer evidence that the date for determining shareholders entitled to provided services that are worth some

amount less than the services paid for. So a worthless services claim asserts that the knowing request of federal reimbursement for a procedure with no medical value violates the False Claims Act regardless of any certification issues. As for the signature of certification claims, the Government basically contends that the rules required a contemporaneous original signature certifying the information in the pre-admission forms, that Vanguard knew the rules, that they -- that there were false certifications made by the use of forged or photocopied signatures, and that the Government paid funds it would not have paid if it had known that the fraudulent activity in the use of forged, unauthorized, or copied signatures used in the initial admission forms process.

Vanguard denies many of the factual allegations in the claims. In addition, a key part of the defense raised by the Vanguard entities is that even if the alleged misconduct could be construed as a misrepresentation or fraudulent, it was not material to the Government's decision to pay. Vanguard argues that there's no evidence that the services should not have been provided or that the patients did not qualify for the care regardless of the precise paperwork utilized in connection with the admission forms.

So how do the False Claims Act allegations play out in terms of feasibility of the plan in Chapter 11? One of the confirmation requirements under the Bankruptcy Code is that

confirmation of a plan is not likely to be followed by the liquidation or the need for further financial reorganization of the debtor except as provided in the plan itself. This feasibility requirement normally comes up in assessing the business prospects of the recognized debtor as opposed to the chances of winning or losing lawsuits. The typical situation this Court sees is where the debtor is proposing a plan that some creditors contend paints an unreasonable rosy picture about what will happen after confirmation from a business or a financial perspective. We may need to deal with some of those more traditional feasibility issues at confirmation, but the narrow issue we have for this hearing involved the exposure of Vanguard in connection with this potential $60-million claim by the Government.

When it comes to the traditional financial business factors, the test normally used is whether there's a reasonable probability that the debtor will be able to make the payments to creditors under the plan that's been proposed. The cases say that the debtor does not have to show that success is guaranteed and that it's not fatal to a plan if there is a possibility of failure. But there must be reasonable assurance of commercial viability based on a realistic and workable framework in the plan. This test is a little harder to apply when you're talking about the potential for success or failure in litigation. There are a fair number of cases around the

country where the feasibility analysis has been applied to litigation, but the majority of those cases deal with efforts by the debtor to bring money into the bankruptcy estate to fund distributions to creditors by winning a lawsuit. In the Vanguard case, the litigation comes up in the context of the likelihood of Vanguard avoiding liability to the Government at a level that would kill the plan.

Even though the test is a little harder to apply in this context, the standard doesn't really change. As the cases indicate, the purpose of the feasibility test is to prevent confirmation of visionary schemes through a plan that makes promises that cannot be kept. The goal is to avoid allowing a plan to be confirmed that makes assumptions that are impractical or not supported by reality. When it comes to litigation specifically, the cases say that success of a plan cannot hinge on an outcome in litigation that is so uncertain and speculative as to render to the results of a plan unattainable. In this case, Vanguard's plan is dependent on being substantially successful in defending the Government claim. So is in that context that the Court is asked to determine if Vanguard's optimism that it will never have to pay any significant claim to the Government is so speculative or uncertain, so impractical and unrealistic, so unattainable based on current information, that it renders the plan not feasible.

In analyzing whether the plan is too speculative or uncertain regarding the debtor's chances of success in this litigation, it's necessary to break the litigation down into parts. From my perspective, the likelihood of success or failure in this litigation varies significantly depending on which part of the claim you're talking about. First, the easiest part, in my mind, relates to the largest part of the claim. The Government asserts a claim of more than $50 million from the worthless care part of the case. With --

(Background noise)

THE COURT: If anyone's on the line that doesn't have their phone on mute, it would be helpful if you would do that.

With one exception I'll discuss in a moment, that part of the case, the worthless care part of the case, is based exclusively on statistics that I found to be very unpersuasive. Basically, we had a Government expert who was told by the Government to make certain assumptions but no evidence about how some of the assumptions were developed. For statistical purposes, a targeted sample instead of a random sample was used, but we have no information on how the sample was selected. Likewise, the expert was told to utilize certain quality measures and risk factors but not others, but, again, we have no evidence about how or why those choices were made. The targeted sample was also extremely skewed with one facility, Imperial Gardens, used in a disproportionate manner

without explanation. In addition, the dates used by -- for the targeted sample were skewed toward certain years with no satisfactory explanation.

