AMERICAN BANKRUPTCY INSTITUTE

2017 Southeast Bankruptcy Workshop

What's Next in Health Care? Challenges for Providers and Opportunities for Restructuring Professionals in an Ever-Changing Landscape

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CONCURRENT SESSION

2017

American Bankruptcy Institute
22nd Annual Southeast Bankruptcy Workshop
July 27-30, 2017
Hilton Head, South Carolina

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Why Healthcare Bankruptcies are Different From Other Bankruptcies

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WHY HEALTHCARE BANKRUPTCIES ARE DIFFERENT FROM OTHER BANKRUPTCIES

Healthcare bankruptcies play out in a highly complex and highly regulated industry and are overlaid by the unique rules that apply to companies in bankruptcy. They almost always pose difficult problems, especially for those unfamiliar with the issues that arise in the bankruptcy of a healthcare entity. The following is a broad overview of certain key issues that make a healthcare bankruptcy different from all other bankruptcies.

I. The Oversized Role of Federal and State Governments

Federal and State Governments are enormous players in healthcare bankruptcies. In a typical Chapter 11 bankruptcy, the major parties tend to be the debtor, the secured creditor (or first and second lien creditors), and the Committee. In a healthcare bankruptcy, federal and state governments tend to have a role that outweighs all of these traditional parties.

Federal and state governments wear multiple hats in healthcare bankruptcies, including as payors, creditors, and regulators. These roles can be intertwined and confused at various points throughout the case. Disputes with the Centers for Medicare & Medicaid Services ("CMS") can frequently be the most pressing, if not case dispositive, issues in a healthcare bankruptcy.

The first issue one must be aware of are the jurisdictional challenges/limits which can arise from the interpretation of 42 U.S.C. § 405(h), which requires that a federal courts may take jurisdiction over Medicare disputes only after a party exhausts applicable appeal processes within the Medicare system. There is a circuit split regarding the plain language and the bankruptcy courts' jurisdictional limitations because 405(h) only references sections 1331 and 1336 of title 28 of the United States Code, and does not refer to section 1334 of title 28 (which grants bankruptcy court jurisdiction). The Ninth Circuit in In re Town & Country held that bankruptcy courts are not limited by section 405(h) while in a 2016 decision in In re Bayou Shores the Eleventh Circuit held that bankruptcy courts are barred from proceeding by section 405(h). There is a petition for cert pending at the US Supreme Court in Bayou Shores, and this issue is also pending before the Sixth Circuit.

Medicare is a major source of funding to the debtor in most healthcare bankruptcies, and, assuming the debtor is experiencing financial distress, the debtor is highly likely to have disputes with CMS regarding payment and other issues early in the bankruptcy case. If the bankruptcy court cannot step in and resolve these disputes, the debtor may be left with no effective remedy. Outside of bankruptcy, the Medicare appeals process is, simply, broken. Currently, HHS admits to there being over 600,000 appeals pending even though the Office of Medicare Hearings and Appeals is only staffed to resolve about 92,000 appeals annually. And HHS projects the number of appeals will rise 3% by the end of 2017 (to just over 687,000) and will rise to over 1 million claims by the end of 2021. Despite pending lawsuits by the American Hospital Association and others to compel HHS to address this issue (there is a statutory 90 day time limit for resolving these appeals which is, obviously, not being met) HHS says that it cannot cut the backlog because of "current funding and legislative authorities." This is not going to get better in the current political climate.

II. The Provider Agreement as a License or Contract?

The relationship between the Medicare or Medicaid programs and the providers of healthcare goods and services is captured in a document commonly referred to as a "provider agreement." Controversy arises when the Debtor seeks a sale of assets because to maximize value the buyer frequently wants to acquire the provider agreement. The provider agreement is a key asset of the seller in a healthcare transaction. By transferring the provider agreement as part of the sale, the buyer is ensured the uninterrupted continuation of payments by the government to the buyer.

