



AMERICAN
BANKRUPTCY
INSTITUTE

2025 Winter Leadership
Conference

Health Care Bankruptcies and Managing Long-Term-Care Facility Distress

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CONCURRENT SESSION

2025



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Health Care is Primarily About Acronyms

Commonly Used Terms in the Senior Living Industry

- **Independent Living (IL):** A form of housing that is restricted by age group, most often for people who are 55 and older.
- **Assisted Living (AL):** For seniors who need help with the daily activities of life and can no longer live completely independently. AL residents typically live in their own apartments but share common rooms for meals, physical therapy/exercise, and other amenities but require assistance with bathing and personal care, medications, housekeeping, and laundry and are typically provided three on site meals per day.
- **Skilled Nursing (SNF):** Used interchangeably with the term “nursing home”. A medical facility that provides near constant skilled nursing and supportive care. The residents of SNFs are often called “patients”, not “residents”, and they typically have significant chronic conditions or have recently been discharged from a hospital and are recovering from an illness, injury, surgery, or other significant medical procedure.
- **Memory Care (MC):** A memory care facility is a residential care community for people with memory loss, dementia, Alzheimer's disease, other significant cognitive impairment.
- **Hospice:** More a “program” than a “facility”, hospice gives special care to individuals who are at or near end of life who have stopped treatment and other efforts to cure their conditions. Generally, to be admitted to hospice, a physician must opine that an individual has a life expectancy of six months or less. Hospice care can be provided in a facility setting or at home.
- **Continuing Care Retirement Community (CCRC):** A CCRC is typically a large facility that initially admits residents to IL but provides that, as the individual ages and their healthcare needs become more elevated, the resident can move from IL to AL and eventually to SNF, MC, or even hospice in some instances. CCRC finances are highly complex, Jordana can explain it.



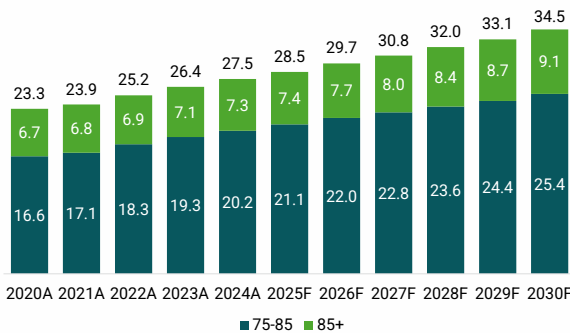
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Senior Living & Long-Term Care Industry

Senior population continues to grow, and patients diagnosed with Alzheimer’s is expected to increase

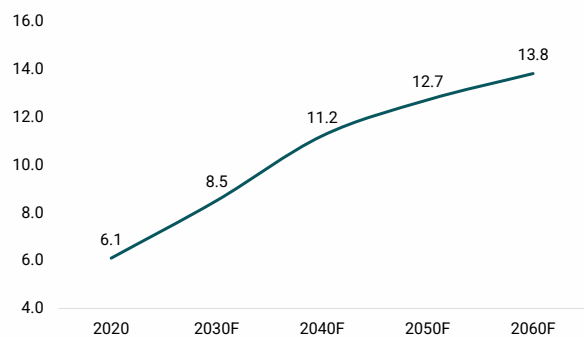
US Senior Population Projection

(# in millions)



Projected People Aged 65+ with Alzheimer's

(millions of people)



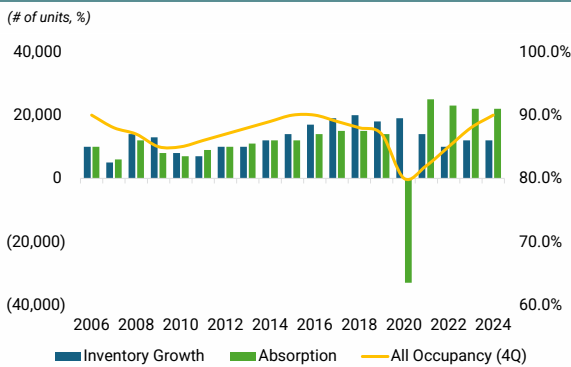
Source: Alzheimer Association, U.S. Census Bureau

