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What's So Unique About Health Care Cases? Attributes, Challenges and Solutions for Sick Health Care Organizations

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What's So Unique About Healthcare Bankruptcies?

Introduction

The authors have considerable experience working with troubled healthcare organizations and submit these materials to augment our interactive conversation to further explain some of the unique features of healthcare cases in general (pre-bankruptcy), the pros and cons of receiverships vs chapter 11, specific healthcare relevant provisions in the Bankruptcy Code (ranging from record keeping and destruction requirements to proper procedures for the transfer of patients), and unique sale considerations in healthcare cases (CHOW and OTAs, for example). Finally, we address whether bankruptcy courts treat provider agreements as statutory entitlements or executory contracts, which affects legacy liabilities, most notably Medicare overpayments.

Bankruptcy Code Specific Provisions

The 2005 BAPCPA amendments to the Bankruptcy Code added several provisions to the Bankruptcy Code with the goal of addressing the unique nature of healthcare reorganizations, sales and restructurings. As part of these revisions, a new term, "health care business," was added and defined in Section 101(27A) as:

> "any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for – (i) the diagnosis or treatment of injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care…"

The definition then proceeds to list specific types of health care businesses that fall within the definition, which examples specifically include (among other examples) hospitals, emergency treatment facilities, hospices, home health agencies, skilled nursing facilities, assisted living facilities, and home health institutions. The breadth of the examples in the definition certainly appears to indicate that Congress intended that any institution that provides medical care is to be included within the definition.

Patient Care Ombudsman (Section 333)

While the 2005 BAPCPA amendments added the concept of a patient care ombudsman to the Bankruptcy Code, the concept is not new. Indeed, the applicable section of the Bankruptcy Code – 11 U.S.C. § 333 – incorporates references to the Older Americans Act of 1965.[1] The section mandates that in a case involving a "health care business," the court appoint a patient care ombudsman "to monitor the quality of patient care and to represent the interests of the patients of

[1] *See* Timothy M. Lupinacci & Eric L. Pruitt, New Player at the Healthcare Reorganization Table: Practical Implications of the Patient Care Ombudsman, Am. Bankr. Inst. J., July/Aug. 2005, at 26, 26.

the health care business unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case."[2]

Perhaps more than any of the other 2005 amendments, the provision mandating a patient care ombudsman evidences the delicate balance of maximizing economic return to creditors that is a fundamental goal of bankruptcy with the essential need to protect patients that is generally present in healthcare cases. To accomplish this, Section 333(b)(2) provides that the patient care ombudsman shall report to the court regarding the quality of patient care provided to patients of the debtor not later than 60 days after the date of appointment, and not less frequently than at 60-day intervals thereafter. Likewise, Section 333(b)(3) provides that the patient care ombudsman shall "file with the court a motion or a written report" if the patient care ombudsman determines that "the quality of patient care provided to patients of the debtor is declining significantly or is otherwise being materially compromised."

In order to appropriately monitor the level of care at a health care facility, some of the tasks performed by a patient care ombudsman include:

- Conducting interviews of residents, family members, guardians and facility staff as required;
- Reviewing license and governmental permits;
- Reviewing adequacy of staffing, supplies and equipment;
- Reviewing safety standards;
- Reviewing facility maintenance issues or reports;
- Reviewing resident, family, staff or employee complaints;
- Reviewing risk management reports;
- Reviewing litigation relating to the debtor;
- Reviewing resident records;
- Reviewing any possible sale, closure or restructuring of the debtor and how it impacts residents;
- Reviewing other information, including resident satisfaction survey results, regulatory reports, utilization review reports, discharged and transferred resident reports, staff recruitment plans and nurse/resident/acuity staffing plans; and

[2] 11 U.S.C. § 333(a)(1).

- Reviewing various financial information to the extent such information may impact resident care.

Disposal of Patient Records (Section 351)

Both federal and state law impose requirements on the duration of time that medical records must be retained. While many states require records be kept for seven to ten years, some states require medical records be retained for 20 years or more. The cost of complying with such statutes has the potential to quickly become overwhelming for some (if not, most) debtors.

The BAPCPA amendments added a new Section 351 to the Bankruptcy Code to provide something of a "safe harbor" for debtors and trustees to dispose of patient records in those cases where the estate does not "have a sufficient amount of funds to pay for the storage of patient records in the manner required under applicable Federal or State law."[3]

The process described in the section is rather burdensome:

1. The trustee or debtor-in-possession must publish notice in one or more appropriate newspapers indicating that if patient records are not claimed by patients or insurers within one year, that the records will be destroyed;[4]

2. Next, within 180 days of the publication, the trustee or debtor-in-possession is to notify each patient or insurance provider that they may claim their records or they will be disposed;[5]

3. Third, the trustee or debtor-in-possession must, by certified mail, request from "each appropriate Federal agency … permission from that agency to deposit the patient records with that agency";[6]

4. Following the above process, written records may be shredded or burned and magnetic, optical or other electronic records may be destroyed in a manner that they cannot be retrieved.[7]

Federal Rule of Bankruptcy Procedure 6011 provides further guidance, including that (i) the publication process described above shall not identify any patient by name or other identifying

[3] *See* 11 U.S.C. § 351.

[4] *See* 11 U.S.C. § 351(1)(A).

[5] *See* 11 U.S.C. § 351(1)(B).

[6] *See* 11 U.S.C. § 351(2).

[7] *See* 11 U.S.C. § 351(3).

information, (ii) the trustee or debtor in possession must maintain proof of compliance that patients were notified as set forth in #2 above (unless the court orders such proof of compliance to be filed under seal), and (iii) the trustee or debtor-in-possession shall file no later than 30 days after the date the records have been destroyed a report certifying such and the method(s) used.

The expense and burdensome nature of complying with the above-described process has caused some commentators to question its effectiveness.[8] As an alternative, many health care businesses elect to obtain the services of third-party records storage facilities that have the capability of storing medical records and ultimately destroying them in compliance with HIPAA and other applicable state and federal laws.

Transfer of Patients (Sections 704(a)(12) and 1106(a)(1))

As is the case with several of the other provisions that were added to the Bankruptcy Code through BAPCPA, to recognize the unique risks to patients associated with closure of a health care business,[9] the 2005 amendments imposed new requirements on bankruptcy trustees (including debtors-in-possession) when transferring patients. Specifically, Section 704(a)(12)[10] requires the trustee to:

> "use all reasonable and best efforts to transfer patients from a health care business that is in the process of being closed to an appropriate health care business that … is in the vicinity of the health care business that is closing … provides the patient with services that are substantially similar to those provided by the health care business that is in the process of being closed; and … maintains a reasonable quality of care."

Federal Rule of Bankruptcy Procedure 2015.2 provides additional guidance with respect to the above section and requires the trustee to give at least 14 days' notice of the transfer to the patient care ombudsman, if any, the patient, and any family member or other contact person whose name has been given to the trustee or the debtor for the purpose providing information regarding the patient's health.

As noted below, the costs associated with such transfers will be afforded administrative priority status pursuant to Section 503(b)(8). Commentators, however, have noted that the statute

[8] *See*, *e.g.*, Martin Bunin, Is the Bankruptcy Code Provision on Disposal of Patient Records Useless?, New York Health Law Blog, March 21, 2019.

[9] *See* H.R. Rep. No. 109-31, 109th Cong. 1st Sess., 21 (2005).

[10] The requirements of Section 704(a)(12) are imposed on a chapter 11 trustee or debtor-in-possession pursuant to Section 1106(a)(1).

(and the rule) are silent on how patient care should be funded when there are no assets in the estate to pay for patient transport or continuing care.[11]

Priority Claim for the Costs of Winding Up a Health Care Business (503(b)(8))

With respect to the costs associated with disposing of patient records in accordance with Section 351 and transferring patients (each discussed above), BAPCPA provided new administrative priority status for such expenses through the addition of Section 503(b)(8). This change was in response to certain decisions that denied administrative priority for such expenses if incurred by a governmental agency.[12]

Priority treatment is limited to the actual and necessary costs and expenses incurred in "closing" a health care business. While the section references two specific examples of such expenses (disposing of patient records and transferring patients), the fact that the preamble uses the word "includes" seemingly opens the door to providing administrative priority status to other costs and expenses incurred in closing a health care business.

