AMERICAN BANKRUPTCY INSTITUTE

Northeast Bankruptcy Conference and Consumer Forum

Health Care Bankruptcies

CONCURRENT SESSION

Hon. Janet E. Bostwick
U.S. Bankruptcy Court | Boston

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FTI Consulting, Inc. | New York

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Aaron M. Williams
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2025

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Hon. Janet E. Bostwick
US Bankruptcy Court Judge, District of Massachusetts

Judge Janet E. Bostwick was appointed to the U.S. Bankruptcy Court for the District of Massachusetts in 2019 after 30+ years as a bankruptcy attorney. She remains professional active, including Director of the American College of Bankruptcy, former IWIRC Chair, and founding chair of IWIRC-New England. Judge Bostwick earned a JD from Cornell Law School and a B.A. in Economics and Mathematics from SUNY Albany.

Adrienne Walker
Partner, Foley & Lardner

Adrienne's expertise in restructuring, finance, workouts, and bankruptcy litigation across healthcare, manufacturing, equipment finance, education, et al serves capital providers and agents, debtors, creditors, and committees as clients. Adrienne also serves as the Unitarian Universalist Association GC, ABI Board Member and VP of D&I, and IWIRC New England Director. She holds a JD from Suffolk University and a BA from Simmons University.

Aaron Williams
Member, Mintz, Levin, Cohn, Ferris, Glovsky & Popeo

Aaron's practice centers on complex commercial transactions, restructurings, and corporate and municipal bankruptcies. He regularly advises institutional investors on their investments in high-yield securities—both taxable and tax-exempt—in distressed situations as well as new-money deals. Aaron holds an LLM (Securities Regulation) from Georgetown University, a JD from Boston College, and an ALB from Harvard University.

Cynthia Romano
Senior Managing Director, FTI Consulting

Cynthia drives transformations, turnarounds, and transactions that maximize liquidity, profitability, and enterprise value. For 25+ years she has led companies in healthcare, real estate, technology and other industries from where they are to where they want to be, as advisor, executive, and fiduciary. An industry leader and recipient of numerous awards, Cynthia holds a BA from Brown University and an MBA from MIT Sloan School.

THE $5T PROBLEM

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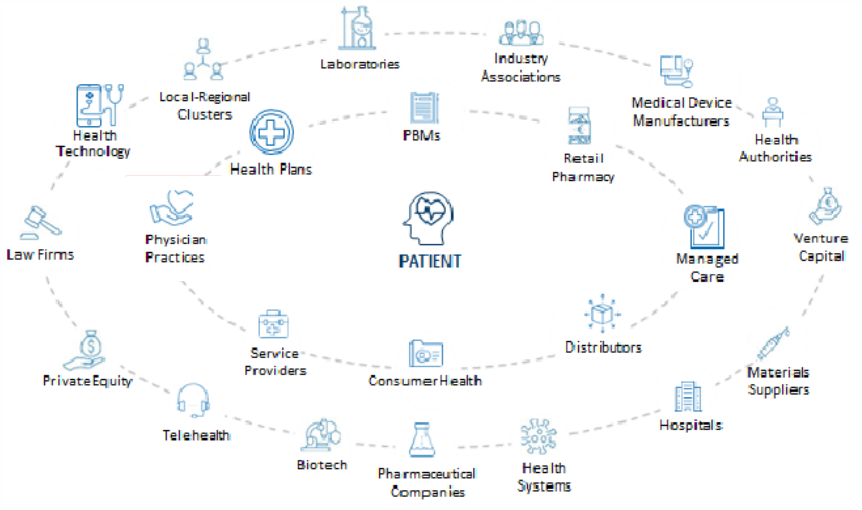
HEALTHCARE INDUSTRY | NOT A SINGLE INDUSTRY



4

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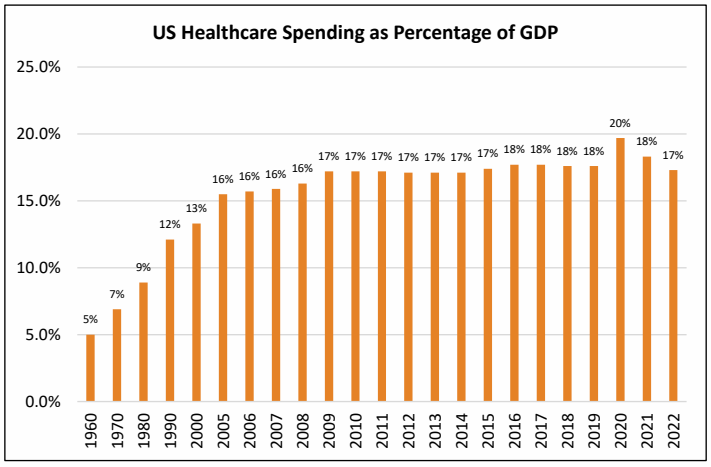
HEALTHCARE MACRO SNAPSHOT | US HEALTHCARE IS BROKEN

- **Expensive.** The U.S. spends more on healthcare than any other wealthy nation, with out-of-pocket costs ~5x higher and overall spending ~3x greater than the OECD average, totaling ~17% of GDP compared to ~12% in both Germany and France.
- **Ineffective.** Despite the high spending, Americans aren't living longer. U.S. life expectancy is 78.4 years, lower than any other developed nation for ~2x the spend of comparable countries.
- **Providers Failing**. Despite high spending, providers are struggling. 2023 healthcare bankruptcies hit a five year high with 2024 down just slightly (not necessarily indicative of a decline in distress).
- **Consumers Failing.** Nearly 20% of Americans have medical debt, which drives 62% of consumer bankruptcies.



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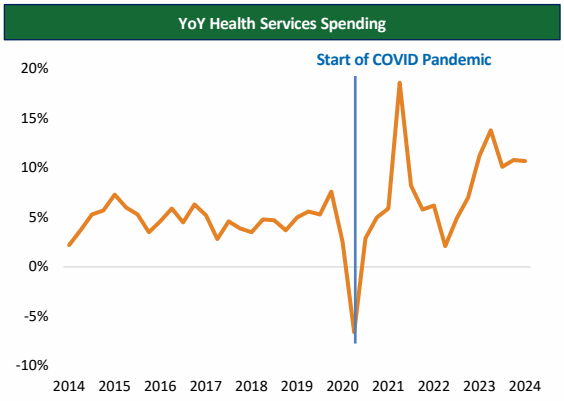
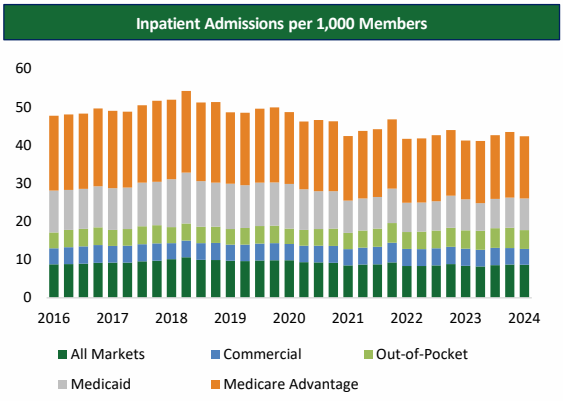
SPEND INCREASED WHILE UTILIZATION DECREASED





