



AMERICAN  
BANKRUPTCY  
INSTITUTE

# Distressed Real Estate Symposium

## **The Pulse of Health Care: Operators, Real Estate and Market Momentum**

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## The Pulse of Healthcare - Agenda

- Welcome and Panelist Introductions
- Taking the Pulse of Healthcare and Implications for Healthcare Real Estate
- Real Estate Typology for Major Healthcare Sectors
- OpCo/PropCo Structure and Key Valuation Considerations
- Current Topics and Issues in Healthcare Restructuring
- Parting Comments: Rants and Raves
- Q&A

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## Learning Objectives

- Understand the real estate related issues that senior healthcare executives are seeing and addressing.
- Learn about the state of the healthcare provider sector and why it's relevant to restructuring and insolvency professionals
- Learn about the diverse array of stakeholders involved in financially distressed healthcare situations, and what factors may be important to those constituents when contemplating a bankruptcy involving healthcare real estate
- Learn about certain different approaches to healthcare restructuring that address key real estate considerations

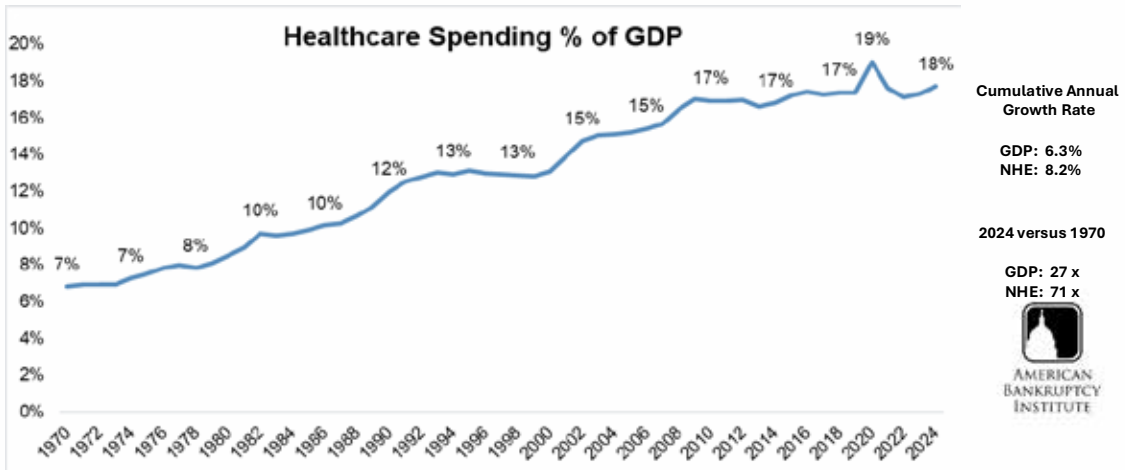
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### Healthcare Spending Continues to Outpace GDP Growth

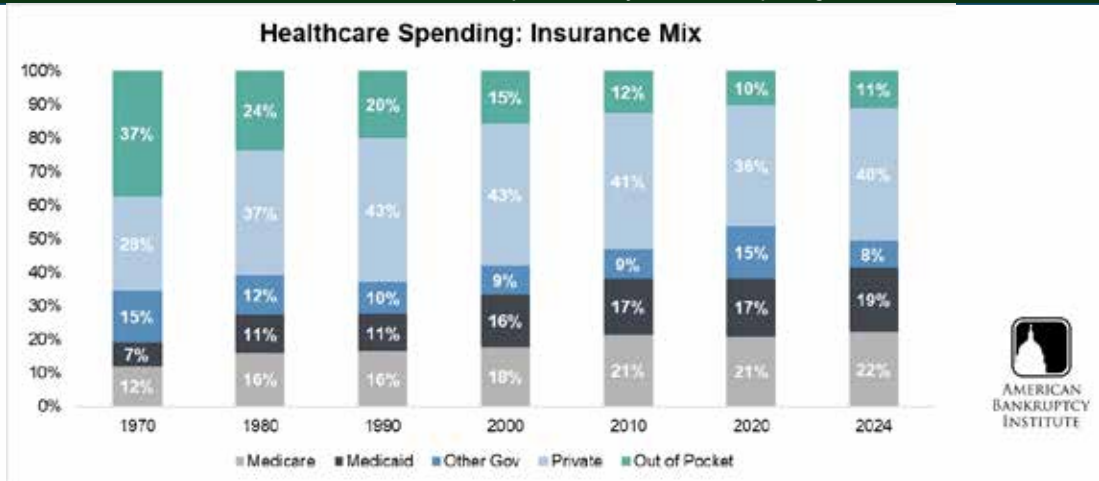
National Health Expenditures are Approaching 20% of US GDP