Other Bankruptcy Provisions Affecting Healthcare Cases

In addition to the provisions discussed above which expressly reference health care businesses, and those discussed below that arise in the context of sales under Section 363 of the Bankruptcy Code, there are several other bankruptcy provisions that affect healthcare cases, including the following:

- **Section 362(b)(28):** Enacted as part of the 2005 BAPCPA amendments, Section 362(b)(28) exempts from the automatic stay "the exclusion by the Secretary of Health and Human Services of the debtor from participation in the Medicare program or any other Federal healthcare program." Exclusion is a specific term under the Medicare program, which prevents a provider from participating the program. There is very little caselaw interpreting the section, which may be the result of the fact that commentators have noted that the subsection makes express, what most professionals believed to be the case before BAPCPA – that Medicare was exempt from the automatic stay pursuant to Section 362(b)(4), which exempts police or regulatory acts by governmental entities.[13]

[11] *See* 7 Collier on Bankruptcy ¶ 1106.3[8] (16th ed.).

[12] *See* 4 Collier on Bankruptcy ¶ 503.15 (16th ed.), citing *In re Allen Care Centers, Inc.*, 163 B.R. 180 (Bankr. D. Or. 1994), aff'd, 175 B.R. 397 (D. Or. 1994) in which the bankruptcy court denied a request of the State of Oregon's Senior and Disabled Services Division of the Department of Human Resources for payment of costs incurred transferring residents and closing a nursing facility as an administrative expense.

[13] *See* Samuel R. Maizel and Rachel Caplan, Chicken Little Comes to Roost in Bankruptcy: Why §362(b)(28) Doesn't Mean the Sky is Falling, 25-AUG Am. Bankr. Inst. J. 22.

- **Section 362(b)(4):** In cases involving Medicare or Medicaid issues other than exclusion, some courts have concluded that the exclusion from the police and regulatory power exception to the automatic stay set forth in Section 362(b)(4) allows termination of a Medicare provider agreement.[14]

- **Section 303(a)**: Section 303(a) of the Bankruptcy Code prevents an involuntary case from being commenced against a "corporation that is not a moneyed, business, or commercial corporation…" This section prevents creditors from placing not-for-profit entities into bankruptcy, which is a bar against filing involuntary bankruptcies against most health care businesses.

- **Section 1112(c):** Similar to the above, Section 1112(c) prohibits the court from converting a case under Chapter 11 to one under Chapter 7 if the debtor is a not a "moneyed, business, or commercial corporation, unless the debtor requests such conversion."

- **The Absolute Priority Rule:** One of the fundamental protections for creditors when faced with a cramdown plan is that the plan needs to be fair and equitable which generally requires that the debtor must comply with the absolute priority rule which prohibits equity from retaining the ownership interest of such equity unless higher-priority creditors are paid in full. Some courts, however, have reasoned that because members of non-profit entities are not entitled to profits or distributions that the absolute priority rule does not apply to such entities.[15]

- **28 U.S.C. § 157(b)(5):** 28 U.S.C. § 157(b)(5) provides that "personal injury tort and wrongful death claims shall be tried in the district court in which the bankruptcy court is pending, or in the district court in the district in which the claim arose, as determined by the district court in which the bankruptcy court is pending." Thus, the bankruptcy court will lack jurisdiction over most medical malpractice claims. Still, bankruptcy courts can approve claims resolution procedures over medical malpractice claims.

Pre-Bankruptcy Considerations

Cashflow & Receivables

Because health care businesses rely on payments from CMS, insurance companies, and patients themselves (rather than from business-to-business customers), there are unique accounts receivable and cashflow issues. Most reimbursements are either paid through Medicare, Medicaid, or some other payer (insurance company) that bases its reimbursement level for any service by predetermined regulatorily based rates or negotiated contractual rates that vary by provider. The

[14] *See Parkview Adventist Med. Ctr. v. United States*, 842 F.3d 757 (1st Cir. 2016); *but see True Health Diagnostics LLC v. Azar (In re THG Holdings LLC)*, 604 B.R. 154 (Bankr. D. Del. 2019) (federal government's withholding of Medicare reimbursement payments to healthcare provider was not exempt from the automatic say under Section 362(b)(4) because government was protecting its pecuniary interests and not to advance public policy).

[15] *See*, *e.g.*, *In re Wabash Valley Power Assoc. Inc.*, 72 F.3d 1307 (7th Cir. 1995).

arduous process of adjudicating the accounts receivable generated by medical coding and billing takes time and is unlike what you see in any other industry. Proper controls are critical. Failure to sufficiently document a service could lead to a claim denial and write-off. The timing of payments versus services rendered can create material cashflow issues. Furthermore, misbilling can be subject to criminal prosecution. Additionally, virtually all healthcare services provided to patients are billed based on a physician's order and, in the majority of cases outside of a physician's office, the ordering physicians are not employed by the healthcare provider billing for the service. That means conserving and nurturing relationships with physicians through an M&A process is paramount to the continuity of revenue and cashflow streams through a reorganization and/or post-acquisition.

Reimbursements are often inadequate to cover costs, even where they are covered by CMS or insurance. In the case of skilled nursing, for example, Medicaid is the payer for over 60% of services, yet it only reimburses 70-80% of the nursing homes actual costs.[16]

Inventory

With regards to inventory, healthcare is the only industry in which necessary supplies include controlled dangerous substances. Disposing of pharmaceuticals is not as simple as just throwing them in the trash or liquidating them – they must be accounted for, and in some cases, disposed of in ways similar to hazardous materials in manufacturing. These supplies must be very tightly controlled because they are often dangerous and frequently have limited shelf life and, of course, they must be available when needed. The COVID – 19 pandemic shed light on inventory management issues as many providers did not have adequate personal protective equipment to protect their staff or adequate ventilators to treat critical COVID patients.

Unique Structures and Missions

Many healthcare organizations are not-for-profits or have local boards that operate similarly to not- for- profits. These boards are frequently made up of community leaders, including philanthropists, doctors, lawyers, and hopefully a few businesspeople; their goal is often to provide services, almost at any cost. In recent years, rural hospitals have been facing distress and provide a good example. With hospitals being the most expensive way to treat patients, and a steady trend of people moving out of rural areas, rural hospitals have seen less of their beds occupied. This has led to the need for many to sell or shut down, leaving many rural communities without a hospital or emergency department. When selling such hospitals in a bankruptcy process, debtors are required to demonstrate that a chosen buyer has submitted the "highest and best offer." In other industries, that is almost always evaluated by dollars, because the goal in insolvency is to pay as many creditors as much money as possible. But courts have ruled that, in the case of a not-for-profit hospital, leadership can consider its charitable mission in determining what is the highest and best offer. Therefore, not-for-profit health care organizations may select a lower dollar offer

[16] (https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/Financial-Struggle-of-Nursing-Homes-Puts-Medicaid-Reimbursement-Rates-Back-in-the-Spotlight.aspx)

because the buyer is better aligned with the charitable mission, which might be to provide critical care that would not otherwise be available.

Labor

Over the last 30 years, the healthcare industry has struggled with recruiting and retaining quality labor. This has only been acerbated by pandemic and the Great Resignation, particularly in long term care. According to the Bureau of Labor Statistics, "[o]verall, long-term care workforce levels are at their lowest in 15 years, with 409,100 jobs lost between February 2020 and January 2022. The decline has been especially noticeable in skilled nursing, which experienced a 15 percent workforce decline during that time … Home health saw a 1.7 percent decline."[17]

Unique Bankruptcy Sale Considerations

Valuation and Sale Challenges

How does one value a healthcare operation, especially if it is losing money? There is some data and historical information that experienced advisors have access to that can guide valuation, but a true market test will ultimately determine real value. But for it to be a "true market test," it is crucial your investment banking team knows what hidden values exist and which suitors will and won't be able to realize each of those values, and how to identify and reach out to those decision makers. The message to each prospective buyer must be tailored to each unique circumstance.

Healthcare properties are special purpose properties, and they often are not suitable for alternative uses without substantial investments of time and money. As a result, where a healthcare facility must be shut down, the value of the real estate assets is likely to be far less than the appraised value for its current use.