Provider agreements often have associated liabilities. A key liability associated with a provider agreement is overpayment liability. Essentially, overpayment liability is when Medicare and Medicaid audit payments made to a provider under the provider agreement going back years and determine the provider has been paid too much. In that instance CMS will want to set off or recoup future payments to recover the overpayment. If a debtor has experienced significant financial distress, the overpayment liability associated with the provider agreement may be so severe (or unknown) as to preclude a sale of the debtor's assets.

Where a debtor seeks to assign its provider agreement in bankruptcy, the government argues that the buyer of a provider agreement takes successor liability for any overpayments made to the seller and, perhaps, even for fraud committed by the seller. Needless to say, buyers are either reluctant to acquire assets in these circumstances, or greatly reduce the purchase price to accommodate this risk. Thus, the treatment of these provider agreements in a bankruptcy proceeding can be controversial and vital to the success of a bankruptcy case involving a sale of assets.

The Government's position in bankruptcy cases is that the provider agreements are an executory contract, which means that defaults must be cured if assumed and that the buyer takes the assignment of the provider agreement *cum onere*. The debtor's preferred position would be that the provider agreement is a license, which can be sold free and clear of successor liability under section 363 of the Bankruptcy Code. This is a controversial issue because outside of bankruptcy the Government argues -- and is uniformly successful -- that the provider agreement is not a contract. Since the Bankruptcy Code does not define what is a contract, and because applicable non-bankruptcy law should control, it is hard to fathom why the filing of a bankruptcy petition should alter a document that is not a contract before the petition is filed, into a contract after the petition is filed. To the contrary, judicial estoppel should apply. This issue is often hotly litigated in healthcare bankruptcies.

III. Setoff and Recoupment by the Government

Outside of bankruptcy, the federal and state government and their contractors routinely withhold Medicare and Medicaid payments when they determine that a healthcare provider has been overpaid. However, section 362 imposes an automatic stay on creditors' efforts to collect on prepetition obligations of the debtor or to exercise control over property of the estate. These withholdings can be characterized as either setoff or a recoupment. The Bankruptcy Code imposes strict rules on a creditor seeking to set off monies owed to a debtor against a claim against the

debtor, but imposes no such restrictions on a creditor with a right of recoupment. While setoff is subject to the automatic stay and requires a creditor to obtain court approval, recoupment is not subject to the automatic stay and does not require court approval.

There is currently a split in the circuits on the scope of what is allowed recoupment. In In re University Medical Center the Third Circuit held that Medicare's recoupment rights were limited to the overpayments and ongoing payments in the same cost report year. However, the Ninth Circuit in TLC Hospitals held that Medicare's recoupment rights were not so limited, and other circuits have agreed with the Ninth Circuit. Another interesting issue is the scope of what is applied as recoupment. Recoupment is meant to be limited to offsetting obligations arising out of the "same transaction or occurrence." However, the state and federal governments will frequently assert that any obligations remotely tied to the Medicare and or Medicaid programs are subject to recoupment against ongoing payments under those programs for patient care.

IV. Allegations of Healthcare Fraud

The False Claims Act (31 U.S.C. §§ 3729–3733) applies to healthcare businesses and there is a widely held perception that the healthcare industry is full of "fraud, waste and abuse." Since the implementation in 1996 of the Health Care Fraud and Abuse Control Program under the joint control of the Secretary of HHS and the Attorney General there has been an ever increasing effort to deal with the perceived fraud against the Medicare and Medicaid programs. The result has been impressive: in FY 2016 the US Department of Justice opened 975 new criminal health care fraud cases, and 930 new civil health care fraud investigations. As of the end of 2016 DOJ had over 1400 civil healthcare fraud matters pending. The financial impact is significant: in FY 2016 the Government won or negotiated over $2.5 billion in healthcare fraud judgments or settlements. As a result of these efforts and the culmination of prior year's efforts, over $3.3 billion was paid to the Government from participants in the healthcare industry. In total, since 1997, this program has "recovered" over $31 billion from the healthcare industry.