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KEY CHALLENGES

- **Staffing**. ~100,000 nurses left the profession during or immediately after the pandemic and it is estimated that 40% of inpatient RNs intend to leave their job within a year with resulting agency usage driving costs significantly up.
- **Access**. Issues driven by provider shortages, lack of insurance coverage and authorization, and socio-economic status. Example: 55/90 counties in Tennessee have no obstetrician and millions of Americans remain under or uninsured with payors denying > 10% pre-authorization. Even for those with access, patients often wait for months to be seen.
- **Inflation and Reimbursement**. Economy-wide inflation grew by 12.4% between 2021 and 2023, whereas Inpatient Prospective Payment System (IPPS) reimbursement only grew by 5.2%
- **Payor denials**. 67% of healthcare leaders say payors are denying claims more often, and 11% of all claims were denied in 2022, an increase of 10.1% from 2021.
- **Drug prices**. January 2022 to January 2023, 46 percent of drugs saw pricing increases that were larger than the rate of inflation. The average drug price increase over the course of the period was 15%.
- **Capex**. Hospitals face a growing list of capital needs, many of which were deferred during the pandemic. On average, 41% of infrastructure assets are in a deferred status, meaning past their useful life.
- **Technology and data security.** Despite actual and potential benefits, the cost of keeping pace with advances in (and nefarious actors using) technology add tremendous cost and risk to an already overburdened system.

7

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SAFETY NET HOSPITALS: WHAT IS A SAFETY NET HOSPITAL?

- Provide a significant level of care to patients regardless of their ability to pay, often uninsured, low income, and vulnerable populations
- Public (Western Massachusetts Hospital), privately owned (formerly Steward), either or nonprofit (Boston Medical Center)
- Are both Rural (Baystate Franklin) and urban (Boston Medical Center)
- Generally, maintain an “open door” policy; receive disproportionate share hospital (DSH) payments from Medicaid
- Estimated 5-25% of all acute care hospitals in US are considered safety net hospitals (large range due to lack of a uniform definition)

9

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SAFETY NET HOSPITALS: FINANCIAL HEALTH

- Since 2010, 182 rural hospitals have closed or stopped in patient care
- 46% of rural hospitals are in the red
- Typically operate on very low margins (2023 data)
  - Average operating margin for all hospitals was 5.2% (for profit at 14%);
  - Safety net hospital margins at 1.7% for urban hospital and 2.3% for rural hospitals
  - 39% of safety net hospitals operate in the red

10

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SAFETY NET HOSPITALS: FREQUENT CAUSES OF DISTRESS

- Capital Market Constraints
- Labor and Supply Cost Pressures
- Revenue Pressures
- Size and System Optimism
- Market Shift to Out of Hospital Care Delivery
- Recent considerations: Tariffs, OBBBA (more later), end of Covid era funds

11

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SAFETY NET HOSPITALS: INDICATORS OF ACUTE DISTRESS

- Days Cash on Hand
  - 2023 Mass. CHIA report of acute hospitals ranged from -44 days (Cooley Dickinson) to 215 days (Winchester Hospital)
- Liquidity Ratio
  - 2023 Mass. CHIA report of acute hospitals ranged from -96.2 (Good Samaritan) to 6.4 (Winchester); 17 of 60 reported < 1.0
- Debt service coverage ratio
  - 2023 Mass. CHIA report of acute hospitals ranged from -6.6 (MetroWest Medical) to 238.5 (Martha's Vineyard); 15 of 60 reported < 1.0

12

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CAREPOINT HEALTH SYSTEM: CASE STUDY

- Operated 3 health centers in Hudson County (approx. 1,000 acute care beds)
- 2 of 3 were identified as safety net systems
- Restructuring included sale of non-safety net Bayonne Medical to affiliate of Bayonne's landlord (Hudson Regional Hospital, or HRH)
- HRH to manage the safety net facilities
- Contested plan process (former owners and secured lenders heavily litigated), but ultimately the Bankruptcy Court confirmed the cramdown plan with limited substantive consolidation
- Created a Hudson County system that would aim to benefit from common management and larger-system efficiencies

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PIPELINE HEALTH SYSTEM: CASE STUDY

- Operated 7 for-profit hospitals in CA, TX, IL
- Stated financial distress included significant losses at IL, with CA and TX largely subsidizing IL losses
- Bankruptcy case accomplished sale of IL facilities
- Debt to equity exchange for CA and TX facilities

PROSPECT MEDICAL: CASE STUDY

- Operated large network in CA, CT, PA and RI, including 16 safety net hospitals
- Significant losses in PA led to a sale process for PA facilities
- PA sale fell through – lots of allegations of blame to be sorted out
- PA facilities were shuttered in March/April 2025
  - Loss of approximately 700 hospital beds at Crozer-Chester (424), Taylor (168) and reductions (maternity, OR, ICU and ED) at Delaware County Memorial (168)

15

BELLEVUE HOSPITAL: CASE STUDY

- Operated single hospital in rural Bellevue Ohio (50 beds)
- Financial distress led to an ownership transition (member substitution) process through chapter 11
- Senior secured creditors principal debt of about $17 million, received about $15 million at member exchange closing
- Case filed Feb. 5, 2025 and plan confirmed in April 2025

16

LESSONS LEARNED: A CASE STUDY

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LESSONS LEARNED FROM STEWARD HEALTH CARE

- Steward Health Care System LLC ("Steward")
  - Had been largest private, for-profit hospital operator in the U.S.
  - Operated more than 30 hospitals across eight states.
    - Many in underserved and/or rural communities.
- Together with affiliates, Steward filed voluntary Chapter 11 petitions in Bankr. S.D. Tex. on May 6, 2024.
- Case No. 24-90213 (jointly administered)

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COMPLEX CAPITAL STRUCTURE

- Founded by Cerberus Capital Management ("Cerberus")
  - 2010: Cerberus acquired six MA hospitals from Caritas Christi Health Care and rebranded as Steward Health Care.
  - Acquisition was part of a leveraged buyout.
    - $246 MM in cash. $895 MM in financed / assumed debt.
- Real estate spun off into Medical Properties Trust ("MPT")
  - Sale-leaseback netted immediate liquidity
  - But burdened operating entity with burdensome lease obligations
    - $400 MM in annual rent payments to MPT.
- Other (sector-wide) stresses:
  - Staffing shortages; declining reimbursement rates; post-pandemic demand shifts

19

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COMPRESSED TIMELINE

- Operating debtors-in-possession are always 'melting ice cubes,' but elevated urgency in the context of critical health infrastructure.
- Aggressive timeline proposed by Steward and approved by Judge Lopez:
  - 5/6/24 – Petition Date
  - 6/3/24 – Date for Entry of a Final DIP Order
    - And note significant objections, incl. DOJ's
  - 6/25/24 – Bid Deadline
  - 6/28/24 – Auction
  - 7/2/24 – Sale Hearing
- Focus – and pressure – then turns to regulatory review and approvals.