Using an OTA

In many cases, following approval of the sale order, all parties are desirous to close as quickly as possible. The proposed buyer may be eager to start making operational changes, and the debtor (as well as the secured lender funding the case) may be advantaged by no longer funding operational losses. A prompt closing, however, may be hindered by the time it takes in many states for the proposed buyer to obtain proper licensing and have a provider agreement in place in order to bill under Medicare and Medicaid since these items may be conditions to closing under an asset purchase agreement.

In order to allow the buyer to start operating the facilities prior to closing of the transaction, an operations transfer agreement (OTA) is typically used to allocate responsibilities and costs and in some cases to allow the buyer to operate under the seller's licenses and provider agreements. In

[17] (https://www.bls.gov/news.release/pdf/empsit.pdf)

some cases, OTA provisions are included in the asset purchase agreement. It can also be a separate document.

Closing the Sale – The Need for Proper Licensing and the Use of a CHOW

Another unique consideration for bankruptcy sales involving health care businesses is that, unlike many other types of industries in which the bankruptcy court can require third parties to consent to the transfer of assets, state and federal healthcare regulators maintain significant autonomy over licensure and other regulatory issues.[18] Indeed, some states have laws that prohibit closing of a transaction without obtaining necessary licenses and other approvals and so closing over a licensing condition in an asset purchase agreement is not an option. The process to appropriately transfer or issue such licenses, provider numbers and other permits is frequently referred to as the "CHOW," an acronym used in the healthcare industry to describe a "change in ownership."

It is essential for the professionals working on the transfer of a health care business to understand the applicable CHOW process as it can have a dramatic impact on the timing of closing. While the specific requirements differ by state, it is generally a very form-intensive and disclosure-based process, and can take anywhere from 30 days to 18 months (or more) to complete. Moreover, professionals should be aware that the CHOW process may be triggered not only by an asset sale, but also by other structural changes such as changes to the equity structure or a change of a sponsor entity.

In addition to the transfer of provider numbers and other requirements of the Medicare/Medicaid program (discussed below), the CHOW process can be thought of as consisting of three categories: licensure, certificates of need, and ancillary permits:

- *Licensure:* The most time-intensive part of the CHOW process involves a transfer of, or application for, a new, operational license. Licenses are required for most health care businesses, including hospitals, senior living facilities, home care agencies, and outpatient and ambulatory clinics for specialized care. While the process varies by state, a form of application is generally required. In addition, many states require a pre-CHOW notice or letter of intent of some sort that informs the applicable agency of the anticipated change in ownership. Some items that are frequently required to be disclosed include new (or

[18] At least one publication has suggested that the fact that the 2005 amendments to the Bankruptcy Code did not alter the prefatory language to Section 1123(a) ("notwithstanding any other applicable nonbankruptcy law") opens the door to an argument that bankruptcy courts may approve transfers of health care businesses notwithstanding the general need for regulatory approval. *See* ABI healthcare Insolvency Manual, at p. 59 (David C. Hillman & William W. Kannel eds., 2d ed. 2005). As that publication notes, however, even if such an argument was successful applicable regulatory agencies may still be able to take action due to the police power exclusion to the automatic stay (discussed above). Moreover, buyers are generally reluctant to be overly aggressive with or otherwise antagonize the same agencies that they will need to work with following closing of the transaction.

changed) ownership, corporate structure including equity interests over a specified threshold, the identity of executive boards and key administrators, applicable transaction documents such as the asset purchase agreement and sale order, business-entity formation documents, lease and property ownership information, management agreements, operational and financial information.[19] The process may also require criminal background checks and fingerprints of certain, key individuals.

- *Certificates of Need:* In order to avoid overcrowding in particular geographic areas, some states require a certificate of need ("CON") for certain health care businesses, including hospitals, nursing homes, senior living facilities, and other medical service providers. Approximately thirty-five states have CON laws or requirements.[20] As with licensing requirements, a buyer of a health care business must procure the transfer of its seller's CON or obtain a new CON. While the difficulty of obtaining a CON varies by state and the type of facility involved, the process generally requires a notice and application process. Because many states use committees to oversee the process, the timing of approval can vary based on when the committee meets.

- *Ancillary Permits and Licenses*: In addition to operational licenses and certificates of need, states may also require other permits. These may include flood inspections, elevator permits, food permits, lab test permits, waste registration and other types of operating permits. The process for obtaining these types of permits is generally less intensive than the process for obtaining operational licenses, and in some cases (in some states) may be addressed as a post-closing item. Still, professionals must still be aware of the requirements because they have the potential to delay a transfer of the assets.

Transfer of Provider Agreements (Executory Contract or Statutory Entitlement)

An issue that arises in section 363 sales of certain health care businesses is whether a buyer is able to acquire the seller's Medicare provider number free of liabilities, most notably Medicare overpayments. Liability for overpayments can be imposed many years after services have been provided and estimated reimbursements received by the provider. The need for a buyer to acquire the seller's provider number is driven by the fact that each institutional provider that participates in Medicare is required to obtain a unique Medicare provider number, and the process to obtain a new provider number can take months. If the buyer is not able to bill under the seller's provider number during the period prior to obtaining a new number, it will be unable to seek reimbursement during that period which can have severe implications on the buyer's cash flow.

The determination of whether a buyer can use a seller's Medicare provider number free of liabilities of the seller turns on whether the bankruptcy court treats the provider agreement as an

[19] *See* Ari J. Markenson & Tammy Ward Woffenden, What Is … CHOW, American Bar Association Health Law Section, at p. 17-21.

[20] *See* Ari J. Markenson & Tammy Ward Woffenden, What Is … CHOW, American Bar Association Health Law Section, at p. 7-8 (2018).

executory contract or a statutory entitlement. In the event the court concludes it is an executory contract, then the transfer to the buyer is made pursuant to Section 365 of the Bankruptcy Code, which requires cure of all existing monetary defaults and adequate assurance of future performance. On the other hand, if the court concludes that the provider agreement is a statutory entitlement, the provider agreement may be transferred free and clear of interests under Section 363(f) of the Bankruptcy Code.

A majority of courts considering this issue have concluded that provider agreements are executory contracts.[21] Treating a provider agreement in this manner likely avoids a protracted battle with state and federal administrators over the issue and allows the buyer to continue billing under the seller's provider number. However, buyers remain exposed to potential liability from overpayments received by the seller.

On the other hand, two bankruptcy courts recently concluded that provider agreements, as statutory entitlements, may be transferred free and clear of any interest. The first of these decisions was an oral ruling issued by the Honorable Kevin Gross in the *Center City Healthcare, LLC* case.[22] The issue arose out of a sale of a residency program. As part of the agreement, a $3 million escrow agreement was proposed by the debtor to address any pre-transfer overpayments or other amounts owing under the provider agreement. The Center for Medicare & Medicaid Services (CMS) objected, arguing that because the provider agreement was an executory contract it had a right to cure of all amounts and the $3 million escrow was insufficient. The bankruptcy court, however, disagreed, instead finding that the transfer could be approved since the provider agreement was a statutory entitlement.

A few weeks later, the Honorable Ernest R. Robles, United States Bankruptcy Judge for the Central District of California, issued an opinion in *In re Verity Health Systems of California, Inc.* reaching the same conclusion as did Judge Gross, namely that provider agreements are statutory entitlements.[23] The case arose out of a proposed sale of four hospitals, which included each of the hospital's provider agreements. The California Department of Health Care Services (DHCS) objected to the proposed transfer, arguing that it was owed in excess of $50 million in overpayments and other amounts under the provider agreements and that such amounts were required to be paid if the agreements were to be transferred. In overruling the objection, the court looked to non-bankruptcy cases to conclude that the provider agreements were not contracts. Moreover, the court relied on the fact that the provider agreements did not impose any obligations on DHCS, and therefore did not meet the Countryman definition of executory contracts.

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[21] *See*, *e.g.*, *In re. Univ. Med. Ctr.*, 973 F.2d 1065, 1076 (3d Cir. 1992); *In re. Bayou Shores SNF, LLC*, 525 B.R. 160, 169079 (Bankr. M.D. Fla. 2014); *In re Heffernan Mem'l Hosp. Dist.*, 192 B.R. 228, 231 (Bankr. S.D. Cal. 1996).

[22] Case No. 19-11466 (KG) (Bankr. D. Del. Sept. 10, 2019).