Many of these the False Claims Act cases are filed under seal, and the defendants do not know the law suit is pending, sometimes for years. However, filing a bankruptcy petition can "flush out" these law suits. First, although such litigation would usually be subject to the automatic stay imposed by section 362(a), which includes a stay of pending litigation, section 362(b)(4) of the Bankruptcy Code exempts acts by the government to enforce police or regulatory powers. False Claims Act are generally treated as exempt from the automatic stay as an exercise of a police or regulatory power. However, if the Government wants to get a distribution as a result of the False Claims Act case, it is still required to file a proof of claim to obtain payment. This can result in the disclosure of previously unknown liabilities. Additionally, section 502(c) of the Bankruptcy Code permits a bankruptcy court to estimate a claims for the purposes of allowance of the claim as to amount, voting on a plan, feasibility of a plan, and distributions under a plan. Thus, once a law suit is disclosed, the debtor can seek a quick resolution of its liability for that law suit, and do so in a forum much more favorable than the federal district court.

V. Medicare Cost Reports

Tied directly to the government's ability to withhold Medicare and Medicaid payments is the Medicare-certified institutional provider's obligation to file an annual Medicare Cost Report (MCR) with a Medicare Administrative Contractor (MAC). The MCR contains provider information such as facility characteristics, utilization data, cost and charges by cost center, in total and for Medicare, Medicare settlement data, and financial statement data. This data is used by the Centers for Medicare and Medicaid Services (CMS) to determine, among other things, whether a provider has either been overpaid or underpaid by the government.

It the bankruptcy context, especially where a health care facility is being managed and/or sold, negotiating which party is responsible for all or a portion of these overpayments or underpayments is significant given that the amounts in question can exceed millions of dollars.

To add additional complexity to the analysis, certain post-petition revenues received from the CMS - such as Inpatient Prospective Payment System payments (IPPS), disproportionate share payments (DHS), periodic interim payments (PIP) and uncompensated care payments (e.g., charity care and bad debt) - may take into account the provider's pre-petition statistical data thereby increasing the likelihood of overpayment liability. Because these overpayment/underpayment amounts are determined from the MCR, the parties will want to engage a qualified cost report consultant to examine these issues before the sale documents are finalized.

Below are a few other important facts about MCRs:

- MCRs must be filed on or before the last day of the fifth month following the close of the cost report period and certified as being true and correct by the facility's officer (or, in the case of a bankruptcy filing, by the appointed Trustee of the Estate). Fraudulent execution of appropriate certifications can lay the foundation for a prosecution by relators or the government under the False Claims Act, 31 U.S.C. § 3729(a)(2). The Provider Reimbursement Manual (PRM) Part 1, Chapter 24, Section 2409.A(2) states that when a MCR is filed indicating an overpayment, a full refund should accompany the cost report submission. However, if a provider has filed for bankruptcy, the provider must notify the MAC for coordination with CMS.

- Once filed, the MAC, using CMS's "Acceptability Checklist", has up to 30 days to accept the MCR as being filed. Thereafter, it may take 12 to 18 months for the MCR to be reviewed at which point the MAC will issue a Notice of Program Reimbursement (NPR) where the provider will either (1) receive money from CMS (for underpayments) or (2) be required to repay any amounts overpaid. For the latter, the provider can either request that the file be reopened or administratively appealed through the Provider Reimbursement Review Board (PRRB).

- Either the provider or CMS can request that a MCR be reopened within three years of the date that the NPR was issued. However, if fraud or similar fault is involved, the MCR can be reopened at any time.

- All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have a National Provider Identifier (NPI), a 10-digit number which is unique to each provider. Upon application to a MAC, the provider or supplier will also be issued a Provider Transaction Access Number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI and is generally limited to a provider's communication with their MAC.

- A provider must enter into an agreement (commonly referred to as a "Conditions of Participation") with CMS and have an NPI in order to submit bills to and receive payments from CMS.