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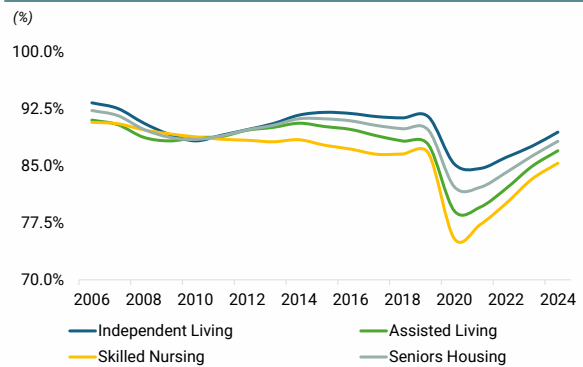
Senior Living & Long-Term Care Industry

Market fundamentals continue to recover from pandemic-induced occupancy volatility

Senior Housing Historical Inventory / Occupancy



Senior Living Stabilized Occupancy



Source: Bloomberg, National Investment Center

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Dynamics of OpCo / PropCo Structures

Role of REIT Landlords

- Lease facilities to operators through master leases with annual rent escalators
- Sale-leasebacks allow operators access to capital and makes balance sheets more efficient
- REIT tenant restructuring issues
 - *Operational control and "true operator" risk*
 - *Operator swap timing and preference exposure*
 - *Transition agreement terms and exit provisions*
 - *Real estate vs. operational value attribution*
 - *Cross-default and cross-collateralization*

REIT Landlord v. SNF Operator

- Treatment of master leases in bankruptcy
- Residential lease or non-residential lease?
- Lease recharacterization risk
 - *"True lease" v. disguised financing*
- Transferring a provider agreement free and clear of overpayment liability
 - *Verity Health Systems decision*
- Bankruptcy court intervention in CMS disputes
 - *Genesis Healthcare temporary injunction*
- Post-petition, post-rejection rent



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Transitioning Control of Skilled Nursing Facilities

- Increased Use of Receiverships
 - The Leverage Shift
 - Options for a Landlord or Lender
 - How Healthcare Receiverships Work
- Allocation of Value Between OpCo & PropCo – OTA vs. APA
 - Challenges by Plaintiff’s Lawyers & Other OpCo Creditors
- CHOWs and IMAs
 - Overview of the CHOW Process
 - Is the “fully-at-risk” IMA Illegal?
- Uptick in OTA Dirty Deeds
 - Understanding Medicare and Medicaid Provider Agreements
 - The OTA True Up
 - Role of Bad Actors
 - Potential Remedies
 - Constructive Trust Language
 - Segregated Accounts
 - DACAs & DAISAs



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OBBBA Impact on the Skilled Nursing Industry

Regulatory relief vs. reimbursement challenges for skilled nursing operators

Pros	Cons
<ul style="list-style-type: none"> • No federal staffing requirements for 10 years <ul style="list-style-type: none"> • <i>Removes requirements for 24/7 R.N. coverage and specific hours per resident day leading to cost saving in tight labor markets</i> • <i>Flexibility to staff based on acuity and local market conditions</i> • <i>Reduced compliance and reporting burden</i> • Protection from states implementing new provider taxes or increasing existing provider taxes 	<ul style="list-style-type: none"> • Medicaid eligibility restrictions to cause lower eligible participants and enrollees <ul style="list-style-type: none"> • <i>Work requirements, citizenship verification</i> • Lower revenue from fewer covered patient days • Additional administrative burden to track patient eligibility changes with redeterminations now required every six months instead of annually <ul style="list-style-type: none"> • <i>Higher uncollectable account receivables from residents losing coverage mid-stay</i> • Medicaid transparency rules stay in place