[23] *In re Verity Health Sys. of California, Inc.*, 606 B.R. 843, 850-51 (Bankr. C.D. Cal. Dec. 9, 2019).

Although the administrators on the losing end of both the *Center City Healthcare* case and the *Verity* case appealed the decisions, there will be no clarity from the appellate courts. With respect to *Verity*, the parties reached a settlement permitting transfer of the provider agreements pursuant to Section 365 subject to the government's rights and the parties agreed the bankruptcy court order was vacated. As to *Center City Healthcare*, before the district court could enter a ruling, the buyer terminated the purchase agreement, rendering the bankruptcy court decision moot.

2022 Mid-Atlantic Bankruptcy Workshop August 4-6

IDENTIFYING AT-RISK HOSPITALS AND NURSING HOMES

By Scott K. Phillips[1]

RESEARCH OBJECTIVE

Using objective data identify the General Acute Care Hospitals ("GACH")[2]and Skilled Nursing Facilities ("SNF")[3] which are operationally and financially distressed to a degree that would indicate that they are unlikely to be able to continue in the future as independent entities[4].

RESEARCH METHODOLOGY

For the approximately 5,000 General Acute Care Hospitals and 15,000 Skilled nursing Facilities in the U.S., we elected to compute the metrics detailed below for each year 2016 to 2020[5] (the "Study Period")

Used for ***BOTH*** Hospitals and Nursing Homes

- Operating Margin[6]
- Inpatient Occupancy Rate[7]
- Overall Facility Star Rating[8]
- Total Labor Cost as a Percentage of Total Operating Revenue[9]

Used ***ONLY*** for Hospitals

- Days Net Patient Revenue in Net Patient Accounts Receivable[10]
- Case Mix Index ("CMI") Adjusted Average Length of Stay ("ALOS")[11]

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[1] Scott is a Managing Director in the Washington, DC office of Healthcare Management Partners, LLC (www.hcmpllc.com)

[2] All hospitals in the United States, including the District of Columbia, excluding Long-Term, Rehabilitation, Psychiatric, Children's and state and federal institutions

[3] Only stand-alone facilities with a unique Medicare provider number, excludes hospital based distinct part units.

[4] High probability that the identified facilities in the near or midterm will either close, be acquired or be subject to some form of judicial or non-judicial corporate restructuring.

[5] 2020 is the last full year for which all of the required data sets was available in an electronic format.

[6] Defined as Net Operating Profit or Loss divided by Total Operating Revenues

[7] Defined as Total Inpatient Days divided by the product of Total Licensed Beds times 365 Days. For Hospitals only acute care patient days and beds were considered.

[8] This an overall "Star Rating" for various quality measures as defined by the U.S. Centers for Medicare and Medicaid Services ("CMS") in its "Hospital Compare" data set. (5 stars is the highest possible rating 1 star is the lowest possible rating)

[9] Total Labor Cost is defined as the sum of amounts paid for: Employee Salaries and Wages + Total Contract Labor, including Agency Staff + Employee Fringe Benefits.

[10] Defined as Total Ned Patient Accounts Receivable divided by the dividend of Total Net Patient Revenue divided by 365 Days.

[11] Case Mix Adjusted ALOS is an indicator of the efficacy with which a hospital manages a patient's program of care during their stay for a single admission. The CMI is a measure of the average complexity of the hospital's inpatient population. It is computed based on relative weights assigned to each patient's assigned Diagnosis Related Group

Used ***ONLY*** for Hospitals

- Average Age of the Facility (Building)[12]

All of the metrics were computed using the HMP Metrics, LLC[13][14], integrated data set. Once the metrics had been calculated for every GACH or SNF operating during the Study Period the following additional steps were taken:

1. ***Eliminate Non-Conforming Facilities*** - All GACHs and SNFs which opened or closed during the Study Period were removed from the target population. The remaining facilities had operated during all five years of the Study Period. In total 4,733 General Acute Care Hospitals and 14,849 Skilled Nursing Facilities remained.

2. ***Quartile Ranking*** - For each of the seven metric for each of the five years were assigned to a specific quartile or percentile. The first quartile for each year for each metric would contain the top 25% of GACH or SNF (the "Best Performers") and so on. (1-25%, 26-50%, 51-75% and below 75%) those below 75% would be in the fourth quartile based on the facility's performance against its peers for the metric being measured.

3. ***Compute Facility Quartile Average*** - Once a Facility had been assigned to a quartile for each of the five years [30 Metric Measurements (6 metrics X 5 years for GACHs)][15] and [25 Metric Measurements (5 metrics X 5 years for SNFs)][16] compute the average quartile ranking for the 30 Metric Measurements (25 for SNF) and assign the computed five-year quartile average to each facility.

4. ***Defined At-Risk Facilities*** – At-Risk Facilities were defined as those facilities with a five-year quartile average below three. In other words, these facilities had on average performance at or below the third quartile for the last five years[17]

("DRG") as established by CMS. The national weighted average DRG weight is 1.00. The CMI adjusted ALOS is computed by dividing the hospital's acute inpatient ALOS by the hospital's CMI.

[12] Computed as the arithmetic average age for each quartile or grouping of SNFs. The age of the individual SNF is based on the age reported in the SNF's Medicare Cost Report for the year or years indicated.

[13] HMP Metrics, LLC is a wholly owned subsidiary of Healthcare Management Partners, LLC (https://hmpmetrics.com)

[14] HMP Metrics, LLC is a data product that uses a custom electronic database that includes data from 11 individual data sets including the Healthcare Cost Report Information System (HCRIS) data from more than 750,000 Medicare Cost Reports filed by hospitals, nursing homes, home health agencies since 1994. For hospitals, the HMP Metrics database also includes selected data elements from the Medicare Limited Data Set (100% Standard Analytic Files) database and data sets licensed by HMP. Metrics in the database included financial, operational, and quality metrics used across the healthcare industry to measure provider performance. Data contained in the HMP Metrics database has been "scrubbed" to exclude partial period or statistically aberrant data elements reported by individual providers. This careful data validation process produces highly accurate and defensible benchmarks for the hundreds of industry metrics reported in the database. Each metric in the HMP Metrics database is chosen to highlight a specific aspect of a provider's performance.

[15] See HOSPITAL EXHIBITS 1-7, below

[16] See SKILLED NURSING FACILITY EXHIBITS 1-6, below

[17] See HOSPITAL EXHIBIT 1 and SKILLED NURSING FACILITY EXHIBIT 1

5. ***Identify At-Risk Facilities in the Mid-Atlantic Region***[18] - The At-Risk facilities located in the Mid-Atlantic region were then separately identified and weighted average metric measurements were computed for each of the individual metrics[19].

6. Determine the Ownership Type[20] of the At-Risk Facilities – The At-Risk Facilities were then sorted by year by ownership type[21].

CONCLUSIONS

1. 969 General Acute Care Hospitals and 2,715 Skilled Nursing Facilities are currently at High Risk of failing.

2. High probability that the identified At-Risk facilities in the near or midterm will either close, be acquired or be subject to some form of judicial or non-judicial corporate restructuring.