In a wide range of ways, the statistical expert accepted assumptions for which we have no proof regarding the validity. Then those assumptions formed the basis to extrapolate statistics to all the facilities involved, including facilities not included in the targeted sample. It's unnecessary for me to go through all the problems for purposes of this ruling today, but I concluded that the evidentiary basis used for asserting more than $50 million in substandard care damages was very weak.

It's important to recognize that it's quite possible that a year or so from now, if the litigation goes to trial, that part of the case will have developed into a much stronger case. Presumably, the ultimate proof presented at trial may not be so dependent on pure statistics and the basis for the assumptions underlying the statistics may be better explained. It is certainly possible that the debtors could end up facing tens of millions of dollars of liability on that broad substandard care theory, but the case, as it was presented to this Court on that point using extrapolated statistical data of essentially origin, is sufficiently weak that I do not think it creates a feasibility problem for the debtors to assume that they will face very little ultimate exposure on that point.

That is not to say that it is a zero risk or that the debtor should not take the claim into account in some manner. Perhaps a prudent plan would factor in some limited potential exposure, but I do not think that this part of the claim that accounts for the largest part of the alleged damages and is tied to the broad statistical proof creates a major feasibility problem by itself.

There's a separate argument made about substandard care that was not tied to statistical evidence or not solely tied to statistical evidence. The Government put on strong evidence of absolutely abysmal care at Imperial Gardens even though I think it takes some fairly unusual evidence to prove that care is so bad that it was essentially worthless under the applicable case law. It's hard to imagine care a whole lot worse than what was described at that one facility. While I do not buy into the statistical argument to support the broad liability across all the facilities involved, the specific evidence that that one facility for a particular period of time in late-2013 to early-2014 is strong enough that I think there's a reasonable likelihood of liability being found on that portion of the claim. And if liability is found in that regard, the number appears to be somewhere in the range of $400,000. If I understand the evidence correctly, the figure could even be a conservative figure since it was based on a small number of patients for only about six months. There may

be the potential for that number to be even higher.

The proof showed that the standard of care at that facility was pretty appalling, so I would not be surprised to see damages assessed at the high end of any range that might ultimately be proved if Vanguard loses on this part of the case. Just as I can't say that there's a zero risk of liability on the statistical part of the substandard care part of the claim, I can't say that there is 100 percent chance of liability on the Imperial Gardens investigated component of the claim. But I believe there's a reasonable likelihood of liability, and I think that liability could be at least $400,000. Failing to account for that very serious contingency is a problem for feasibility.

The assessment of potential exposure on the signature or certification portion of the case, likewise, has varying degrees of seriousness. Maybe this is a good time to make a point about this whole signature and certification issue. The Government loosely used the term "forgeries" with both the nurse signatures and the doctor signatures while Vanguard tried to paint all of these issues as mere paperwork problems or technical glitches. I know the cases are not terribly consistent about where you draw the line on -- in this type of situation when it comes to identifying intent, knowledge, reliance, and other factors. But it seems to me that there could be big differences in the circumstances that could arise

where an original signature of a doctor or a nurse is not obtained.

I do not necessarily accept the proposition that all circumstances of the -- of a missing original signature would be treated the same if this case is fully litigated. On the one hand, you could have a situation where the medical professional actually examines a patient, determines the certification -- that certification is appropriate and contemporaneously agrees that the necessary form needs to be signed but fails to put an original signature on the document rather than someone else signing on his or her behalf or using a photocopy with expressed consent and contemporaneous authorization. Taking that hypothetical to the extreme, you could conjure up a scenario where everything is done correctly except that some substitute for an original signature is used due to some temporary disability of the medical professional in terms of being able to physically sign the document.

On the other hand, you could have the situation where there's no contemporaneous examination, no review of the authorization needed, and merely forged signature or photocopied with, at best, an after-the-fact ratification or rationalization by the medical professional saying that he or should would have signed if asked.