- In the event of a provider's change of ownership or control (CHOW), if the new owner assumes ownership of the former owner's NPI, the new owner accepts the terms and conditions (and liabilities) under which the NPI was originally issued and will receive a "tie-in notice" from CMS. In addition, the MAC will continue to adjust payments to the provider to account for prior overpayments and underpayments even if they relate to services provided before the sale/transfer.

- If the buyer rejects assignment of the NPI (and its provider agreement), the buyer must file a new application to participate in the Medicare program. The buyer cannot bill or collect for services it provides until CMS issues the new NPI. Therefore, it is imperative that the buyer and seller negotiate any payment arrangements (and liabilities for overpayments/underpayments) for services furnished during the CHOW processing period.

- More likely than not, a distressed health care facility has already entered into an extended repayment plan (ERP) with CMS. ERPS are typically used when a provider needs longer than 30 days to repay the full amount of an overpayment. One advantage of an ERP is that, once executed, CMS will not withhold interim payments (unless the interim payments are currently being suspended or withheld for another outstanding overpayment or investigation).

Medicare and Medicaid payments to health care entities constitute a significant percentage (e.g., 50% to 75%) of their revenue. Because distressed health care entities often incur Medicare overpayments (both pre- and post-petition assuming the entity has filed for bankruptcy protection) and continue to receive revenues from a variety of Medicare sources (IPPS, DSH and PIP), what CMS will do with respect to these claims is a significant concern for buyers and sellers alike. For example, can CMS withhold post-petition payments to collect pre-petition overpayments? What happens if CMS chooses to reopen a provider's prior year MCR and make additional adjustments? These issues are complex and involve a myriad of conflicting laws. Therefore, the parties will want to engage a qualified cost report analyst as part of the negotiating team and reach an agreement on their respective obligations in advance of the execution of the transaction documents (and approval of the bankruptcy court, if applicable).

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Retention and Destruction of Medical Records for Health Care Businesses in Chapter 7, 9 and 11 Cases – Why Section 351 Does Not Work

Another often-overlooked issue in health care provider bankruptcies is managing and paying for the retention and destruction of the provider's medical and other non-medical (e.g., business, accounting, corporate, personnel/employment) records.

Both State-specific and Federal (e.g., the Health Insurance Portability and Accountability Act of 1996 (''HIPAA'') and the Health Information Technology for Economical and Clinical Health ("HITECH")) laws govern medical record retention and destruction; therefore, attorneys must (1) familiarize themselves with the applicable law for each state and (2) default to the Federal or State provision which requires the record to be maintained the longest period of time since there is no Federal vs. State pre-emption. In most instances, however, the general rule is that hospital medical records for adults should be retained for at least six years after the patient's most recent discharge.[1] Minor patients' records are handled differently; they should be maintained until the patient reaches 23 years of age (or five years after the age of majority which, in most states, is 18 years of age).[2]

Bankruptcy counsel and judges may believe that Section 351 of the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, 11 U.S.C. §351, provides sufficient relief. This section dictates a notice and disposal procedure for patient records in Chapter 7, 9 and 11 cases filed by a "health care business"[3] if the estate lacks the funds "to pay for storage of patient records in a manner required under applicable Federal or State law." As such, the trustee or debtor-in-possession is required to retain patient records for at least 365 days after publication of a notice that the records will be destroyed if not claimed by the patient or an insurance provider.