Skilled Nursing Industry – Distress Factors


Industry Distress Factors / Risks	Bankruptcy Specific Developments
<ul style="list-style-type: none"> • Labor shortages and declining quality of care • Occupancy volatility • Growing regulatory requirements • Cashflow collection dependent on government / 3rd party reimbursement <ul style="list-style-type: none"> • <i>Both government and private payers are becoming stricter on reimbursements</i> • Revocation of licenses and certifications significantly reduces asset marketability and transferable value • Malpractice and regulatory penalties 	<ul style="list-style-type: none"> • Post-pandemic Chapter 11 filings are surging due to occupancy losses and cost inflation • Growing scrutiny of pre-bankruptcy transfers and related-party transactions, especially in PE-backed deals • Piecemeal liquidations increasing as buyers cherry-pick assets, leaving distressed facilities to close • State regulatory intervention is complicating license transfers and delaying asset sales • Lease classification battles over whether SNF leases are "residential" vs. "non-residential" property, affecting rejection damages



Understanding Municipal Bond Structures

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Senior living, CCRCs (Continuing Care Retirement Communities), and nursing home facilities are often financed through **tax-exempt municipal bonds**.
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These financings blend **public bond structures** with **private-sector operational risk**.
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When financial stress arises, the complex stakeholder landscape requires a coordinated restructuring approach.





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Types of Municipal Bonds

General Obligation (GO) Bonds

- **Backed by:** The “full faith and credit” (i.e., taxing power) of the municipality (a city, county, or state)
- **Implication for healthcare:** If a city issues GO bonds to support a hospital or healthcare project, repayment comes from broad tax revenues, not from the hospital’s own performance
- **Risk profile:** Considered safer, since bondholders can rely on the municipality’s taxing authority even if the healthcare facility struggles
- **Key nuance:** Still political risk — if a hospital closure damages the local economy, tax revenues may be indirectly affected, but GO bondholders have first claim on tax collections.

Revenue Bonds (Healthcare-Specific)

- **Backed by:** Revenues generated by a specific project or entity — in this case, the hospital or healthcare system.
- **Implication for healthcare:** Repayment depends on patient revenues, insurance reimbursements, and the financial health of the provider.
- **Risk profile:** Higher risk — if the hospital system goes bankrupt, revenue bonds can suffer steep losses.
- **Key nuance:** Many nonprofit hospital systems issue *conduit revenue bonds* through state or local authorities — but ultimate repayment rests on the hospital’s credit, not the government’s.



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Key Features of Healthcare Financing