HOSPITAL EXHIBIT 1

Providers by Average Quartile
2016 through 2020 (4,733 facilities[1])

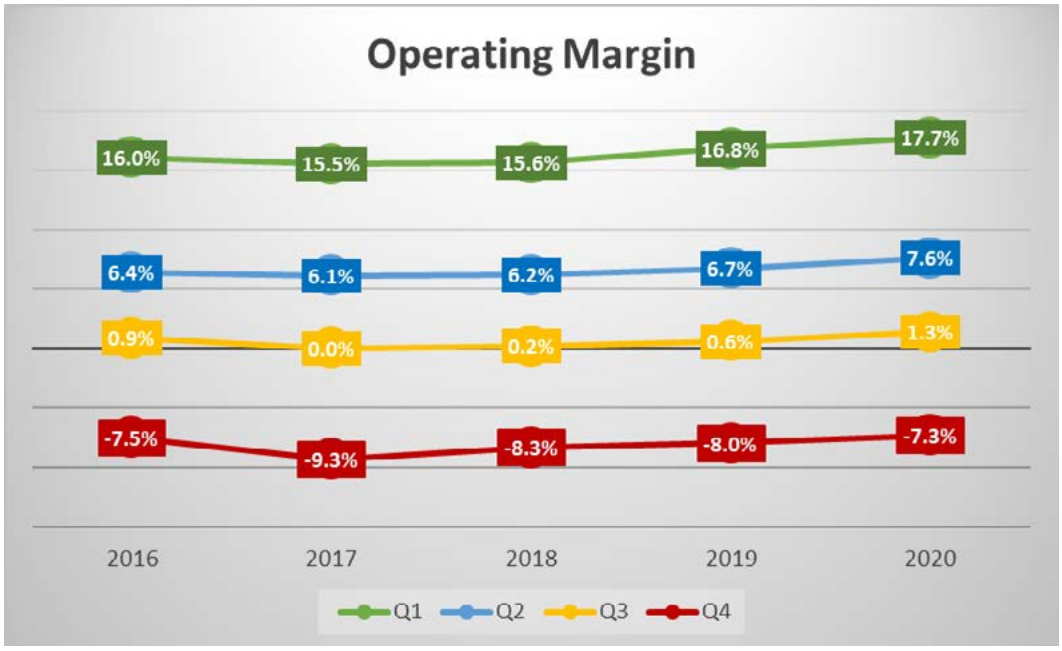
	Top Performers [2] (n = 645)	Average Performers [3] (n = 3119)	At-Risk Facilities [4] (n = 969)	At-Risk Mid-Atlantic Facilities (n = 95)
Operating margin	14.2%	1.4%	-10.1%	-8.9%
Occupancy rate	68.2%	47.5%	35.5%	23.9%
Star rating	3.86	3.23	2.95	2.92
Labor / revenue	34.5%	41.0%	47.5%	40.0%
Days AR	35.28	54.09	100.05	60.74
LOS / Case mix	2.53	5.53	6.17	3.63
Percent of providers	**14%**	**66%**	**20%**	**8%** [5]

1) Some facilities are excluded to remove outliers from the dataset.
2) Indicates an average quartile rank below 2.
3) Indicates an average quartile rank between 2 and 3.
4) Indicates an average quartile rank below 3.
5) 8% indicates the percentage of mid-Atlantic facilities deemed at-risk. 95 mid-Atlantic facilities of 1,188 mid-Atlantic facilities fall in the at-risk group.

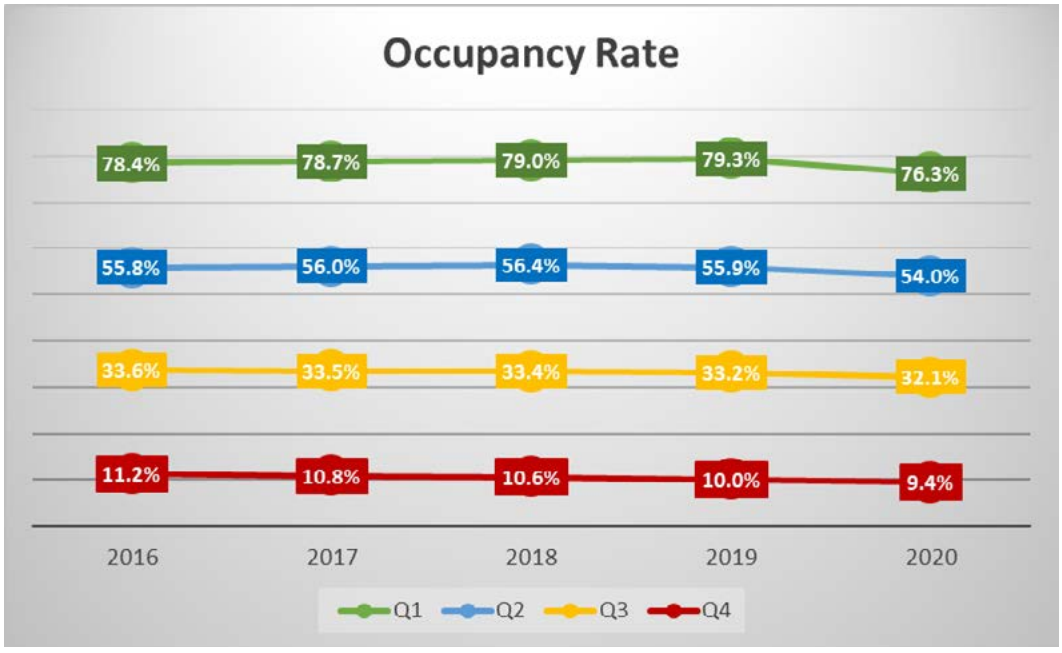
[18] New York, New Jersey, Pennsylvania, Delaware, Washington D.C., Maryland, Virginia, and West Virginia
[19] See HOSPITAL EXHIBIT 1 and SKILLED NURSING FACILITY EXHIBIT 1
[20] For Profit, Private Not For Profit, Government and Other
[21] See HOSPITAL EXHIBIT 8 and SKILLED NURSING FACILITY EXHIBIT 7