I make that point because I see the nurse signature issues involving Peggy Smallwood (phonetic) as potentially

different from the doctor certification issues. The proof, as it related to the nurse certifications at Imperial Gardens and Crestview, was fairly clear that Peggy Smallwood's authorization was being falsified. More importantly, the evidence indicates that there was no contemporaneous review going on by Peggy Smallwood herself. This did not appear to be merely some technically incorrect method used in affixing her signature but otherwise a proper contemporaneous review and authorization by Peggy Smallwood. And the proof was not limited to what Ms. Smallwood said to the Government investigator, which did raise an evidentiary question, but it was based on other credible proof, as well.

It is certainly not a lock that the Government will win on the claims tied to Peggy Smallwood's signatures, but based on the evidence I heard, I think it is unrealistic for the debtors not to assume that there is serious exposure on those claims. The exposure on those claims is in the range of 1.2 million, lower if you do not accept certain aspects of how the Government has calculated civil penalties but much higher if the Government could convince the district court to impose the maximum civil penalties. I think the chances of the Government succeeding on that part of the case are fairly significant. Therefore, I also think that the likelihood of the debtors walking away without a claim is sufficiently speculative and uncertain that a plan that fails to do with

that -- with those claims in a practical way has a feasibility problem.

The doctor's signature photocopy claim -- the issue relating to the doctor's signature photocopied that involve Boulevard, Glen Oaks, Manchester, and Poplar Point is much more complicated. There are a couple of key aspects to those claims. One is whether the district court buys into the argument that there was some legitimate confusion about whether it was okay to use photocopies of a signature. The impact of ambiguity in the rules is an important factor in some of the cases that I've seen, and the proof is not terribly clear on that point in the limited hearing conducted here. There was some indication that other nursing homes owned by other companies were using similar practices as Vanguard and that the methods used by Vanguard were not that unusual.

But even if the district court accepts the proposition that there was ambiguity or confusion about the need for original signatures, I don't think the debtors could necessarily avoid liability unless the district court also believes that each of the doctors consistently met all the requirements for admitting patients and gave contemporaneous approval for adding the photocopied signatures. In other words, I don't think the case law supports the idea that you can just claim no harm, no foul after the fact. I don't think it will likely work to just say the patients were sick and the

services were rendered if there is really a fatal flaw in the admission process and there was not the level of review and authorization required by statute and rules.

But I also think that the Government is not likely to prevail if it turns out that the only defect in the -- is the mere use of photocopied signatures rather than an original if the overall process used by the facilities was otherwise proper. The Sixth Circuit decision in MedQuest Associates a few years ago provides a strong message that the False Claims Act should not be a, quote, "vehicle to police technical compliance with complex federal regulations," unquote. So overall, the exposure here is extremely fact-specific as it relates to the doctor signature issue.

Unfortunately, the limitations of this hearing were such that it was impossible to get a firm grip on how this might turn out. Vanguard attempted to supplement the evidence by adding declarations from the doctors, but that was after the proof had closed, and I am not considering that evidence in this opinion. But even if I did accept the declarations as evidence, I don't think it would be determinative. That's because I don't believe that broad, conclusory, self-serving statements would carry the day when this goes to trial. I think how this issue turns out in district court would depend very much on the credibility of the witnesses, the level of detail provided by the individual doctors, and how they handled

cross-examination. Based on the limited evidence I heard, I think the edge may go to Vanguard. But ultimately, I think there might be different results from one facility to another, from one doctor to another, from one period of time to another, or even from one patient to another.

Given the limited evidence I have on this at this time, my best guess is that there is a reasonable chance of the debtors avoiding liability on this part of the case, but there is also much more than merely a nominal chance of losing this part of the case. In that regard, it may not be necessary for the debtors to have a plan that assumes certainty of needing to pay the Government the full amount of this portion of the claim, but a plan that fails to recognize a material risk of losing or having to pay at least some portion of this component of the claim has a problem from a feasibility standpoint.

As it relates to the doctor photocopied signatures, we have numbers indicating potential exposure in the range of 4.7 million. I recognize that the maximum civil penalties would make that number much larger under the Government's theory and that the debtors contend that each reimbursement should not be treated as a separate claim for civil penalty purposes. I think the chance of the debtors losing on the doctor certification issue is less than on the nurse certification issue, so any reasonable analysis of how to provide for that contingency in the plan involves something

more complicated than merely adding together the numbers of potential liability. The -- both of those potential claims, as well as the substandard care claim involving Imperial Gardens, dictate that the plan seriously deal with the prospect of having to pay the Government some allowed claim.