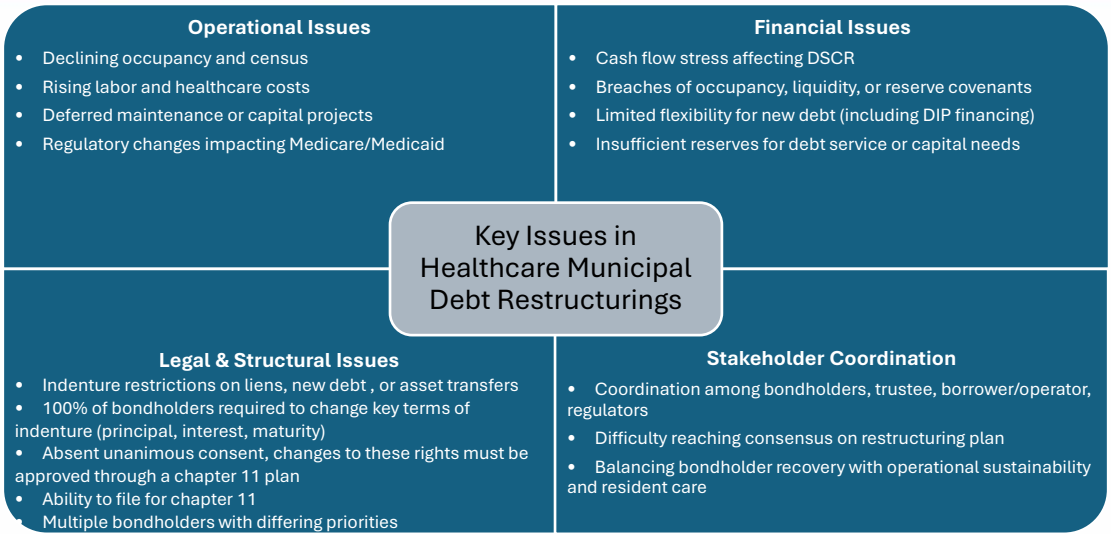
Typical Financing Structure

- **Issuer:** State or local conduit authority (e.g., health facilities development corporation)
- **Borrower/Obligor:** Nonprofit or for-profit senior living operator
- **Indenture Trustee:** Represents bondholders’ collective interests and enforces rights
- **Bondholders:** Institutional or retail investors in tax-exempt debt
- **Credit Enhancement (sometimes):** Debt service reserve fund, mortgage lien, or revenue pledge

Common Structural Features

- **Revenue Bonds:** Secured primarily by facility revenues and accounts
- **Indenture / Trust Agreement:** Defines security, covenants, and default remedies
- **Loan Agreement:** Obligation of the borrower to repay the issuer
- **Covenants:** Debt service coverage ratios, liquidity requirements, occupancy levels
- **Security:** Often includes a mortgage, UCC liens, and gross revenue pledge
- **Reserves:** Debt service, repair and replacement, and operating reserves

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Common Issues in CCRC Workouts & Restructurings

- Overview of the CCRC Structure
 - IL > AL > SNF > Memory Care > Hospice
- Treatment of Entrance Fee Refunds
 - Overview of the Model or “Scheme”
 - Country Club Model
 - Unit-by-Unit Model
 - Resident Refunds vs. Bondholder Recoveries
 - Conversion to Rental
 - Does the Model Make Sense?
- Securities Laws
 - NDA, MNPI, Restricted Groups, No-Trade Agreements, EMMA, and Cleansing
- Tranched Indenture Structures
- Tax-Compliant Restructurings
 - WAM & Useful Life
 - Must Restructurings Be Tax-Compliant?



Unique Issues in Non-Profit Restructurings

- Healthcare Has a Very High Concentration of Not-for-Profit Providers
 - 60% of Hospitals
 - 30% of Nursing Homes
 - 17% of Home Health Agencies
- Fiduciary Duties of Non-Profit D's&O's in the Zone of Insolvency – the Third Fiduciary Duty
- Bankruptcy Code Sections 363(d)(1) & 1129(a)(16) Specifically Incorporate “Nonbankruptcy Law” Applicable to the Transfer of Assets of a Not-for-Profit
 - Narrow View – AG Approval
 - Broad View – The Charitable Mission



Hypothetical Sale Scenario

- Non-profit CCRC is insolvent, has \$50M in bond debt, \$20M in contingent future entrance fee refund obligations.
- Runs a sale process and two bidders emerge:
 - For-profit operator to purchase for \$45M and convert to casino with nightly performances by the band Creed
 - Non-profit operator to purchase for \$40M, keep the community as senior living consistent with charitable purposes, commit to honor future entrance fee refund obligations
- Which bid should the board choose?
- What if the for-profit bid was \$50M and the non-profit bid was \$25M?
- What if the for-profit group would keep the facility as a senior housing facility but just convert to rental and raise rents?



Faculty

Thomas R. Buck, CTP, CIRA is a partner at Province and a crisis-management specialist with more than 25 years of experience guiding distressed companies through operational turnarounds, financial restructurings, divestitures and complex bankruptcy proceedings. He has served in both debtor and creditor roles on matters including Transit Group, Parmalat USA, KidsPeace Corp. and Saint Michaels Medical Center, and he has delivered innovative, stakeholder-aligned solutions as a financial advisor, interim manager and Chief Restructuring Officer. Prior to joining Province, Mr. Buck held senior restructuring roles at Glass & Associates/Huron, EisnerAmper and B. Riley Advisory Services, and earlier in his career spent nearly a decade in industry. He received his B.S. in economics from Lehigh University and his M.B.A. from Wake Forest University.