IDENTIFYING AT-RISK HOSPITALS AND NURSING HOMES

HOSPITAL EXHIBIT 2



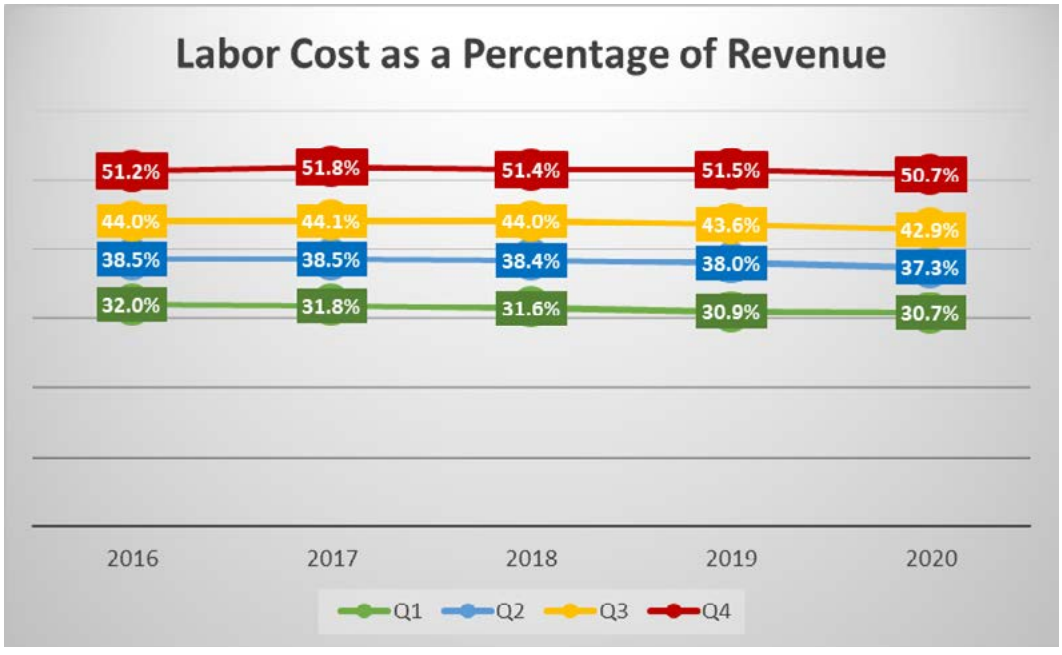
HOSPITAL EXHIBIT 3



IDENTIFYING AT-RISK HOSPITALS AND NURSING HOMES

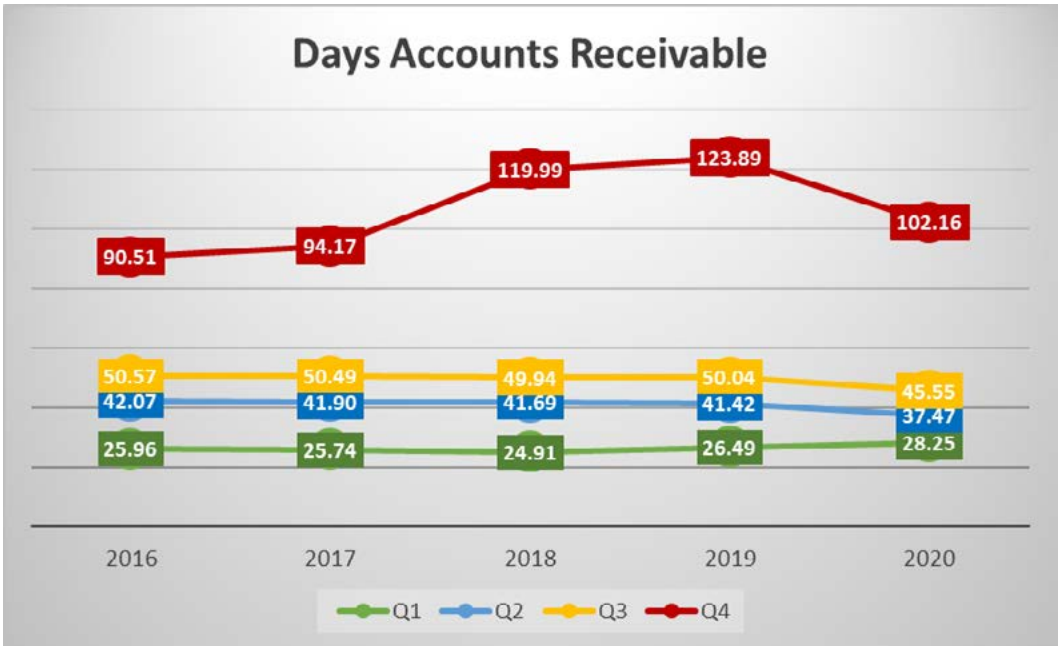
HOSPITAL EXHIBIT 4

HOSPITAL EXHIBIT 5

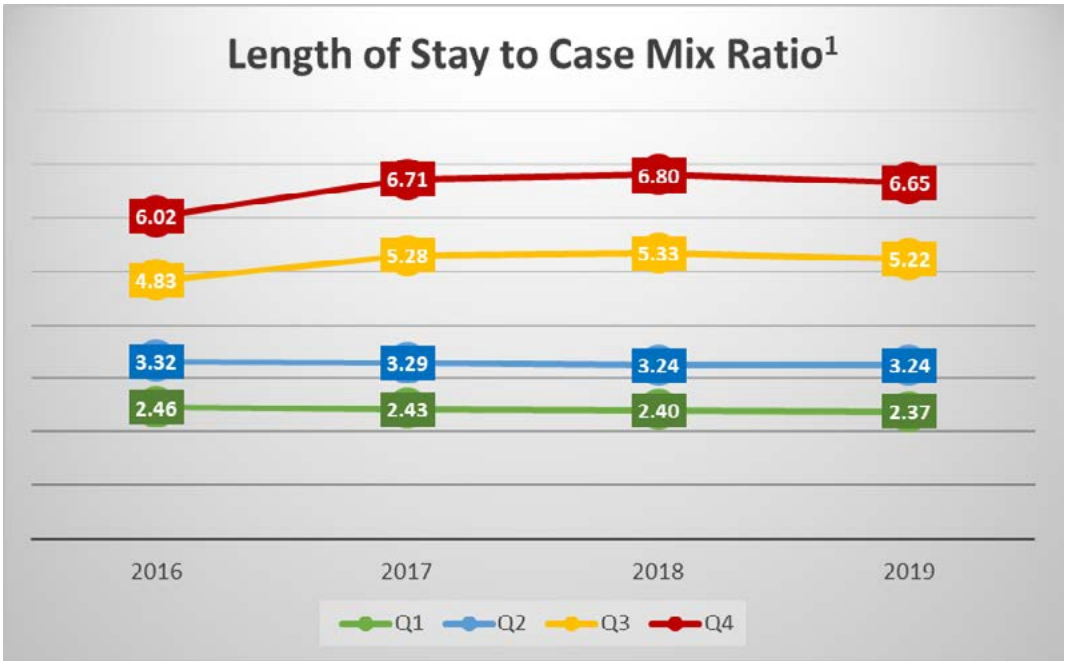


IDENTIFYING AT-RISK HOSPITALS AND NURSING HOMES

HOSPITAL EXHIBIT 6



HOSPITAL EXHIBIT 7



IDENTIFYING AT-RISK HOSPITALS AND NURSING HOMES

HOSPITAL EXHIBIT 8

Percentage of At-Risk Facilities by Ownership

	2016 (n = 816)	2017 (n = 743)	2018 (n= 769)	2019 (n = 731)	2020 (n = 881)
Private (For Profit)	13%	14%	16%	15%	17%
Private (Not For Profit)	35%	32%	34%	34%	33%
Government	42%	43%	39%	40%	36%
Other structures [1]	10%	11%	12%	10%	14%

1) Other includes tribal ownership, church ownership and other ownership structures.

SKILLED NURSING FACILITY ("SNF") EXHIBIT 1

Providers by Average Quartile
2016 through 2020 (14,849 facilities[1])

	Top Performers [2] (n = 2,027)	Average Performers [3] (n = 10,107)	At-Risk Facilities [4] (n = 2,715)	At-Risk Mid-Atlantic Facilities (n = 134)
Operating margin	7.4%	-3.1%	-13.7%	-10.0%
Occupancy rate	88.6%	80.1%	68.8%	74.2%
Star rating	4.23	3.33	2.36	2.25
Labor / revenue	36.9%	50.2%	55.2%	54.5%
Facility age	19.25	27.27	33.71	41.52
Percent of providers	**14%**	**68%**	**18%**	**6%** [5]

1) Some facilities are excluded to remove outliers from the dataset.

2) Indicates an average quartile rank below 2.

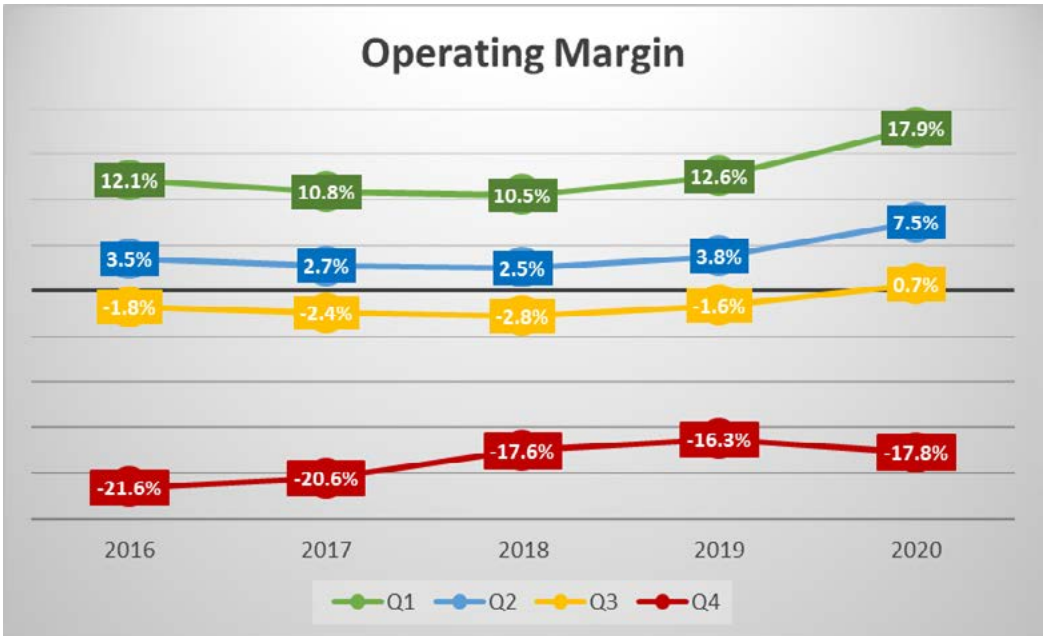
3) Indicates an average quartile rank between 2 and 3.

4) Indicates an average quartile rank below 3.