20

STAKEHOLDER MANAGEMENT

- In addition to usual suspects (secured lenders, creditors committee, DIP financiers, U.S. Trustee), need to consider and manage:
  - Communities, patients, families
  - Physicians, labor unions
  - State and local governments
  - Media and public at-large
- Massachusetts officials offered loud, sometimes brutal (and probably deserved) criticisms around (inter alia) lack of transparency, poor planning
  - Investigation into executive compensation
  - Legislation banning sale-leasebacks of core hospital real estate

21

PRIVATE EQUITY IN HEALTH CARE

- Cerberus reportedly extracted hundreds of millions in real estate profits and left behind a woefully undercapitalized operating entity
  - $790 MM special dividend, including $71 MM to CEO de la Torre
- Bankruptcy tools for suspect transactions
  - Rule 2004 examinations
  - Fraudulent transfer and preference frameworks
  - Beyond the Code: Reputational risk and broader legal exposure
- Debtor-side protections and prophylactics
  - Fair-value for real estate divestitures
  - Maintenance of fiduciary duties and observation of corporate formalities
  - Independent directors and special committees

22

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POTENTIAL IMPACT OF OBBBA ON SAFETY NET HOSPITALS

- Medicaid is a joint federal-state program for low-income people
  - Not a singular system – rather, 56 different Medicaid programs, (including states and territories)
- Approximately 71.3 million people (1 in 5 residents in the US) are enrolled in Medicaid as of early 2025 – the largest single source of health care coverage in the US
- Over 40% of births (nearly 50% of births in rural areas) are covered by Medicaid
- Medicaid expansion, as part of the ACA, allowed states to extend Medicaid eligibility to adults under 65 with income up to 138% of federal poverty (about $21,600 for a single person)
  - 40 states + DC have expanded
  - Feds pay 90% of costs for Medicaid expansion population
  - 24% of net patient revenue at safety net hospitals come from Medicaid (compared to 10% in states that did not expand)

24

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POTENTIAL IMPACT OF OBBBA ON SAFETY NET HOSPITALS (CONT.)

- Congressional Budget Office estimates $1 trillion in cuts to Medicaid over the next decade and may increase the number of uninsured people by 11.8 million
- Most significant provisions impacting Medicaid start in 2027
  - semi-annual redeterminations (expansion population)
  - 2 month retroactive enrollment (expansion population)
  - Limited to few exceptions, limits Medicaid eligibility to US citizens or permanent residents
  - Requirements for adults between 19-64, with meaningful exceptions (HHS guidance by 2026)

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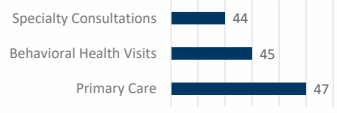
DIGITAL IMPERATIVES: CYBERSECURITY & EMERGING TECHNOLOGIES

Digital Transformation

45%
of executives
AI and automation are a significant consideration for them and their organizations

36%
of executives
Focused on enhancing **digital platforms** to improve operational resilience and patient outcomes

% of Visits by Telehealth



Cybersecurity and Data Privacy

50%
of executives
Highlighted security and privacy risks as their **greatest digital challenge**

Who? *Threat Actors*	Why? *Actor Motives*
External (67% of breaches)	Financial (90% of breaches)
Internal (30%)	Espionage (16%)
Partner (4%)	
Multiple (1%)	

Costliest industry for data breaches

$9.77
million USD
Average breach cost for healthcare

42%
of hospitals
Adopted **cyber insurance** for additional financial protection

Sources: FTI Consulting's 2025 Hospital Operations Survey Report. IBM's 2024 Cost of a Data Breach Report. Verizon's Data Breach Investigations Report.

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DIGITAL MODERNIZATION TRENDS ARE RAPIDLY SHAPING THE FUTURE OF HEALTHCARE

Rising Consumer Expectations	Workforce Shortage	Artificial Intelligence	Smart Health
Consumers expect personalized care anytime, anywhere that considers the holistic factors that contribute to their wellbeing.	**The impact from the clinical workforce shortage will require new staffing models and digital tools to augment human interactions.**	**AI revolutionizes patient and caregiver experiences by leveraging technology to streamline workflows, enhance communication, and improve outcomes.**	**Healthcare organizations rethinking care delivery, with the H@H model enabled by virtual care and remote monitoring gaining traction.**
Delivering care across care settings and channels that aligns with preferences proactive and seamless participation in care.	Empowering staff to do more with less while meeting patients where they are is vital for maximizing revenue and access opportunities.	Creating governance models and Centers of Excellence to support AI is imperative for organizations to be competitive.	Treating beyond confines of hospital walls is a promising trend, especially for aging populations, prompting new businesses lines.
60% Consumers who expect their **digital healthcare experience** to mirror that of retail[1]	**93%** Physicians who believe **digital health tools** are an advantage for patient care[2]	**$150B** Amount that AI capabilities and applications could **cut US healthcare costs by 2026**[3]	**93%** Patients are interested in **home monitoring** via wearables and at-home devices[4]

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DIGITAL HEALTHCARE: AN OVERVIEW

Digital Enablement & Innovation (DE&I)				Go-to-Market (GTM) Strategy	
Digital Health Maturity	Consumer Experience Strategies	Technology Strategy and Transformation	AI & Data Strategy and Transformation	Growth Strategy	Value Creation
Commercialization of Digital Products	Transformation Management Office	Centers of Excellence: Innovation, Automation, AI	Partnership and Ecosystem Development	Business Modeling	Human-Centered Tech Experience

28

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DIGITAL AND AI CAN CREATE SUSTAINABLE VALUE AND UNIQUE EXPERIENCES

RISING CONSUMER EXPECTATIONS: Rising consumerism is driving new entrants and pushing healthcare to offer a more retail-like, shoppable experience

~75% Millennials/Gen Z switch providers after bad experience

CRITICAL WORKFORCE SHORTAGES: The growing healthcare workforce shortage is pushing employers to expand capacity and maximize existing resources.

3.2M Projected US healthcare worker shortage by 2026

CHRONIC DISEASE BURDEN: Rising rates of multiple chronic conditions are driving costs, with those managing five or more accounting for over 40% of total spending.