David E. Gordon is a shareholder with Polsinelli PC in Atlanta and leads Polsinelli's national distressed health care practice. He counsels on business bankruptcies and insolvencies with a distinct focus on health care industry restructuring. Mr. Gordon has represented health care providers, REITs, hospitals, lenders, landlords, health care systems, skilled-nursing and assisted-living facilities, purchasers of distressed assets, secured and unsecured creditors, committees, trustees and other parties-in-interest in chapter 11 reorganization proceedings, receiverships and workouts throughout the U.S. His transactional experience includes representing purchasers in § 363 sales and representing various parties in problem loan workouts, bridge loans and other financings, forbearance agreements and other distressed transactions. Prior to joining Polsinelli, Mr. Gordon taught as an adjunct professor of law at the Emory University School of Law for more than seven years. He received his B.A. in 2003 from Georgetown University and his J.D. with honors in 2006 from Emory University School of Law.

Russell A. Perry, CFA, CIRA is a senior managing director at Ankura Consulting Group, LLC in Southlake, Texas, and has more than a decade of experience across complex financial situations involving distressed companies, with an emphasis on the U.S. health care market. His financial advisory experience spans interim management, financial statement analysis, financial projection development, liquidity and cash management, M&A support, stakeholder negotiations, balance-sheet recapitalization/restructuring, DIP financing/sourcing and bankruptcy preparation. His current and former clients include private and public companies, nonprofit institutions, equity sponsors, secured and unsecured creditors, bond insurance companies, bondholders and other related parties. Mr. Perry received The M&A Advisor's 2016 40 Under 40 Emerging Leaders Award. He holds inactive NASD licenses 7, 65 and 63 and has provided advisory services to clients across energy (exploration and production) and materials, retail, technology, hospitality, media and real estate. In addition, he has *Till* cramdown interest rate expert witness experience. Mr. Perry is a member of the DFW Chapter of the Turnaround Management Association, ABI, the CFA Institute's DFW Society and the Association of Insolvency & Restructuring Advisors, and he is a former treasurer of the DFW Association of Young Bankruptcy Lawyers and a former business division liaison of the Young Lawyers Committee of the Bankruptcy Law Section of the State Bar of Texas.

Jordana L. Renert is senior vice president of Distressed Debt/Specialty Corporate Trust at UMB Bank in New York, where she manages a portfolio of corporate and municipal workout transactions

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as part of a seasoned distressed-debt specialty corporate trust team. She previously served as a partner with Lowenstein Sandler LLP and with ArentFox LLP, and was an associate at Willkie, Farr & Gallagher LLP. Ms. Renert is experienced in financial restructurings, distressed situations, bankruptcy reorganization, and municipal and liquidation proceedings, having represented creditors' committees, indenture trustees, agents and bondholders, as well as acquirors and investors in troubled and bankrupt companies. Her restructuring work spans oil & gas, energy, mining and exploration, publishing, manufacturing, retail and health care, and she has played lead roles in such major chapter 11 cases as PG&E Corp., R.E. Gas Development, Sabine Oil & Gas, SandRidge Energy, Magnum Hunter Resources, SquareTwo Financial Services and Cengage Learning. Ms. Renert is Education Director for ABI's Business Reorganization Committee and is a member of the New York Institute of Credit and the International Women's Insolvency & Restructuring Confederation. She also has participated in the Family Court Clinic Project, providing *pro bono* family court legal consultations. Ms. Renert received her B.S. in 2003 in industrial and labor relations from Cornell University and her J.D. *magna cum laude* in 2007 from Brooklyn Law School, where she received the Professor Barry L. Zaretsky Bankruptcy Fellowship.