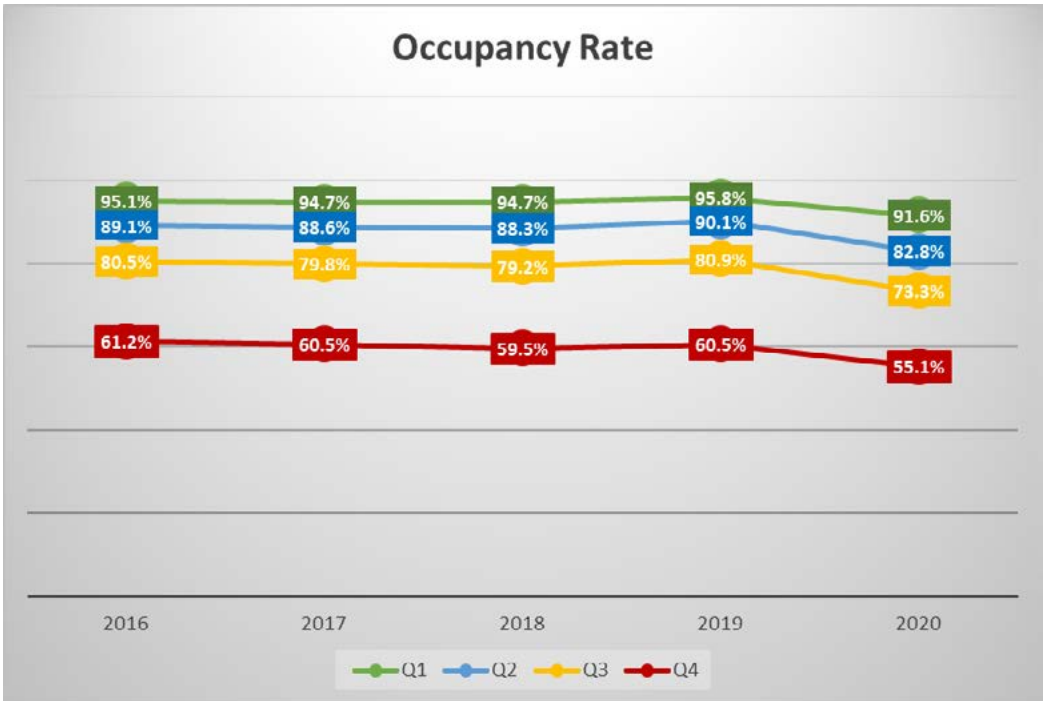
5) 6% indicates the percentage of mid-Atlantic facilities deemed at-risk. 134 mid-Atlantic facilities of 2,216 mid-Atlantic facilities fall in the at-risk group.