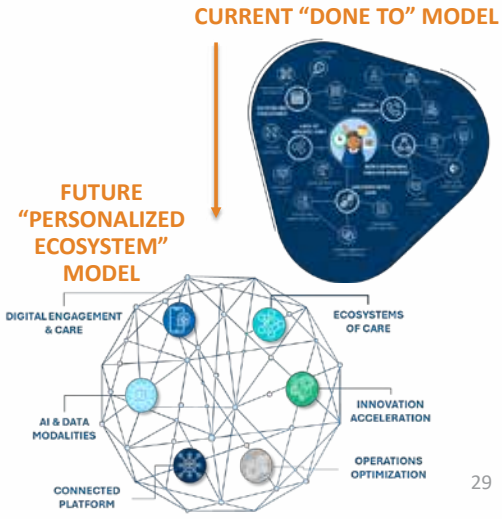
90% 1+ Chronic Issue
67% 3+ Chronic Issues

AGING POPULATION: An aging population is straining healthcare with higher chronic disease costs, fewer caregivers, and growing financial pressure.

53.9% Old Age Dependency Ratio

UNSUSTAINABLE COSTS: U.S. healthcare costs now exceed $4.3 trillion annually, outpacing wage growth and straining households and businesses while delivering less value than other nations.

1 in 3 (>100M) Americans struggling with unpaid medical bills



29

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KEY ISSUES: LOOKING FORWARD

- **Strong Recovery of Profit Pools:** Healthcare industry grew ~5% pre-COVID and remained flat during the pandemic. Estimated go-forward growth of 5%+ would add **over $30 billion in incremental profits**
- **Evolving Payer Matrix:** Government segments are expected to lead to charge of payer mix shift, as **aging population and preference for Medicare Advantage** over traditional FFS Medicare takes hold
- **Shift in Sites of Care:** COVID-19 **accelerated the movement of care** from high-cost acute / post-acute care to lower-cost alternative sites, paving the way for an uptick in home-based care
- **Improved but Challenged Outlook for Hospitals:** While hospital utilization has largely returned to pre-COVID levels, **patient mix continues to evolve and financial performance lags**
- **Proactive Approach to Patient Care:** Rapid adoption of data and advanced analytics is **spurring analytics in population health management, revenue cycle management, and patient engagement**
- **Specialty Drug Spend Catalyzing Pharma Spend:** New models of patient engagement and the entrance of new digital pharmacy models have **driven specialty drug development while amplifying margin pressure on PBMs and traditional drug** dispensers

30

ABI Northeast Conference
Heath Care and Bankruptcy
July 14-16, 2025

Recent Trends in Safety Net Hospital Bankruptcies

Adrienne Walker
Foley & Lardner LLP

A. Introduction

Safety net hospitals provide a vital resource to the health outcomes in the communities they serve. While there is no precise definition of a "safety net hospital", they are generally characterized as providing a significant level of care to patients, regardless of their ability to pay, often uninsured, low income, and vulnerable populations. These medical systems are both privately owned and nonprofit and most often characterized as maintaining an "open door" policy that receive a disproportionate share hospital (DSH) payments from Medicaid and/or Medicare.[1] While may consider safety net hospitals to be limited to urban settings, many rural hospitals are considered safety net hospitals typically because of the limited access to other healthcare providers in the area, resulting in the only option for residents including those who are low-income, uninsured or receiving Medicaid funding.

Safety net hospitals, regardless of structure or scope, are increasingly facing significant financial headwinds, leading to consolidation, closures and restructuring in and out of chapter 11 bankruptcy. According to a study published in 2025 by The Chartis Center for Rural Health, since 2010, 182 rural hospitals closed or converted to an operating model that excludes inpatient care, representing approximately 10% of all rural hospitals.[2] The Chartis report concluded that "46% of rural hospitals are in the red, and 432 are vulnerable to closure."[3] Rates of closures of urban safety net hospitals in the past several years are not similarly tracked, but a report from the Lown Institute recognized several safety net hospital closures or significant reductions of inpatient services, including Wellstar Hospital in Atlanta, Texas Vista Medical Center in San Antonio, St Vincent Charity Medical Center in Cleveland, and Delaware County Memorial Hospital in Philadelphia.[4]

The financial challenges facing safety net hospitals are nothing new; however, the increasing number of bankruptcies, closures and consolidations warrant consideration of the contributing

[1] Marion Lewin and Stuart Altman, eds. Institute of Medicine, America's Health Care Safety Net: Intact but Endangered (Washington, DC: National Academy Press, March 2000) https://www.ncbi.nlm.nih.gov/books/NBK224521/ (last visited July 6, 2025).
[2] Chartis, 2025 Rural Health State of the State, Instability Continues to Threaten Rural Health Safety Net, at 3 https://www.chartis.com/sites/default/files/documents/CCRH%20WP%20-%202025%20Rural%20health%20state%20of%20the%20state_021125.pdf (last visited July 6, 2025).
[3] *Id*. at 1.
[4] *See* Judith Garber, What happens when safety net hospitals close, dated May 4, 2023, https://lowninstitute.org/what-happens-when-safety-net-hospitals-close/ (last visited July 6, 2025).

factors of financial distress leading to recent chapter 11 cases. These materials first briefly address factors most often associated with the financial distress of safety net hospitals. Next, the materials provide a high-level summary of recent chapter 11 cases involving safety net hospitals to better understand the benefits and limitations of chapter 11 in resolving the financial distress these systems face.

B. Financial Distress in Safety Net Hospitals

The sources of financial distress impacting safety net hospitals that are frequently referenced in first day declarations include low liquidity due to high levels of "free and inadequately reimbursed" services, lopsided payer mix, and "unsustainable levels of accumulated debt."[5] For rural safety net hospitals, additional factors include dwindling access to care with approximately 10% of rural hospitals removing their inpatient beds since 2010.[6] As rural hospitals become "care deserts", particularly with sharp reductions in obstetrics and cancer care, the overall financial viability of many rural safety net hospitals are at risk.[7]

While not limited to safety net hospitals, according to a 2023 report from Gibbins Advisors, the following five factors are most often referenced when a health care business is facing financial distress:

1. Capital market constraints
   - Softening of interest rates expected in 2024 but refinancings, access to capital, valuations and transactions are still impacted by relatively high rates.
   - New requirements of FTC and state antitrust protections may limit strategic options.
2. Labor and Supply Cost Pressures
   - Large cost increases over the past 2 years have set a new baseline, creating a margin squeeze.
   - Agency labor settling down in some markets, but workforce headwinds continue and possible federal mandates for minimum staffing ratios would compound the challenges.
3. Revenue Pressure
   - Payment rate increases often not in line with cost inflation.
   - Material increase in denials from payors, especially Medicare Advantage.
   - Unwinding of Medicaid Continuous Enrollment during 2023 may materially increase the number of uninsured patients.

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[5] *In re CarePoint Health Systems Inc.*, Declaration of Shamiq Syed in Support of First Day Pleadings [ECF 23], Case No. 24-12534 (D. Del), November 4, 2024.

[6] Chartis, 2025 Rural Health State of the State, at 3

[7] *Id*. at 4-5. Notably, the Chartis report stated that between 2011 and 2023, nearly 300 hospitals stopped providing obstetrics services, representing approximately a quarter of all rural obstetrics units. In addition, between 2014 and 2024, approximately 425 rural hospitals stopped providing chemotherapy services, representing approximately 20% of all rural hospitals offering chemotherapy.