In addition, during the first six months of that period, the trustee or debtor-in-possession must attempt to directly notify each patient and the patient's insurance carrier by mail. Upon expiration of the 365-day notice period, the trustee or debtor-in-possession must then by certified mail request permission from "each appropriate Federal agency" to deposit the patient records with that agency – although Section 351 does not specify the appropriate Federal agency and does not require the

[1] This time period for maintaining certain hospital medical records for adults is generally six years; however, if the hospital owns a physician practice (as most hospitals or health systems do), that physician's medical records for adult patients will likely need to be retained for a longer period of time. For example, in Georgia, the law requires such a record to be maintained for at least ten years. *See* O.C.G.A. § 31-33-2. *See also* AMA Policy E-7.05.
[2] See, e.g., Ga. Comp. R. & Regs. 111-8-40-.18.
[3] The Bankruptcy Code, 11 U.S.C. §101(27)(A), defines ''health care business'' very broadly to include ''any public or private entity,'' for-profit or not-for-profit, ''that is primarily engaged in offering to the general public facilities and services for: (1) the diagnosis or treatment of injury, deformity, and disease; and (2) surgical, drug treatment, psychiatric and obstetric care.''

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agency to accept the records. Only if the Federal agency does not grant the request may the trustee or debtor-in-possession proceed with destruction of patient records by shredding or burning for written records or, if the records are stored electronically, by making the records irretrievable. Finally, the debtor must retain proof of its compliance with the destruction procedures and file a report with the court detailing the process.

The costs incurred in notifying patients of the impending destruction of their records, and in destroying the records, are entitled to administrative expense priority.[4] Depending on the size of the health care business, these expenses may total millions of dollars. If the debtor is administratively insolvent, the costs of destroying these records could potentially be surcharged against a secured lender's collateral.[5]

Health care businesses (particularly hospitals) usually maintain hundreds of thousands of records both in written and electronic formats. Often, these records are kept in off-site storage facilities and managed by third-party contractors who will likely have significant pre- and post-petition balances owing. Therefore, access to and obtaining an accurate inventory of these records becomes an immediate issue. Given the estate's limited financial and human resources, the ability to notify each patient before the record can be destroyed, as Section 351 mandates, is cost prohibitive, logistically challenging and, to a certain extent, administratively impossible.

To ease the financial and administrative burden on the estate, the trustee or debtor-in-possession should:

1. Obtain an accurate listing of all medical, financial and other records as early in the bankruptcy process as possible.

2. Identify the location of the records and any third-party vendors who maintain custody of the records.

3. Identify any pre- and post-petition amounts owed to the records vendors and the vendor's cost to maintain the record in either a paper or electronic format.[6]

4. Review the applicable State and Federal law addressing record retention and destruction of such records.

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[4] 11 U.S.C. § 503(b)(8)(A).
[5] *See* H.R. Rep. No. 109-31, at 139 (2005).
[6] While scanning, destruction and storage costs will vary depending on the vendor and the condition of the record, the cost to destroy a banker's box of records generally ranges between $7 to $10 per box. In addition, a banker's box typically holds a maximum of 2,400 pages and vendors will charge between $0.5 to $1 per page to scan.

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5. Attempt to sell all of the records to the purchaser of the assets (and include a representation and warranty in the purchase documents that the purchaser will maintain the records in accordance with the law and grant the estate access on an as-needed basis).

6. For records which are not sold to the purchaser and which are not eligible to be destroyed:

    a. Determine whether it is more cost effective to have the record scanned to a disk or maintained in a paper format; and

    b. Negotiate with the purchaser whether it is willing to store or maintain the record for a fee.

While Section 351 may appear to be the panacea for handling health care business records, its statutorily mandated patient notification procedures render the law ineffective for addressing the cost and sheer volume of records at issue. A more effective approach would be for Section 351 to prescribe a less complicated notification process (e.g., the local newspaper and the entity's website); however, this prescription requires that either the statute be amended or Federal regulations are promulgated which specify less-onerous forms of notification and immunity for the estate/trustee that following Section 351 preempts an action (by the government or a private party) under any other State or Federal law.

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What's Next in Health Care? Challenges for Providers and Opportunities for Restructuring Professionals in an Ever-Changing Landscape

Industry Perspective on Distressed Asset Investment

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The author's views are personal and not attributable to HealthSouth Corporation or its affiliates.