I started out today by pointing out that the hearing was not a determination of liability or the liquidation of any particular claim amount. It is not necessary and probably not really possible to put a precise number on the dollar exposure that the debtors have from the Government litigation. However, it is also impossible to provide any real guidance for the parties about feasibility without talking about dollar figures. If I conclude that the False Claim Act potential liability is a problem for feasibility, as I do, it makes no sense to leaves the debtors guessing about my view on how significant the Court considers that problem. Obviously, at one end of the spectrum, zero liability would have no impact on the plan, whereas, at the other end of the spectrum, the claim of about $60 million would certainly doom it to failure. Based on the evidence as I've explained today, I think it is somewhat of a sliding scale in terms of significance of risk to the debtors ranging from low risk on the statistical part of the case to higher risk on the nurse certification part and the Imperial Gardens part and with the doctor certification component falling somewhere in between.

There is no formula to this, but when I consider these various components of the litigation and think through the strengths and weaknesses of each part of it, I come to the view that there's a feasibility problem with any plan that does not seriously deal with at least $5 million in potential liability to the Government. That's less than 10 percent of the total alleged claim asserted by the Government, but it's still a significant number for these debtors. Overall, I think the Government is taking an extremely aggressive approach in asserting $60 million in damages, particularly when there are numerous court decisions that would call into question major elements of their damage analysis.

However, despite my skepticism about some of the Government theories in light of the evidence presented to this Court, I also think that it is unrealistic to think that the debtors can somehow manage to win across the board on all the various theories and walk away from $60 million in this Government lawsuit with no allowed claim to deal with in their plan. Likewise, if you were trying to place some value on this litigation exposure for some other reason, whether it be for settlement efforts, financial disclosures, insurance purposes, or otherwise, it would not be logical to me to simply assume the debtor wins every part of this litigation. Not providing in some practical way for something at least in the range of $5 million just does not seem realistic.

The interesting thing is that page 26 of the debtor's disclosure statement indicates that the debtor has considered -- considered the maximum exposure to the Government to be $5 million. So my guess about exposure is not necessarily that different from the debtors. The problem was that elsewhere in the disclosure statement the debtors also gave the maximum exposure for all the disputed claims at that same $5-million figure. The exhibit to the debtor's disclosure statement showing projections for payments to unsecured creditors was based on about 9.8 million being paid, which did not include any of the disputed claims, those for the Government, CCP Mustang, disputed claims that have been subsequently settled, or any of the other disputed claims. However, the text of the disclosure statement did indicate that the debtors could potentially handle up to $5 million more in payments, presumably from accumulated cash, but the debtor said this would leave, quote, "no margin for error."

The revised projections included with the debtor's post-petition brief have increased the anticipated payments to unsecured creditors to about 14.8 million, thus increasing the amount by the $5 million referenced in the earlier version of the disclosure statement and thereby substantially decreasing accumulated cash during the course of the plan. It's hard to know how seriously to take these new projections since they were not part of the evidence and not part of the disclosure

statement already approved by the Court. But aside from those concerns and the fact that the debtors have already said that paying this additional $5 million amount would be pushing the envelope, the problem with the math is there.

And here's how I understand the math. The CCP Mustang claim and other previously disputed but now settled claims already total 5.7 million. If the debtors were to provide for the potential payment of a minimum of $5 million on the Government claim based on the analysis I've explained today, the plan is at least 5.7 million in the hole. If as much as half of the other disputed claims are ultimately allowed, the deficiency would be about 7.5 million. If most of the remaining disputed claims are allowed, the shortfall could be in excess of 9 million. So the debtors have a plan based on the revised projections that calls for payment of unsecured debt of about 14.8 million while the plan arguably needs to provide for payment of at least 20.5 million and potentially up to nearly 25 million, depending on the outcome of the other disputed claims.

I recognize that this analysis may be oversimplified since it does not take into account how the debtors might choose to deal with a subordination issue that comes into play with CCP -- with the CCP Mustang claim. But there does not seem to be any easy way around the fact that the $5-million maximum contingency amount anticipated under the current plan

for all disputed claims should probably be at least double that amount and potentially up to triple that number. And of course, even that assumes that the debtors can avoid liability on more than 90 percent of the Government claim.