4. Possible Optimism
   - Mixture of rate and volume increases may be expected in 2024, but costs will likely remain a challenge, and smaller organizations with revenue under $500 million may fare worse than larger health systems.
   - COVID-19-related Federal Emergency Management Agency (FEMA) funds may be available as one-time grants.
5. Continuing shift to out-of-hospital care delivery
   - Care is moving from hospitals and skilled nursing facilities to outpatient, community and home-based settings, creating both opportunities and headwinds. [8]

An empirical study *The Predictive Factors of Hospital Bankruptcy – an Exploratory Study*, published in 2023[9], considered whether there are predictive factors for hospital bankruptcies, According to this study, the following factors are most likely to be determinative of whether or not a hospital files for chapter 11:

1. Levels of 'net patient revenue'. This is logical, the lower revenue, the greater impact on liquidity.
2. Levels of accounts receivable. Similar to above, if a facility does not create sufficient accounts receivables, it will not convert sufficient net patient revenue.
3. Joint Commission (TJC) accredited. The study reflected hat "the TJC 'brand name' recognition to insurers and levels of performance which TJC accredited facilities attain are factors which likely have an impact in our study."
4. Government-operated hospitals. These facilities tend to be larger academic medica centers and have access to taxpayer support and municipal bonds that reduce borrowing costs.
5. Current revenue ratio. The more liquidity that the hospital maintains, the less likely it is that it will go bankrupt.
6. Patient referrals. A positive patient experience is associated with increased referrals and overall profitability.
7. Total Assets. If lower total assets, the hospital does not have an asset cushion to liquidate if in financial distress.
8. Debt to Equity Ratio. This implies a reasonable use of debt financing, including tax advantages and limiting payouts to for-profit stockholders.

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[8] *See* Record Bankruptcy Filings in the Healthcare Sector in 2023 at https://gibbinsadvisors.com/record-bankruptcy-filings-in-the-healthcare-sector-in-2023/ (last visited July 6, 2025).

[9] Beauvais B, Ramamonjiarivelo Z, Betancourt J, Cruz J, Fulton L. The Predictive Factors of Hospital Bankruptcy-An Exploratory Study. Healthcare (Basel). 2023 Jan 5;11(2):165. doi: 10.3390/healthcare11020165. PMID: 36673533; PMCID: PMC9858769 https://pmc.ncbi.nlm.nih.gov/articles/PMC9858769/#B18-healthcare-11-00165 (last visited July 5, 2025). It is notable to report that the study excluded all Veterans Administration, Indian Health Services, and Military Healthcare Systems as they are indemnified against bankruptcy by the US taxpayers.

9. Percentage of Uncompensated Care. While counterintuitive, a high percentage may be offset by additional Medicaid DSH targeted payments.
10. Medicare as a Percentage of Total Payor Mix. A higher percentage is actually associated with a lower overall risk. While not intuitive, the study postures that while Medicare reimbursement rates may not sufficiently cover costs, the relatively quick days to pay for Medicare may avoid a critical liquidity event.

Paul Chatterjee, a recognized researcher at the University of Pennsylvania, Leonard Davis Institute of Health Economics reflected that with regard to safety net hospitals, the study "Acquisitions of Safety-Net Hospitals from 2016-2021: A Case Series", published in June 2024, recognized that "safety-net hospitals rely on a complex patchwork of subsidies from local, state, and federal levels, yet we see evidence that these subsidies aren't always effectively targeted to the hospitals with the greatest need. Recent policy initiatives are attempting to improve subsidy targeting to ensure these funds consistently reach safety-net hospitals."[10]

Research by America's Essential Hospital, an organization representing safety-net hospitals, reflected that while only 5% of acute care hospitals meet general understanding of "safety-net" hospitals, they provide approximately 25% of charity care nationwide. Given the rates of uninsured and low-income patients, safety-net hospitals operate on very low margins (-8.6%, compared to -1.4% for other hospitals).[11]

Finally, another study considering predictors of financial distress and bankruptcy found that the safety net hospitals "were also associated with low occupancy rate, slow collection of account receivables, poor payer mix in terms of a high percentage of Medicare and Medicaid patients, and aging facilities as well as poor management, fraud allegations, demographic changes, financial strategy/desire to sell, quality issues, physician malpractice insurance, physician politics and external politics."[12]

The referenced research studies are validated by anecdotal statements in several of the "first day" affidavits filed in recent safety-net hospital system chapter 11 cases. These declarations frequently referenced similar causes of financial distress for the affected debtors, including "increased technology costs, declining governmental sponsored insurance reimbursement, inflationary staffing cost pressures, increased demand from the uninsured in states where Medicaid coverage

[10] Miles Meline, MBE, What Happens to Access and Services When Safety-Net Hospitals are Sold, November 20 2024, https://ldi.upenn.edu/our-work/research-updates/what-happens-to-access-and-services-when-safety-net-hospitals-are-sold/ (last visited July 5, 2025).
[11] America's Essential Hospitals, Results of America's Essential Hospital 2021 Annual Hospital Characteristics Survey (2023) https://essentialhospitals.org/wp-content/uploads/2023/10/2023-Essential-Data_single-pages.pdf (last visited July 5, 2025).
[12] Carroll N.W., Landry A.Y., Erwin C.O., Cendoma P.J., Landry R.J., III, Factors Related to Hospital Bankruptcy: 2007–2019. J. Account. Financ. 2021; 21:11–23 http://www.na-businesspress.com/JAF/JAF21-2/1_CarrollFinal.pdf (last visited July 5, 2025).

was not expanded, intensified competition, and, more recently, loss of non-COVID related services."[13]

C. Recent Safety Net Hospital Bankruptcies: Trends and Study

i. CarePoint Health Systems d/b/a Just Health Foundation – Hudson County, New Jersey

CarePoint Health System Inc. d/b/a Just Health Foundation is a New Jersey non-profit corporation that operated the following three health centers in Hudson County, New Jersey, two of which serve as safety nets for a large underprivileged community:

- Bayonne Medical Center, (IJKG Opco LLC d/b/a CarePoint Health – Bayonne Medical Center)
  - 278 bed acute care facility
- Christ Hospital, Jersey City (Hudson Hospital Opco LLC d/b/a CarePoint Health – Christ Hospital)
  - 349 bed acute care facility
- Hoboken University Medical Center (HUMC Opco LLC, d/b/a CarePoint Health – Hoboken University Medical Center ("HUMC")).
  - 348 Bed acute care facility

In the first day declaration filed with its chapter 11 petition on November 4, 2024 by Shamiq Syed, the debtors' chief financial officer[14], the debtors cited their financial and liquidity challenges to include unreimbursed COVID-19 expenditures and the amount of free and inadequately reimbursed services provided to disadvantaged communities.