Forward-Looking Statements

Statements contained in this presentation that are not historical facts, such as those relating to the likelihood, timing and effects of any acquisition, joint venture or other development project, are forward-looking statements. In addition, HealthSouth may from time to time make forward-looking public statements concerning the matters described herein. All such estimates, projections, and forward-looking information speak only as of the date hereof, and HealthSouth undertakes no duty to publicly update or revise such forward-looking information, whether as a result of new information, future events, or otherwise. Such forward-looking statements are necessarily estimates based upon current information and involve a number of risks and uncertainties. HealthSouth's actual results or events may differ materially from those anticipated in these forward-looking statements as a result of a variety of factors. While it is impossible to identify all such factors, factors which could cause actual results or events to differ materially from those anticipated include, but are not limited to, the regulatory review and approval process; any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings that may be brought by or against HealthSouth or any potential development partner or counterparty; the possibility any project will experience unexpected delays; the ability to successfully complete and integrate any acquisition consistent with HealthSouth's growth strategy, including realization of anticipated revenues, cost savings, and productivity improvements arising from the related operations and avoidance of unforeseen exposure to liabilities, including cyber or privacy security breaches; changes in the regulation of the healthcare industry at either or both of the federal and state levels; competitive pressures in the healthcare industry and HealthSouth's response thereto; the ability to maintain proper local, state and federal licensing; potential disruptions, breaches, or other incidents affecting the proper operation, availability, or security of HealthSouth's or any of its partner's information systems; the ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages and the impact on labor expenses from potential union activity and staffing shortages; changes, delays in (including in connection with resolution of Medicare payment reviews or appeals), or suspension of reimbursement for services by governmental or private payors; general conditions in the economy and capital markets; and other factors which may be identified from time to time in HealthSouth's SEC filings and other public announcements, including HealthSouth's Form 10-K for the year ended December 31, 2016 and Form 10-Q for the quarter ended March 31, 2017.

I. HealthSouth Corporation is a leading provider of post-acute care. Patients leaving an acute-care hospital may be discharged to a number of settings, based on their acuity and healthcare needs, including (in descending order of acuity):

- Hospice.
- Long-term acute care hospitals.
- In-patient rehabilitation facilities.
- Skilled nursing facilities.
- Home health.

HealthSouth is the nation's largest owner and operator of inpatient rehabilitation facilities (IRFs) and the fourth-largest provider of Medicare-certified skilled home health services. As of March 31, 2017, HealthSouth owns and operates 123 hospitals in 31 states (including Puerto Rico) and 193 home health agencies in 25 states. The home health segment also owns and operates 35 hospice locations.

IRFs are fully-licensed hospitals, but do not have emergency rooms or intensive care units. IRFs provide physicians to oversee the patient's rehabilitation program and to manage and treat medical conditions. IRFs are fully-staffed, around the clock, with nurses that provide personal care and oversee treatment plans. Physical, occupational and speech-language therapists provide a full-range of rehabilitation therapy to address physical function, speech, memory and language function, mobility, balance, strength and safety, and to promote independence through activities of daily living. The home health and hospice segment provides skilled nurses, home health aides, social workers and physical, occupational, and speech-language therapists.

IRFs are subject to strict admissions and coverage requirements. Patients must meet medical necessity requirements for hospital admission and must be medically stable and have the potential to tolerate at least three hours of rehabilitation therapy per day. To maintain IRF status, at least 60% of patients must have at least one medical diagnosis or functional impairment from a list of 13 conditions (CMS-13).

II. IRF growth strategy includes bed expansions at legacy hospitals, acquisition of existing hospitals and construction of new hospitals.