IDENTIFYING AT-RISK HOSPITALS AND NURSING HOMES

SKILLED NURSING FACILITY ("SNF") EXHIBIT 2

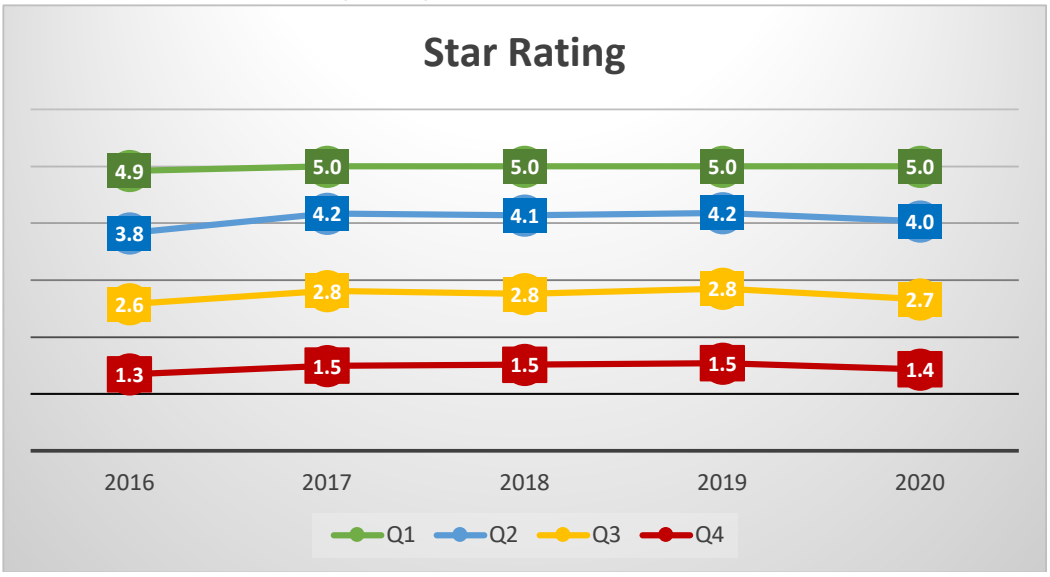


SKILLED NURSING FACILITY ("SNF") EXHIBIT 3

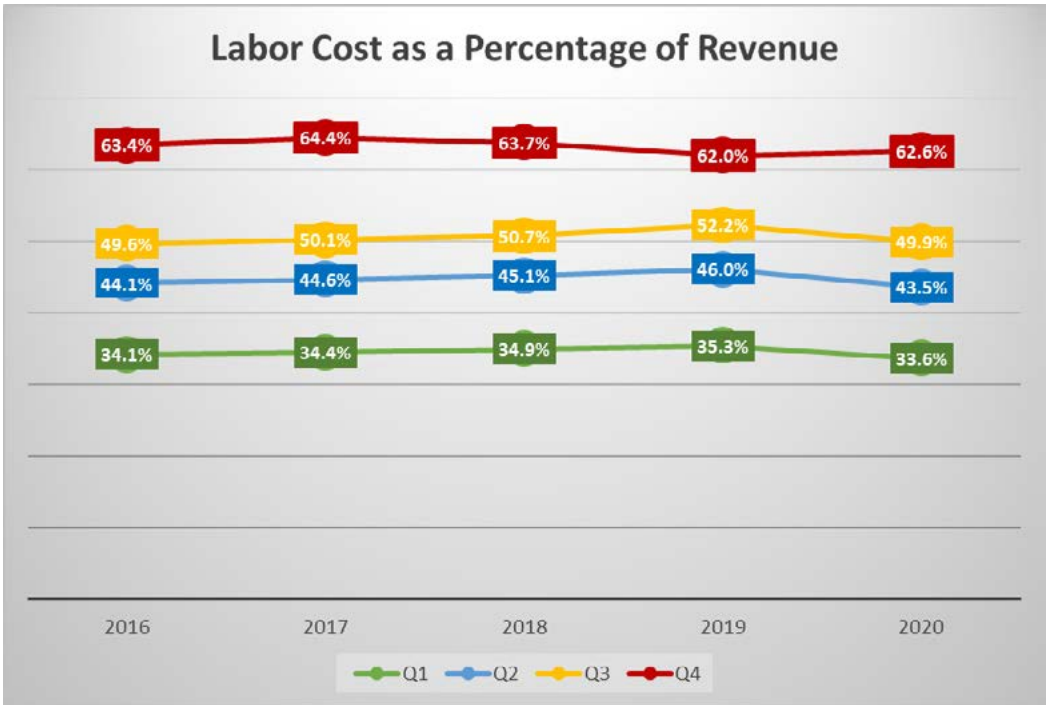


IDENTIFYING AT-RISK HOSPITALS AND NURSING HOMES

SKILLED NURSING FACILITY ("SNF") EXHIBIT 4

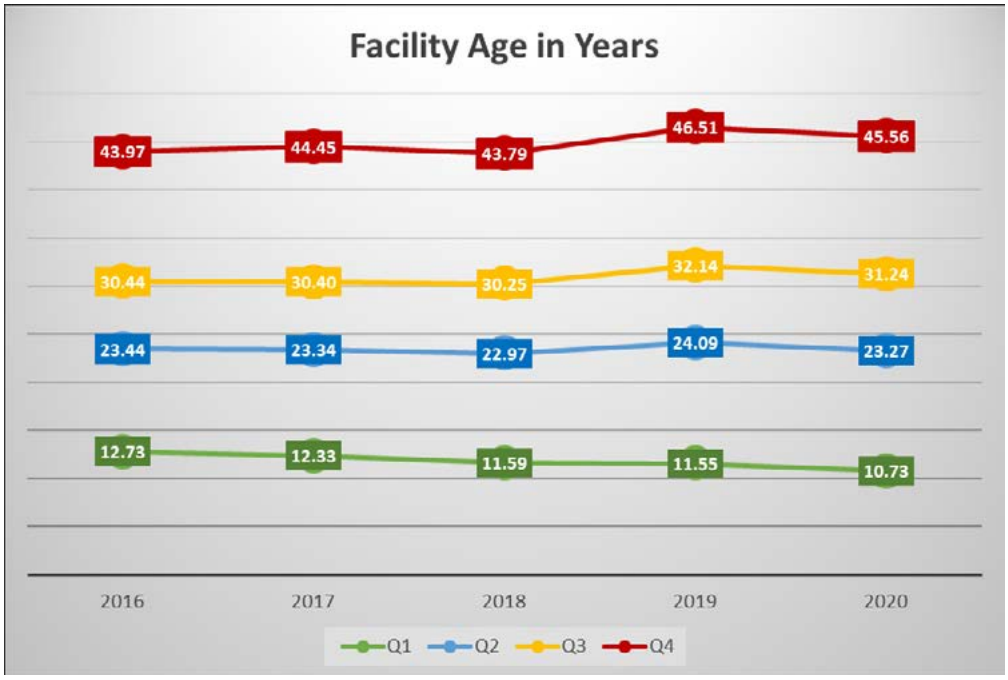


SKILLED NURSING FACILITY ("SNF") EXHIBIT 5



IDENTIFYING AT-RISK HOSPITALS AND NURSING HOMES

SKILLED NURSING FACILITY ("SNF") EXHIBIT 6



SKILLED NURSING FACILITY ("SNF") EXHIBIT 7

Percentage of At-Risk Facilities by Ownership

	2016 (n = 2,375)	2017 (n = 2,349)	2018 (n= 2,341)	2019 (n = 2,549)	2020 (n = 2,365)
For Profit	78%	76%	75%	76%	73%
Not For Profit	16%	16%	16%	15%	18%
Government	6%	8%	9%	8%	10%

Faculty

Charles W. Azano is a senior attorney in Greenberg Traurig, LLP's Restructuring & Bankruptcy group in Boston. He represents parties in all areas of bankruptcy, most commonly representing indenture trustees, institutional investors and other creditors in receiverships, bankruptcies and out-of-court workouts involving tax-exempt municipal bonds. Mr. Azano works in a broad array of sectors, including energy, hospitality, housing, manufacturing, and most commonly senior-living facilities, frequently working in cases involving continuing care retirement communities and assisted-living facilities. He has been actively involved in ABI for more than 20 years, having edited and contributed to publications, authored articles and served on committees. He is a frequent speaker on bankruptcy and issues arising in bond workouts. Previously, Mr. Azano clerked for Hon. Joel B. Rosenthal in the U.S. Bankruptcy Court for the District of Massachusetts. He received his undergraduate degree from Colgate University and his J.D. from Boston College Law School.

Suzanne A. Koenig, CTP is the founder and CEO of SAK Management Services, LLC in Riverwoods, Ill., a health care management firm and consultancy. She is experienced across several segments of the health care industry, including post-acute, senior housing and long-term care, with expertise in the areas of operations improvement, staff education, quality assurance, marketing and census-development. Ms. Koenig is one of the most frequently appointed patient care ombudsmans by courts across America. Her experience includes court-appointed service as an examiner, receiver, chapter 11 trustee and patient care ombudsman; health care bankruptcy filings under chapters 11 and 7, particularly since the enactment of BAPCPA in 2005; leadership of more than 500 facilities to cultivate teams that restore quality care and fiscal soundness; consulting and advising clients involved with bankruptcy proceedings, restructurings and workouts, as well as turnaround management scenarios; and executive positions in marketing, development and operational efficiencies and management for numerous regional and national health care providers. Ms. Koenig testified before the Illinois House of Representatives as an industry expert in funding issues facing the long-term care industry, was a member of the Negotiating Team Task Force in Arizona who designed and negotiated the contract between the State and counties for delivery of indigent health services, was the only non-lawyer and non-Attorney General invited by the National Association of Attorneys General to participate on the "Patient Care Ombudsman" panel addressing the PCO's interaction with the States in their role as patient care monitor, served as a member of the board of directors of both ABI and the Summit Healthcare REIT, Inc., and co-chaired ABI's Health Care Insolvency Committee. In addition, she was elected to the Global Turnaround Management Association's board of trustees, co-chaired the Steering Committee of the Midwest Chapter of the Turnaround Management Association (TMA), served on the board of directors for the School of Social Work at the University of Illinois at Urbana - Champaign, and was elected officer and director for several long-term care provider associations. Ms. Koenig is a Licensed Nursing Home Administrator and a Licensed Social Worker in multiple states. She is a frequent speaker for leading health care industry associations and business affiliates, where she conducts continuing education and training programs. Ms. Koenig received her Bachelor of Social Work degree from the University of Illinois at Urbana-Champaign and her M.S. from Spertus College.

Kenneth W. Mann is a managing director for the Special Situations practice at SC&H Capital in Easton, Md., where he provides distressed M&A, employee stock ownership plans (ESOP) and business valuation advisory for middle-market companies. Prior to joining SC&H Capital in 2020, Mr. Mann had served as the managing director of Equity Partners, providing going-concern solutions (debt, equity, entirety sale) to distressed businesses. His team has completed more than 600 transactions with troubled companies, including approximately 300 approved transactions in 70 bankruptcy court districts. Mr. Mann has personally handled investment banking services for hundreds of companies in a host of industries. In chapter 11 cases, he has served as investment banker, bid examiner and expert witness, and he has testified more than 100 times in support of transactions produced by the firm. Mr. Mann has been a speaker at events hosted by ABI and the Turnaround Management Association (TMA), Florida Bar, Association of Insolvency & Restructuring Advisors (AIRA) and Mississippi Bankruptcy Conference, and he has been an author for ABI, TMA, and various secured lender trade and general business publications. He was named "Distressed M&A Dealmaker of the Year" by M&A Advisors and a "Top 100 Restructuring Professional" by *Turnarounds & Workouts*. Mr. Mann currently co-chairs ABI's Financial Advisors and Investment Banking Committee, and he serves on the board of TMA's Chesapeake Chapter. Prior to joining Equity Partners, Mr. Mann's experience included investment banking, public relations and marketing consulting, and he has owned and exited several successful businesses. He holds Series 7, 63 and 79 licenses, and he has been a licensed real estate agent since 2008. Mr. Mann received his Bachelor's degree with honors in business administration with a marketing concentration from Salisbury University.

Rachel Nanes is a partner with DLA Piper in Miami, where she focuses her practice in the area of corporate restructuring, particularly health care restructurings. She represents debtors, secured creditors, committees of unsecured creditors, purchasers and other interested parties in corporate restructurings, bankruptcy litigation and other bankruptcy-related matters. Ms. Nanes has been listed as a *Chambers USA* "Up and Coming" professional in South Florida Bankruptcy/Restructuring for 2021 and as a 2020 Associate to Watch in South Florida Bankruptcy/Restructuring, and she made the Daily Business Review's "On the Rise" list for 2020. She also received the "Non-profit Turnaround and Transaction of the Year Award" in 2020 by the Turnaround Management Association. Ms. Nanes received her B.S. in accounting from the University of Miami, her M.S. in accounting from Florida International University and her J.D. from the University of Florida Levin College of Law.

Scott K. Phillips, CPA is a managing director with Healthcare Management Partners in Washington, D.C. He has significant experience with government, tax-exempt and investor-owned health care service providers. Mr. Phillips has executive-level experience with mergers, acquisitions and turnaround situations, including restructuring in bankruptcy. In all of his health care provider turnaround assignments, he has successfully designed and implemented plans that simultaneously added patient volume and revenues while conserving cash and reducing unit costs. In addition to other responsibilities, Mr. Phillips is currently serving as the president and CEO of HMP Senior Solutions LLC, a wholly owned subsidiary of HMP that provides long-term management services to eldercare facilities (assisted living, skilled nursing and CCRCs). He also recently led the successful financial turnaround and chapter 9 reorganization of a 179-bed county-owned hospital, and in 2016, he was appointed CRO for a regional hospital company in chapter 11 that owned or managed eight critical-access hospitals, a billing and management company and a therapy services company. In addition, Mr. Phillips was the financial advisor to 18 tax-exempt continuing-care retirement communities, with more than 20,000 residents in 12 states who were affected by the bankruptcy and sale of Erick-

son Retirement Communities. He also has been the testifying expert, lead investigator or arbitrator in more than 50 high-profile health care industry legal disputes. Mr. Phillips received his B.S. in accounting from the University of Florida.