At the time of the chapter 11 filing, CarePoint had approximately $107 million in secured debt and $165 million of trade debt that it has been unable to service, resulting in the debtors being named as a defendant in 53 pending lawsuits. The debtors outlined their goals for the chapter 11 cases as "(a) staying the multiple pending collection actions, (b) resolving significant Debtor claims against certain insurance carriers, (c) rejecting unfavorable contracts or leases where necessary to efficiently streamline the Debtors' operations, and (d) giving the Debtors breathing room to effectuate the prepetition restructuring arrangements that are already underway and to implement them through a plan of reorganization."[15]

As reflected in the first day declaration, the restructuring proposal centered around a prepetition agreement to transfer the non-safety net Bayonne hospital to Hudson Regional Hospital (HRH), which is an affiliate of Bayonne's landlord. In addition, HRH would become the replacement manager for Christ Hospital and HUMC, the safety-net hospitals. HRH agreed to provide DIP

[13] *See* Predictive Factors of Hospital Bankruptcy.

[14] Declaration of Shamiq Syed in Support of First Day Pleadings, In re CarePoint Health Systems Inc., Case No. 24-12534 [ECF 23] (Bankr. D. DE).

[15] *Id*. at ¶16.

funding, which amounts would be used to credit bid the sale of Bayonne. The ultimate result of the restructuring would be a four-location healthcare system in the Hudson County area, which would include an existing HRH entity (not in bankruptcy).

The CarePoint case faced many hurdles in its restructuring path, including an initial involuntary petition against an affiliate debtor, a contested restructuring plan with significant objections from the secured parties, and debtor entities with differing restructuring goals, including certain physician practice debtors that sought to maintain their equity interests. Prior to the initial confirmation hearing, the parties engaged in a mediation process before Judge Kaplan, which resolved many issues but was ultimately unsuccessful.

The CarePoint plan contemplated two tracks: (i) incorporating the prepetition agreement with HRH, including a right to credit bid its prepetition claim and (ii) a short period of time of "exposing" the deal to see if there are any other parties interested in submitting competing bids or offers. No competitors submitted offers and the Court considered confirmation of the contested plan in March 2024. The plan included several characteristics worthy of consideration, including a limited substantive consolidation, retention of equity interests for certain physician group debtors, and allegations of conflicts and total recovery value to HRH. Recovery to holders of general unsecured claims was anticipated to be nominal, dependent on recoveries under the liquidation trust.

While the debtors acknowledged their financial distress was due to liquidity problems resulting from significant unreimbursed care and lower Medicaid and Medicare reimbursement rates, the restructuring plan largely left the revenue sources unmodified. Given the necessity to maintain the Medicare, Medicaid and third-party provider agreements and the inability under the Bankruptcy Code to modify executory contracts, the debtors did not seek to modify the provider agreements. Rather, the plan focused on operational efficiencies to operate under a unified 4 facility system, resolve pending litigation and ultimately provide a *de minimis* return to unsecured trade vendors.

After a contested confirmation process, the Bankruptcy Court initially denied confirmation of the debtors' fifth amended plan because it left the potential for HRH to receive greater than 100% recovery and certain physician practice group debtors could not retain equity if unsecured creditors were not paid in full, in violation of the absolute priority rule.[16]

The debtors thereafter made certain modifications to the plan to address the Bankruptcy Court's concerns and basis for denial of confirmation. The debtors filed a further amended plan on April 15, 2025, which was confirmed by the Bankruptcy Court on April 17, 2025. The confirmed plan has been appealed by the secured creditor Maple Healthcare and related, "prior owner" entities, which the debtors suggest is related to potential litigation claims and not the restructuring plan.[17] Thus, more to come.

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[16] CarePoint Health, Bench Ruling re Confirmation [ECF 1151] (April 14, 2025).
[17] CarePoint Health, Notice of Appeal [ECF 1207] (May 1, 2025)

ii. Pipeline Health System – California, Texas and Illinois

Pipeline Health System operates a for-profit seven-hospital safety net system located across California, Texas, and Illinois, with only two of the debtor entities being nonprofit companies. Pipeline filed for chapter 11 bankruptcy protection on October 2, 2022, in the Southern District of Texas. According to the first day declaration, the filing was attributed to rising expenses, including labor costs, aging facilities, and delayed funding from government programs.[18] As described in the first day declaration, the Pipeline system included 1,150 beds, approximately 310 physicians and a companywide workforce of over 4,200.

Pipeline's first day declaration stated that the debtors rely on government reimbursement payments and other governmental funding to fund operations, with approximately 2/3 of all Pipeline patients in 2020 dependent on government programs for healthcare coverage.[19] As summarized in the first day declaration, many of the following factors that led to the debtors' financial distress are predictors of chapter 11 referenced above:

- Pipeline experienced "a number of material funding delays in connection with governmental health coverage programs, which has placed the Debtors under significant financial strain." Further, there were increased recoupment by Medicare. [20]
- "In the wake of the COVID-19 pandemic, Pipeline's costs for nurses and other contract labor and medical supplies skyrocketed."[21]
- The debtors' aging facilities require "extensive" capital expenditures to maintain.[22]
- The debtors are burdened by legacy contracts for labor, goods and technology services.[23]
- In 2022, Pipeline's Illinois operations experienced significant net losses of $68.74 million, while California had a positive EBIDAR of $2.64 million.[24]

The capital structure of the debtors consisted of aggregate secured debt obligations of approximately $357 million.

The debtors' stated that while the entire system experienced financial challenges, the financial distress impacting the Illinois facilities was acute. As a result, the California and Texas facilities

[18] Declaration of Russell A. Perry, Chief Transformation Officer of Pipeline Health System in Support of Chapter 11 Petitions and First Day Motions, In re Pipeline Health System, Case No. 22-90291 [ECF 23] (S.D. Tex. October 3, 2022).
[19] *Id*. at ¶ 7.
[20] *Id*. at ¶¶ 7, 46.
[21] *Id*. at ¶ 8.
[22] *Id*.
[23] *Id*.
[24] *Id*. at ¶ 33.

were effectively subsidizing the Illinois facilities (Weiss Memorial Hospital and West Suburban Medical Center), leading to a destabilization of the debtors' overall healthcare network.[25]

The key aspects to Pipeline's restructuring were (a) the sale of the Illinois facilities, which was negotiated prior to the petition date, and (b) an exchange of the existing funded debt for equity, resulting in a reorganization of the California and Texas facilities. The restructuring plan initially faced challenges, including by the committee, seeking to recharacterize a master lease. Ultimately, the parties negotiated a resolution to the disputes to proceed with a substantially consensual plan confirmation. While general unsecured claims did not receive any distributions under the plan, certain additional consideration was made for holders of cure claims and release of many preference actions that could have been asserted against unsecured creditors.

iii. *Prospect Medical Holdings – California, Connecticut, Pennsylvania, and Rhode Island*

Prospect operated a network of hospitals and affiliates, including 16 safety net hospitals providing acute and behavioral health facilities across California, Connecticut, Pennsylvania, and Rhode Island. Prospect filed for chapter 11 protection on January 11, 2025, in the Northern District of Texas. The debtors stated their hospitals play a "vital role" in their communities. The first day declaration attributes the debtors' financial distress to decreased revenue and increased costs arising from Covid-19, which disrupted normal operations. The debtors also stated their financial condition had been further impacted by skyrocketing expenses, including due to inflationary challenges.[26] The Company has approximately $2.3 billion in total funded debt obligations, of which approximately $1.1 billion sits at the debtors.[27]

As this case is still active and premature for study, the scope of review here is expressly limited to the outcome of the Pennsylvania facilities.