A. Bed expansions totaled 83 beds in 2016 and 156 beds projected for 2017.

B. New store growth (acquisitions and de novo), includes four new hospitals in 2016 (Modesto, CA; Savannah, GA; Hot Springs, AR; Bryan, TX) and five in 2017 (Pearland, TX; Westerville, OH; Broken Arrow, OK; Jackson, TN; and Gulfport, MS), plus a new satellite facility in July 2017 (St. Peters, MO). In 2016 HealthSouth also sold its hospital in Beaumont, TX and consolidated two hospitals in Austin, TX, closing one facility. HealthSouth targets four to six new IRFs per year. HealthSouth typically has 10-12 new hospitals in its development pipeline and is open to acquisition opportunities. Announced developments include hospitals in Winston-Salem, NC; Hilton Head, SC; Murrells Inlet, SC; Murrieta, CA; and Shelby County, AL.

C. Considerations for targeting a new IRF market include:

- Demographics, including (1) forecasted growth in population requiring hospital-level rehabilitation; and (2) number of CMS-13 compliant patients.
- Bed need and demand.
- Presence of competitors, including other standalone IRFs, acute-care hospitals with in-patient rehabilitation units, and skilled nursing facilities that offer therapy.
- Proximity to other HealthSouth IRFs.
- Proximity of HealthSouth home health segment location, or ability to enter the market.
- Whether the location is in a CON state (see discussion below).
- In CON states, approval process and time line.
- Potential joint venture partners, and fair market valuation of contributed assets (see below).

D. Development costs for a typical 40-50 bed IRF range between $22 to $28 million, including $17 to $21 million for construction, design, permitting, etc., $3 to $4 million for equipment and $2 to $3 million for land. Real estate prices are variable depending on location. Prototype design includes all private rooms and core infrastructure designed to accommodate future expansion. In non-CON states, HealthSouth typically anticipates 20 months between permitting and opening. In CON states, the CON process may extend the timeline by six months to three years. In California (a non-CON state) design and permitting may take an additional year or more.

E. Joint ventures. HealthSouth is an owner/operator of 37 joint venture IRFs, with five more opening this year or in development. Joint venture partners own 2.5% to 50% of the IRF, which HealthSouth manages. Joint venture partners include major

academic and non-profit systems such as Vanderbilt University, University of Virginia Medical Center, Methodist Healthcare-Memphis, Mercy Health Systems, Geisinger Health and BJC Healthcare. Prospective joint venture partners typically operate an IRF as a unit of their acute-care hospital. The partner contributes to the joint venture its IRF unit and HealthSouth contributes additional beds and constructs and contributes a new facility. If the partner owns a standalone IRF, it may lease the building to the joint venture or contribute the building. HealthSouth and the partner also may contribute cash to the joint venture. Because acute-care hospitals are referral sources, to comply with Stark and anti-kickback laws, the value of the partner's share must equal the value of the contributed assets and any lease must be market. A fair market valuation will dictate ownership percentages and cash contributions.

F. Real Estate: as of March 31, 2017, HealthSouth owned the building and land for 58 of its IRFs. At 38 IRFs, HealthSouth leases the building and the land. At 27 IRFs, HealthSouth owns the building and leases the land under a ground lease. Joint ventures may operate under a short term lease of the existing facility during construction of a new hospital.

III. Home health and hospice growth strategy: HealthSouth targets $50 to $100 million a year towards home health and hospice acquisitions to complement organic growth. Home health acquisitions are prioritized in existing IRF markets; hospice acquisitions in existing home health markets.

IV. A certificate of need (CON) is a regulatory mechanism that requires state authorization of proposed acquisition or expansions of existing hospitals and construction of new hospitals. According to the National Conference of State Legislatures, some 36 states, plus Puerto Rico and Washington, D.C., have some form of CON regulation. Most of the states with no CON laws are west of the Mississippi. As of March 31, 2017, HealthSouth has approximately 4,344 licensed beds in CON states and 4,184 licensed beds in non-CON states. CON requirements are in addition to licensing, zoning, environmental and other regulation.