Probably the most important question is not the number I place on the realistic exposure of any of the facilities but whether the holding company can be hit with the liability for cumulative exposure of those individual facilities. Without liability at the holding company level, the entire outcome of this hearing is arguably of limited significance. One facility, Imperial Gardens, has been shut down for three years and will probably never pay any creditors anything. Two facilities, Crestview and Poplar Point, have been held free and clear of claims and will likely end up with very limited distributions to creditors.

In short, if liability is limited to the facility level, the Government would likely be paid very little based on the subsidiary level liability of three of the six nursing homes involved. Further, it appears that about two-thirds of the dollar exposure we're dealing with applies to those three facilities that have already been sold or shut down. Therefore, in the absence of liability at the holding company level, the majority of the Government claims becomes just a theoretical exercise about assessing hypothetical liability on uncollectible debt. The other three facilities involved are

still operating in the Vanguard system and are covered under the Chapter 11 joint plan and could potentially generate the necessary amounts to service the debt if the levels are low enough.

But if there is no exposure beyond the facility level, Vanguard would have other options regarding those three facilities as well. It could shut down or sell one or more of those facilities if the numbers can't be made to work. In fact, the plan is proposed currently in such a way that it makes it clear that the related companies will not assume the False Claims Act liability of any of the -- of any of the other entities. A problem with any single facility being unable to service a government claim would not necessarily render the whole plan unconfirmable as long as Vanguard does not have to worry about exposure at the holding company level. It is only if the collective liability of all six facilities is also placed on the holding company and the management company level that it has much broader implications for the plan. In that case, you have alleged exposure of around $60 million with this Court concluding today that it's too speculative not to have a mechanism to handle at least 5 million of that exposure.

If the holding company, which is retaining its ownership of all the nursing homes in bankruptcy, is also liable for debt to the Government of the subsidiaries, it effectively means that the joint plan must show that the full

amount of the allowed Government claims can be satisfied and the majority of the claim cannot simply be disregarded because certain facilities are no longer part of the Vanguard system. With holding company level liability, that would mean that there's not merely a possible absolute priority rule question that comes into play regarding retention of ownership of some of the facilities, but instead there's a -- would be a direct exposure by the holding company for the Government claims tied to all six facilities.

The Government had two theories for making the holding company and the management entities liable. One was basically that they were so involved in directing the decisions relating to patient care that the particular facilities -- at the particular facilities that they should be responsible. The evidence of that was not very strong, and I think the Government has an uphill battle to win on that basis. The other theory is a traditional alter ego approach tied to the structure of the enterprise and financial entanglement of the many related entities. The proof there is fairly significant in volume but somewhat limited in quality. But that I mean simply that there are numerous factors cited that could possibly support an alter ego approach, but there are only a limited number of factors that are potentially compelling enough to differentiate it from any other small businesses enterprises that have multiple entities with common ownership

and shared management capital and financing. There's several factors that ultimately cause me to conclude that there is a real risk of alter ego exposure.

If the case were decided today by the district court based on the limited evidence presented at the hearing that occurred here, that issue might very well go in favor of the debtors. However, it is not being decided today by the district court and I think I have to be realistic about how things may develop by the time the case is tried. Even though I have tried to limit my consideration of the evidence to the proof actually presented at the two-day hearing, it is impossible for me to totally ignore my feel for the case after being involved in a wide range of hearings over the past year. Indeed, I think it would be a disservice to the parties for me to completely ignore what I know about the debtors in this regard even though there were restrictions on the evidence specifically presented at the hearing.

And my impression from the experience, in this case, is that ultimate -- that the ultimate evidence presented to the district court at trial could easily get worse instead of better for the debtors as it relates to the alter ego issue. It may not turn out that way, but there's a lot of grist for the mill as it relates to some of the issues that have been raised by the Unsecured Creditors Committee about the manner in which various lease and financing transactions were handled

over the years. Some of the arguments being made in connection with other aspects of confirmation and pre- and post-petition financing could provide ammunition for the Government by the time this case is tried in district court. Unless there is a consensual resolution of this case, some of the proof that develops in the related proceedings could easily be used against the debtors in the alter -- on the alter ego issue.