Prospect stated its restructuring goals were to divest its operations outside of California and to sell the Roger Williams Medical Center and Our Lady of Fatima Medical Center in Rhode Island to Centurion Foundation within the chapter 11 cases. Additionally, the debtors announced at the time of the filing that they were working with the Commonwealth of Pennsylvania to divest the Crozer-Chester Medical Center.

From the outset of the chapter 11 cases, the debtors acknowledged the challenges to sell the Pennsylvania hospitals, including pending litigation by the Attorney General's office for the Commonwealth of Pennsylvania. Soon after commencing the chapter 11 cases, the debtors announced a pending private sale of the Pennsylvania assets to a nonprofit entity. [28] However, the sale hit certain roadblocks and was unable to progress to closure. Ultimately, the debtors agreed

[25] *Id*. at 10.
[26] Declaration of Paul Rundell in Support of Debtors' Chapter 11 Petition and First Day Pleadings, In re Prospect Medical Holdings, Inc., [ECF 41, at ¶ 8], Case No 25-80002 (Banrk. N.D. Tex).
[27] *Id*. at 39.
[28] Debtors' Emergency Motion for Entry of an Ordre (I) Approving and Authorizing (A) the Asset Purchase Agreement and the Private Sale of the Pennsylvania Hospitals, In re Prospect Medical Holdings, Inc. [ECF 332].

with the PA Attorney General's Office to place the Pennsylvania entities into a receivership for an initial 30 day period, until early March 2025. While the Pennsylvania facilities remained open during the receivership and discussions continued to explore the possibility of a sale of the Pennsylvania entities as a going concern, the sale negotiations ultimately stalled in late March 2025, which the debtors attribute to "orchestrated" state court litigation commenced by the Foundation for Delaware County seeking to transition the Pennsylvania facilities to nonprofit operators.

The debtors, PA Attorney's General and other parties in interest continued to negotiate potential divestment of the PA hospitals in March and April of 2025, but with limited liquidity to operate, the debtors obtained approval from the bankruptcy court and state regulators in late April to begin closing the PA hospitals. The closure of the three hospitals has resulted in significant disruptions to patient care. The debtors are undergoing liquidation asset sales of the Pennsylvania assets.

iv. The Bellevue Hospital – Ohio (single location)

Bellevue Hospital, located in Bellevue, Ohio, is a 50 bed nonprofit rural hospital in north-central Ohio. On February 5, 2025, the hospital filed for chapter 11, identifying financial distress due to rising operational costs, regulatory complexity, funding constraints, and access to capital. The first day declaration attributed the bankruptcy filing to cost increases and inflation that outpaced reimbursement gains from Medicare and Medicaid. In addition, the debtor is an independent facility that lacks a connection to a larger system, which does not benefit from larger hospital system efficiencies for shared services and purchasing strength. Further, the debtor identified increased denials by third-party payors, provider shortages, the cessation of pandemic funding as contributing factors to Bellevue's financial distress.

The debtor stated that the chapter 11 case was to implement a restructuring support agreement, which contemplated a member substitution, whereby Fireland Regional Health System, the debtor's 20% owner, would become the debtor's new member. The debtor's secured creditors were owed over $17 million and supported this restructuring plan under a prepetition restructuring support agreement.

Soon after the petition date, on February 28, 2025, the debtor filed its plan and disclosure statement. The plan was confirmed by the bankruptcy court on April 16, 2025, and went effective on May 16, 2025. The secured creditor ultimately received $15 million from Fireland Regional on account of its secured claim, and administrative claims were scheduled for payment.

ABI Northeast Conference
Health Care Bankruptcies
July 14-16, 2025

Lessons Learned From Steward Health Care: A Discussion Outline

Aaron M. Williams, Mintz

I. Introduction
   a. Steward Health Care System LLC ("Steward")
      i. Had been largest private, for-profit hospital operator in U.S.[1]
      ii. Following acquisition of IASIS in 2017, Steward operated 36 hospitals across ten states
         1. Many in underserved and/or rural communities
   b. On May 6, 2024, Steward at its affiliates filed voluntary petitions under Chapter 11 filing in Bankr. S.D. Tex.[2]
      i. Schedules reflected over $9 billion of liabilities
         1. Incl. $6.6 billion of lease obligations
      ii. Critics viewed the bankruptcy as a consequence of ill-conceived real estate maneuvers; private equity entanglements; systemic failure in oversight[3]
      iii. Lessons to be learned in areas of: corporate structuring; landlord-tenant dynamics; regulatory interplay; PE-driven healthcare models
II. Complex Capital Structures – Obscuring and Accelerating Distress
   a. Founded by Cerberus Capital Management
      i. Positioned as a savior for struggling community hospitals
   b. 2016: Real estate spun off into Medical Properties Trust (MPT) (a REIT)[4]
      i. Sale-leaseback netted immediate liquidity
         1. But saddled operating entity with burdensome lease obligations
   c. Structural fragility: Rent payments to MPT > $400 million
      i. Adding to sector-wide stresses – *e.g.* ...
         1. Staffing shortages
         2. Declining reimbursement rates
         3. Post-pandemic demand shifts
   d. Without real estate, debtor is asset-bare (*i.e.*, lenders deeply undersecured)
      i. Complicates DIP financing
      ii. Harms prospects of reorganization

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[1] Healthcare Dive, "Steward becomes largest private for-profit hospital system with IASIS purchase." Oct. 3, 2017; available at https://www.healthcaredive.com/news/steward-becomes-largest-private-for-profit-hospital-system-with-iasis-purch/506324/

[2] *In re* Steward Health Care Sys., No. 24-90213 (Bankr. S.D. Tex.)