A. CONs originated in the middle decades of the 20th century as part of state and federal efforts to centralize healthcare planning and to control costs by limiting the supply of healthcare facilities, equipment and services. The theory was that to cover higher capital and fixed operating costs, overbuilt healthcare facilities would charge more for services, and have the incentive to render unnecessary services. The Hill-Burton Act of 1946, which promoted construction of community and rural hospitals, required states receiving federal funds to

implement health policy planning initiatives. In the 1960s and 70s, as healthcare prices continued to rise in spite of public health plans, Congress further regulated the industry, including amendment of the Social Security Act to allow the federal government to withhold Medicare and Medicaid funds from healthcare facilities that had not received construction or expansion approval from the state health planning agency. Finally, in 1974 Congress effectively mandated state CON laws by withholding federal funds from states without them. In the ensuing decade, healthcare prices continued to rise, and studies confirmed that CON laws did not achieve cost savings. In 1987 Congress repealed the CON mandate, which left the states free to discontinue their CON programs. However, only 14 states fully have availed themselves. In spite of evidence that CON laws do not control costs, and the intuitive observation that competition tends to drive costs down and benefit consumers, most states continue to restrict the construction and expansion of hospitals and other healthcare facilities.

B. The scope of CON laws varies widely from state to state. Policymakers reach different decisions about the types of facilities and services to restrict. Most states with CON laws restrict acute care hospitals beds, surgery centers, and nursing home/skilled nursing facilities. Many states also restrict home health care agencies, hospices and substance abuse and obstetric programs. Fewer states may restrict assisted living facilities and even medical office buildings. CON programs also tend to focus on higher-cost procedures, such as open heart surgery, organ transplants, and radiation therapy. Fewer states may restrict dialysis, burn care and even ultrasounds. Most states with CONs restrict distinct service lines, such as psychiatric care, and in-patient rehabilitation.

C. CON application and approval procedures also vary widely, with a byzantine array of jurisdiction, filing requirements, deadlines, board appointment and composition, and objection, hearing and appeal rights. The process can be lengthy, expensive, arbitrary and highly political. Local consultants, lobbyists and legal counsel almost always are necessary. From time to time, states will impose moratoria on certain facilities and services, so that no applications will be approved. State health plans may state various methodologies and formulas for determining "bed need" by county, region or other geographic area. The results of these calculations may range from obscure to debatable and often fail to account for the actual occupancy rates and demonstrable demand for facilities and services. Other factors may include population and demographics, travel time to available facilities and services, and adverse impact on existing providers. If an

applicant exhausts administrative remedies, it may have to meet an arbitrary and capricious standard on judicial review.

D. In the current healthcare market, CONs run contrary to several trends. Primarily, CONs restrict provider access to markets and the supply of facilities and services available to the consumer. Existing providers are shielded from competition, which reduces market incentive to increase efficiency, contain costs, improve care and invest in new technologies, specialties and procedures. The Affordable Care Act specifically promotes competition as a means of reducing cost, but does not address CONs as a barrier to entry. Moreover, CONs were conceived when the prevailing form of reimbursement by the government and by private payors was a cost-plus model. If the government effectively reimburses the provider's overhead as an element of pricing, then it legitimately may concern itself with the cost of expansion and capital investment. However, fixed fee and prospective payment models have eliminated any artificial incentive for providers to expand. The on-going shift away from volume based fee-for-service pricing towards capitation, episodic and value-based pricing further undermines the justification for CONs. Some arguments in favor of CONs—including distribution of care to underserved areas, and the cross-subsidization of indigent care with higher margins—are essentially anti-competitive. Patchwork regulation, inconsistent administration and political instability impose significant financial and other burdens on the industry for reasons that are often difficult to justify by the needs of patients and the best interests of the community. The Department of Justice and the Federal Trade Commission both advocate the reformation or elimination of CONs as barriers to entry and unnecessary restrictions on competition.

E. Transferability and transactional value: CONs generally are transferable, although the transfer itself often is subject to regulation. In some states, the ability to transfer a CON is so limited that the CON may have little or no practical value. In most states, however, purchasing beds may be much cheaper and much more attractive to providers than the CON application process. Major restrictions may include the locality and use of the bed.