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### Government Health Programs Will Soon Fund More Than 50% of Total Health Spending

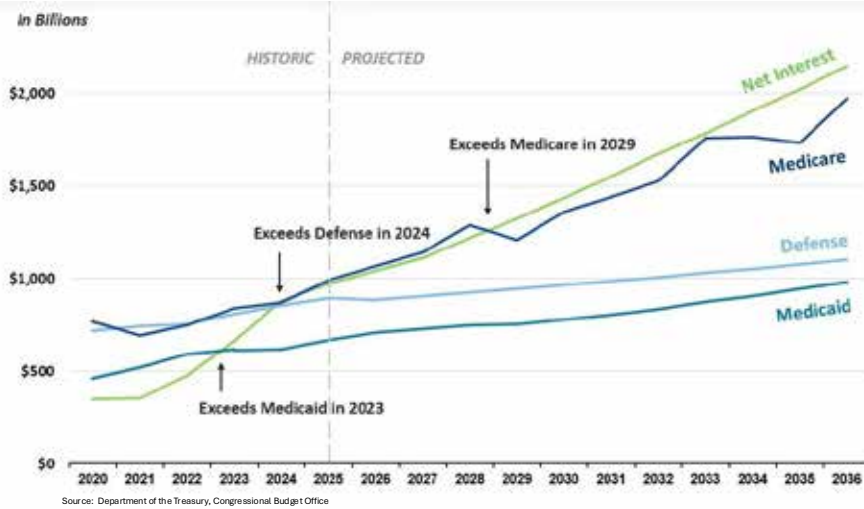
Government Funded Health Insurance Represents Nearly Half of Health Spending



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Federal Budget Deficits are Projected to Squeeze Out Spending on Other Programs

Interest Cost Projected to Outpace Key Federal Spending Categories



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State of the Industry

- Staff shortages and employee burnout
- Higher costs vs. stagnating payer rates
- Payor denials and payment delays
- Lack of investment in infrastructure
- Longer life expectancy and improved health later in life
- Improved surgical procedures
- Declining patient volumes
- Shift from small nonprofits to large health systems
- Cybersecurity threats and breaches



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## Healthcare Real Estate Typology

- Acute Care Hospitals
  - Academic Medical Institutions
  - Community Hospitals: Urban vs. Rural
  - Long-Term Acute Care (“LTAC”s)
- Senior Living Facilities
  - Continuing Care Retirement Communities (“CCRC”s)
  - Skilled Nursing Facilities (“SNF”s)
  - Memory Care (“MC”s)
  - Assisted Living Facilities (“ALF”s)
  - Independent Living (“IL”s)
- Medical Office Buildings (“MOB”s)
  - Ambulatory Surgery Centers
  - Urgent Care Centers
  - Specialty clinics
- Mental Health Hospitals and Facilities



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## Dynamics of OpCo / PropCo Structures