[3] Private Equity Stakeholder Project, "The Pillaging of Steward Health Care." June 26, 2024; available at: https://pestakeholder.org/reports/the-pillaging-of-steward-health-care

[4] Business Insider, "Plunder, sell, repeat: How wealth investors keep bankrupting needy hospitals." May 17, 2025; available at https://www.businessinsider.com/american-hospitals-bankrupt-closing-wealthy-investors-looting-reselling-private-equity-2025-3

III. Health Care Bankruptcies – A Race Against Time
- a. Bankruptcies of operating entities = inherently a melting ice cube
  - i. Heightened urgency and complexity in the context when critical health infrastructure at risk
    1. Not just a commercial event, but a public health emergency
- b. Ups the stakes and turns up the heat on practitioners and the court
  - i. From first days → DIP financing; avoidance of service interruptions
  - ii. Aggressive timeline for DIP financing and asset sales:[5]
    1. Petition Date – May 6, 2024
    2. Entry of Final DIP Order – June 3, 2024
    3. Bid Deadline – June 25, 2024
    4. Auction – June 28, 2024
    5. Sale Hearing – July 2, 2024
- c. Initial DIP financing and objections thereto:
  - i. Initial $75 million DIP from MPT – sought another $300MM[6]
  - ii. Among other significant and substantive objections,[7] the UST/DOJ objected to the proposed DIP financing on various grounds, including:[8]
    1. Rushed schedule / milestones;
    2. Undermining regulatory rights and ability to complete antitrust review prior to transaction closings.
- d. Focus turned to regulatory review and approvals:
  - i. CMS, state health departments, licensure boards
  - ii. Narrow timelines for highly technical reviews related to regulator consents to transfers of hospital licenses and provider agreements
  - iii. Possible consequences of regulators not responding on accelerated timeline:
    1. Closures, fines, abandonment of patients
    2. *See also* Amsterdam at Harborside (Ch. 33)[9]

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[5] See *In re Steward Health Care*, "Declaration of John R. Castellano in Support of Debtors' Chapter 11 Petitions and First-Day Pleadings' [Dkt. No. 38] at ¶ 15. Timeline was approved, substantially as proposed, by Judge Lopez.

[6] *In re Steward Health Care*, "Emergency Motion of Debtors for Interim and Final Orders (I) Authorizing the Debtors to (A) Obtain Junior Lien Postpetition Financing ..." [Dkt. No. 46].

[7] Other objectors included (without limitation) existing lenders, insurance companies, labor unions, contractors, providers of goods and services, and the patient care ombudsman.

[8] *In re Steward Health Care*, "United States' Limited Objection and Reservation of Rights Regarding the Debtors' Motion for Entry of a Final Order Authorizing Debtors to Incur Debtor-In-Possession Financing ..." [Dkt. No. 448].

[9] *In re Amsterdam House Continuing Care Retirement Community, Inc. d/b/a The Harborside*, Case No. 23-70989 (Bankr. E.D.N.Y.) Approved sale to for-profit acquirer failed when acquirer withdrew from sale, purportedly on account of inaction on the part of New York Department of Health; *see* McKnights Senior Living, "Deal to save New York CCRC off the table after state's rejection." Oct. 11. 2024; available at https://www.mcknightsseniorliving.com/news/deal-to-save-new-york-ccrc-off-the-table-after-states-rejection/

IV. Increased Scrutiny on Role of Private Equity in Health Care
   a. Cerberus reportedly extracted hundreds of millions in real estate profits, dividends and left behind a dramatically undercapitalized operating entity[10]
      i. PE firms painted in Congressional hearings and in the court of public opinion as today's 'robber barons,' while operating companies (and creditors) relying on razor-thin margins from public payors, unprofitable services (behavioral health, trauma care)[11]
         1. $790MM special dividend, incl. $71MM to de la Torre
   b. Turning the microscope on transactions with affiliates / insiders
      i. Applicability of fraudulent transfer and preference frameworks
      ii. Examination of fair-value for real estate divestitures
      iii. Propriety of dividends in light of underlying (or approaching) insolvency
      iv. Observation of fiduciary duties, corporate formalities
   c. Remedies
      i. Clawbacks can be difficult to realize upon
      ii. But reputational risk and broader legal exposure (AG investigations) may be greater threats
         1. Door opened to discovery (*e.g.*, Rule 2004 examinations) into alleged prepetition malfeasances (dividends, recapitalizations, conflicts of interest)

V. Stakeholder Management – Not Just the Usual Suspects
   a. In addition to the usual array of secured lenders, creditors committee, DIP financiers, the UST (etc.), also need to grapple with:
      i. Communities, patients, families
      ii. Physicians, unions
      iii. State and local governments
      iv. Media and public at-large
   b. Massachusetts officials offered loud and brutal (and arguably deserved) criticisms, incl. around perceived lack of transparency, poor planning
      i. AG demands rel. to executive compensation, transition plans
      ii. Legislation banning sale-leasebacks of core hospital real estate[12]

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[10] *See* The American Prospect, "Reversing Private Equity's Looting of Hospitals." Feb. 13, 2024; available at: https://prospect.org/health/2024-02-13-reversing-private-equitys-looting-hospitals

[11] *See* Fierce Healthcare, "With Steward's struggles on full display, clinicians, lawmakers sound the alarm of private equity's impact on healthcare." Apr. 3, 2024; available at: https://www.fiercehealthcare.com/regulatory/steward-healthcares-struggles-full-display-clinicians-policy-researchers-tell-senators

[12] *See* Proskauer, "Spurred on by the Steward Health Care Bankruptcy, Massachusetts Adopts Bill Regulating Private Equity and REITs in Health Care Continuing a National Trend." Jan. 31, 2025; available at: https://www.proskauer.com/blog/spurred-on-by-the-steward-health-care-bankruptcy-massachusetts-adopts-bill-regulating-private-equity-and-reits-in-health-care-continuing-a-national-trend

Faculty

Hon. Janet E. Bostwick is a U.S. Bankruptcy Judge for the District of Massachusetts in Boston, appointed on Sept. 27, 2019. Prior to her appointment, she practiced as a bankruptcy attorney with more than 30 years of experience with financially troubled companies, dealing with chapter 11 business reorganizations, liquidations and wind-downs, loan workouts and creditor negotiations. From 2001-19, Judge Bostwick practiced at her own firm, Janet E. Bostwick, PC, which focused on business bankruptcy and restructuring. Before launching her firm, she practiced at the Boston firms of Goldstein & Manello, PC and Sherin and Lodgen, LLP. Judge Bostwick is a director of the American College of Bankruptcy and serves on the *Pro Bono* Committee of the American College of Bankruptcy Foundation, which is the largest funder of bankruptcy *pro bono* projects and grants. Judge Bostwick frequently lectures on bankruptcy topics for professional organizations and bar organizations. She is a member of the American Bar Association, for which she serves as co-chair of the Administration and Courts Subcommittee of the ABA Business Bankruptcy Law Committee. She also is a member of the National Conference of Bankruptcy Judges, where she serves on the Membership and Next Generation Committees. Judge Bostwick is a member of the International Women's Insolvency & Restructuring Confederation, the Boston Bar Association and the Massachusetts Bar Association. In 2016, the U.S. Bankruptcy Court for the District of Massachusetts awarded her the District of Massachusetts *Pro Bono* Award for her work with the program as well as her other *pro bono* activities over the years. Judge Bostwick received her B.A. in economics and mathematics from the State University of New York at Albany and her J.D. from Cornell Law School.

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