Alter ego findings are extremely fact specific and in many instances tied to credibility findings where there is a good bit of discretion. And since I think the proof indicates that it could ultimately become a close call on the alter ego issue, particularly if more evidence is developed through discovery, I frankly think that a close call could end up going against the debtors in a case of this type. In the end, I do not believe it is realistic to assume that the debtors can keep liability at below 10 percent of the alleged Government chest claims and also shelter the holding company from even having exposure on that relatively small amount. In other words, it may not be too speculative to provide in the plan for a Government claim in the range of $5 million rather than 60 million, but I think it is a bridge too far to also assume that even the smaller number can be limited to the facility level and that the holding company can be sheltered from any financial exposure whatsoever.

So I come down on the side of believing that the

debtors need to face the fact that the holding company stands a sufficient chance of exposure at that same $5-million level and that any plan needs to deal with this possibility and not merely assume that the holding company can escape unscathed. The chance of alter ego liability is at least serious enough that it creates a feasibility problem to simply assume that any liability under the False Claims Act could never end up affecting the holding company.

So what does all that mean for feasibility under the plan? Probably much to the disappointment of everyone here, I'm not sure I can say with absolute certainty what this means other than that I do not believe the plan can be confirmed as is. Whether it could be modified in a way that would make it workable, I'm not sure. I'm also not sure whether any modification would be so substantial as to require a new disclosure statement and confirmation process. Based on what is currently in the plan, the math doesn't work. Liquidated disputed claims already exceeded the $5-million level before we started the False Claims Act hearing, and now I have concluded that a failure to provide a mechanism to cover a loss to the Government of at least an additional $5 million is a serious problem.

Where does that leave us? I think the debtor is going to have to regroup and consider their options. I'm not going to attempt to dictate what the debtor should do or

predicate what the debtors will do to deal with this problem. I'm not in a position to know what contingency plans the debtors may have in mind, whether that might be some infusion of capital from some third party, the sale of additional facilities, a different time table for payment to creditors, or some other possible approach. In light of everything going on in this case, and particularly considering the cash collateral issues that are tied to the current plan process and the recent additional order dealing with the Shady Lawn transaction, I think it is critical to address the status properly. That's particularly true as to whether the debtors believe that a reorganization is possible, whether amendments to the plan will be made, and whether any change in the current schedule will be necessary.

Obviously, if the debtors were to decide that my ruling today totally destroys the chance of reorganization and the debtors need to move to a liquidation mode, we would have one set of issues. At the other end of the spectrum, if the debtors believe they can make a few plan modifications and still proceed on the current schedule, we will need to see if the other parties are in agreement to stay on that time track or whether they contend that a new disclosure statement process, voting, and objection period is required. If there is a different time period necessary, then it has implications for various issues relating to the secured lender, cash collateral,

the Shady Lawn transaction, and perhaps other matters.

Rather than me dictating some time table, I want all the key players to talk and see what -- if there's any consensus about the next step. I would encourage some discussions among at least counsel for the debtors, the Committee, the secured lender, and the Government. I'm not available for an in-person hearing next week, but I'll try to make myself available otherwise, to the extent possible, to consider any approach that might be suggested, whether that be some type of status conference, scheduling conference, or if a hearing is needed to address any dispute about what comes next. As I indicated earlier, I'll be entering a brief order that incorporated by reference my findings from the bench. That concludes my ruling.

Does anyone have any questions at this point?

UNIDENTIFIED: No. Thank you, Your Honor.

THE COURT: All right. If there are no questions, we will be adjourned.

THE CLERK: All rise.

(Proceedings concluded at 2:23 p.m)

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C E R T I F I C A T I O N

I, Sara Winkeljohn, court-approved transcriber, hereby certify that the foregoing is a correct transcript from the official electronic sound recording of the proceedings in the above-entitled matter.

/s/ Sara Winkeljohn

SARA WINKELJOHN, AAERT NO. 808 DATE: July 14, 2017

ACCESS TRANSCRIPTS, LLC

C E R T I F I C A T I O N

I, Lisa Luciano, court-approved transcriber, hereby certify that the foregoing is a correct transcript from the official electronic sound recording of the proceedings in the above-entitled matter.

Lisa Luciano

LISA LUCIANO, AAERT NO. 327 DATE: July 18, 2017

ACCESS TRANSCRIPTS, LLC