### Role of Landlord: PropCo

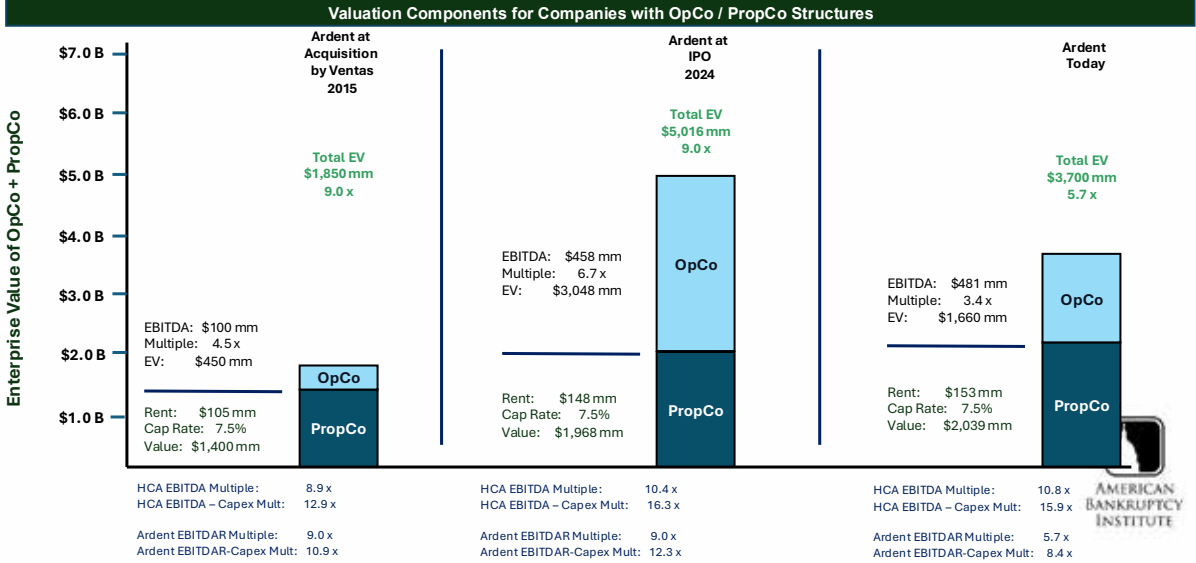
- Lease facilities to operators through master leases with annual rent escalators
- Often via sale-leasebacks from REITs to allow REITs tax efficient investments
- Landlord restructuring issues
  - *Real estate vs. operational value attribution*
  - *Lease recharacterization risk*
  - *Operator transfer considerations (timing and preference exposure)*
  - *Cross-default and cross-collateralization*

### Role of Tenant Operator: OpCo

- Lease facilities from landlord through master leases with annual rent escalators
- Often via sale-leasebacks from REITs to allow operators access to capital
- Tenant Restructuring Issues
  - *Real estate vs. operational value attribution*
  - *Lease recharacterization opportunity*
  - *Operator transfer considerations (liability for pre-petition obligations)*
  - *Cross-default and cross-collateralization*

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Valuation Framework for OpCo / PropCo Structures – The Ardent Health Example



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## Recharacterizing leases

Courts distinguish between true leases and disguised financing arrangements by examining economic substance of transactions

- **Bright-Line Tests for Per Se Security Interests**

Lease creates a security interest if the lessee cannot terminate the obligation and **one** of four conditions exists

- Original lease term equals or exceeds remaining economic life
- Lessee must renew for remaining economic life
- Lessee option to purchase for nominal consideration
- Lessor has no substantial interest in leased property at the expiration

- **Economic Substance Analysis**

When bright-line test is not satisfied, courts examine all facts and circumstances to determine transaction's economic substance:

*Does lessee assume and discharge substantially all the risks and obligations of ownership?*

*Does lessor retain a meaningful reversionary interest in the property at lease's conclusion?*



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## Recharacterizing Leases

In *Steward Health Care Systems* and *Prospect Medical Holding*, lease recharacterization a key issue

### 1. Landlord Dispute Over Lease Recharacterization

- **Medical Properties Trust (MPT)** had significant lease arrangements with Steward and with Prospect for hospital property (including sale-leaseback structures).
- In bankruptcy, Steward's and Prospect's creditors' committee threatened legal action to **recharacterize MPT's leases as disguised financings**

### 2. Settlement Instead of a Court Ruling

- In both cases the parties reached a **settlement**
- Bankruptcy court **approved the settlement**, which resolved how MPT's claims would be treated

### 3. No Published Opinion on Recharacterization Test



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## Selling Free and Clear of Leases

• Debtor-landlords can assume or reject leases, but tenants have rights to stay in the property (11 USC 365(h))

• Small minority of cases where landlords can sell free and clear of leases

• *WA3 Properties Renton LL*, Case No. 8:24-71121 (Bankr. EDNY)

- Propco filed bankruptcy related to larger bankruptcy of the owner with SNF tenant/operator.
- Debtor asserted lease terminated, but no court ruling on lease termination.
- Court ruled could sell free and clear of the lease obligation and compensate tenant for their interest
- Set trial to determine damages



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## Successor Liability

- Asset Purchase Agreement vs. Operations Transfer Agreement
- Purchase price allocation between Opco/Propco
- User fees
- Payroll tax obligations
- Medicare/Medicaid obligations
  - Recoupments
  - Civil Monetary Penalties
- **Potential limitation:** A recent bankruptcy court decision held that conditions the state attorney general sought to impose on a sale of nonprofit assets were a form of successor liability and a property interest and a sale could be free and clear of those interests. *In re Verity Health System of Calif., Inc.*, Case No. 2:18-BK-20151-ER, 2019 WL 5585007 (Bankr. C.D. Cal. Oct. 23, 2019), vacated, No. 2:18-BK-20151-ER, 2019 WL 6519342 (Bankr. C.D. Cal. Nov. 13, 2019).



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## 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
- **11 U.S.C. § 363(d):** sale or use of property must follow any special state laws that apply to charitable or nonprofit organizations.
- **11 U.S.C. § 541(f):** property held by a nonprofit debtor may be transferred to an entity that is not such a corporation, **but only under the same conditions as would apply if the debtor had not filed a case under this title.**



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## Unique Issues in Non-Profit Restructurings

- **11 U.S.C. § 1129(a)(16):** All transfers of property under the plan shall be made **in accordance with any applicable provisions of non-bankruptcy law** that govern the transfer of property by a corporation or trust, typically state rules including attorney-general review and court approvals.
- Courts and debtors can consider charitable mission when selecting the best offer and must consider implications of state law when selling nonprofit assets. *In re Gardens Regional Hospital and Medical Center, Inc.*, 567 B.R. 820 (Bankr. C.D. Cal. 2017); *In re United Healthcare Sys., Inc.*, No. CIV. A. 97-1159 (D.N.J. Mar. 26, 1997).

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## Rants and Raves





# Questions?



# Reference Material



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## U.S. Healthcare

- Annual revenue in the health care industry is over \$4.9 trillion — and health care spending is 17.6% of GDP (Source: CMS)
- 14% of U.S. adults are employed in the healthcare industry
- Healthcare administrative spending accounts for 8% of U.S. GDP, compared to 3% in other nations

Distress creates challenges

. . . but also opportunities!

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## Hospitals

- There are approximately 5,100 community hospitals in the U.S.
  - 58% of hospitals are non-profit.
  - 24% are for profit.
  - 18% are state or local government owned.
- 2/3 of community hospitals are system-affiliated
- 65% Urban / 35% Rural
- Annual admissions are 32.3 million (Source: American Hospital Association)
- Hospital margins were ~5.2% in 2023, but 40% of hospitals had negative margins. Margins are even lower for rural hospitals. (Source: KFF)

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## Hospital Concerns

- **Financial Sustainability**
  - Rising costs and declining reimbursements are squeezing margins.
  - Reevaluation of service lines, geographic footprints, and capital investments to optimize returns.
- **Workforce Challenges**
  - Recruitment and retention remain critical, especially among nurses and frontline staff.
  - Burnout and disengagement are driving turnover, prompting flexible work models, psychological safety, and leadership development.
- **Trust and Transparency**
  - Public confidence in healthcare institutions has eroded since the pandemic.
  - Prioritizing transparency, direct engagement with staff, and initiatives to rebuild trust both internally and externally.
- **Health Equity and Access**
  - Addressing social determinants of health through mobile clinics, school-based telehealth, and community partnerships is a growing priority.
  - Access to care, especially behavioral health services, remains a pressing issue.
- **Regulatory Preparedness**
  - Anticipating and adapting to evolving healthcare policies and compliance requirements is essential for strategic resilience.
- **Technology Integration**
  - AI, automation, and digital health tools are reshaping care delivery.
  - Building leadership structures to support tech adoption while maintaining human-centered care.

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## Rural Hospitals

- Approximately 1800 community hospitals are considered rural
- 46 million Americans live in rural areas
- 46% of rural hospitals are losing money
- 400-700 rural hospitals are at risk of closing with common issues:
  - Low reimbursement rates
  - Staffing shortages
  - Low patient volume
- Since 2010, 182 rural hospitals have either closed or converted to an operating model that does NOT provide inpatient care
- 293 rural hospitals stopped offering OB services between 2011 and 2023
- Policy-related reimbursement cuts will cost rural hospitals more than \$650 million
- Sources: *Chartis; Center for Healthcare Quality & Payment Reform*

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## Rural Hospital Concerns

- Insufficient revenue for sustaining the cost structure of acute care hospitals
- Declining population of the communities and other market conditions that contribute to financial instability
- Populations that are aged, poor, uninsured, and underinsured
- High percentage of patient revenue from public payers (Medicare, Medicaid, etc.), who often reimburse less than the cost of providing care
- Shifts in health care delivery from inpatient care to outpatient care, resulting in declining inpatient utilization and associated revenue
- Growing trends in health insurance and plan design that can increase bad debt and charity care burdens of hospital, such as high-deductible health plans and narrow provider networks

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## Skilled Nursing & Assisted Living

- In the U.S., there are ~15,000 skilled nursing facilities (SNF) and ~30,000 assisted living facilities (AL)
- Loss of 15% of SNF workforce and 7% of AL workforce post-COVID
- Substantial increases in wage rates from pre-COVID, in many cases greater than 50%
- Improvements in homecare and surgeries
- Lack of technology adoption
- Bad debt/uncollectible receivables
- Increased regulatory oversight (CMS revalidation)
- Entrance fees for CCRCs
- Deferred Capital Expenditures
- High-cost medications without reimbursement can result in significant margin reductions (i.e., weight loss drugs, chemo)

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## Skilled Nursing/Assisted Living Concerns

- **Occupancy and Demand Recovery**
    - After years of volatility, occupancy rates are rising—but not evenly across markets (i.e., impact of Entrance Fee vs. rental)
    - Data-driven strategies to match supply with shifting regional demand.
  - **Affordability and Consumer Expectations**
    - The aging population is growing, but many seniors face financial constraints.
    - Balancing high-quality offerings with affordability, especially as preferences shift toward more personalized, lifestyle-oriented care.
  - **Capital Constraints and M&A Activity**
    - Access to debt capital remains tight, delaying new construction and refinancing.
    - Ownership transitions and regional consolidation are accelerating as operators seek scale and financial resilience.
  - **Regulatory Uncertainty**
    - A new administration is reshaping oversight of assisted living and skilled nursing.
    - Potential changes to staffing mandates, Medicare Advantage reimbursement, and tax policy.
  - **Workforce and Staffing**
    - Recruiting and retaining caregivers remains a top challenge.
    - Investing in automation, flexible staffing models, and culture-building to address burnout and turnover.
  - **Loneliness and Social Connection**
    - With 28% of older adults living alone and childless, combating isolation is a major priority.
    - Innovating with resident matching programs, community-building initiatives, and tech-enabled engagement.
  - **Technology and Operational Efficiency**
    - Digital tools and automation are streamlining operations and improving financial sustainability for those engaging.
    - Modernizing back-office systems and care coordination platforms to stay competitive.
- Sources: McKnight's Senior Living; CliftonLansonAllen; Senior Housing News



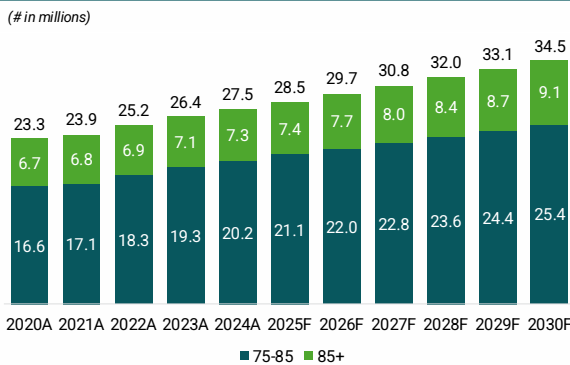
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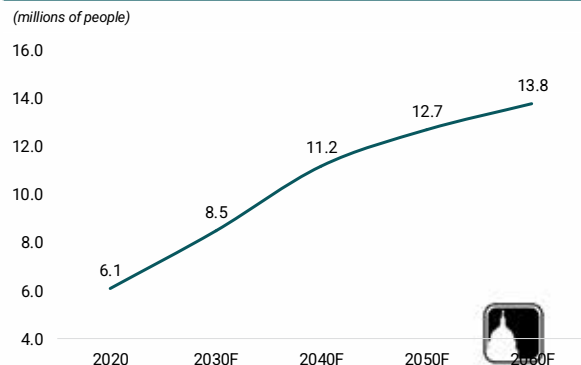
## Senior Living & Long-Term Care Industry

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

US Senior Population Projection



Projected People Aged 65+ with Alzheimer's



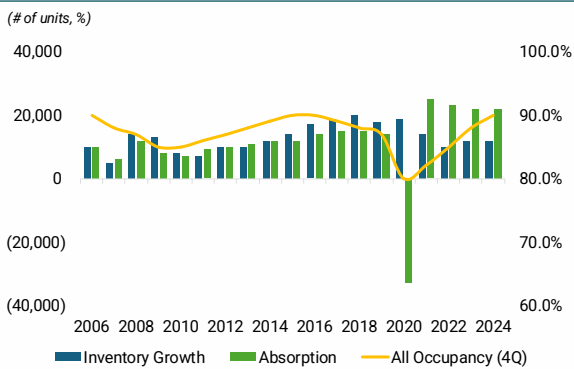
Source: Alzheimer Association, U.S. Census Bureau

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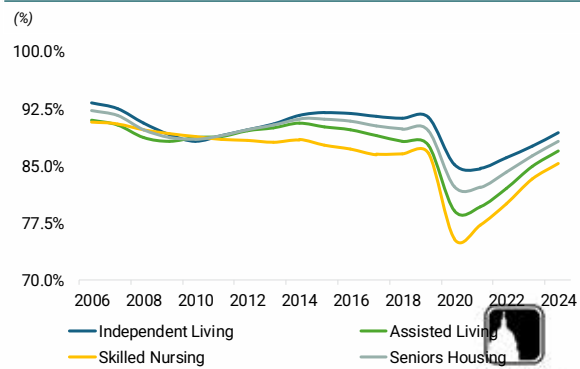
## Senior Living & Long-Term Care Industry

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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## Senior Living

### 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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## 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
  - NDAs, MNPI, Restricted Groups, No-Trade Agreements, EMMA, and Cleansing
- Tranching Indenture Structures
- Tax-Compliant Restructurings
  - WAM & Useful Life
  - Must Restructurings Be Tax-Compliant?

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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

# Private Equity in Healthcare



## Private Equity (PE)

- Private equity acquisitions in healthcare have grown rapidly over the past decade, both in skilled nursing and hospital systems.
- As of January 2024, at least 460 hospitals were owned by private equity firms, comprising ~25% of for-profit hospitals in the U.S. (Lown Institute)
- Private equity's involvement in health care has been controversial and has raised concerns about the prioritization of profits over patient care.
- One CMS working paper examining 18,000 nursing home facilities over a 17-year period found that private equity ownership was associated with:
  - increased excess mortality for residents by 10%
  - increased prescription of antipsychotic drugs for residents by 50%
  - decreased hours of frontline nursing staffing by 3%
  - increased taxpayer spending per resident by 11%



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## Private Equity Cases: Steward Health Care

- Steward Health Care, a for-profit system formerly owned by Cerberus, filed chapter 11 in May 2024.
- Steward operated over 30 hospitals across Arizona, Arkansas, Florida, Louisiana, Massachusetts, Ohio, Pennsylvania, and Texas and has more than 400 physician practice locations.
- Partnered with REIT Medical Properties Trust (MPT) to structure a sale-leaseback transaction to provide liquidity.
- Steward CEO cited various healthcare market factors as reasons for chapter 11, including insufficient reimbursement by government payors, decreasing reimbursement rates, increasing labor costs, increased material and operational costs, the Covid-19 pandemic, declines in patient visits and revenue, the continued movement of inpatient services to outpatient settings (resulting in lower margins), a tightening labor market, inflationary pressures, and regulatory and political pressures.
- Challenges to the chapter 11 cases include:
  - State regulatory approval of sales
  - State and federal investigations of Steward
  - Challenges by various case constituents: state AGs, tort patients, doctor groups
  - Threat of hospital closures

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## Private Equity Cases: Prospect Medical Holdings

- Prospect Medical Holdings — a Los Angeles-based network of hospitals and affiliated medical groups located in California, Connecticut, Pennsylvania, and Rhode Island.
- Filed chapter 11 petitions on January 11, 2025, to facilitate sales of the company's operations outside of California.
- Previously owned by PE firm Leonard Green & Partners.
- Entered into a sale-leaseback transaction with MPT in 2019.
- Was subject to ongoing investigations in CT and RI and recently released Senate report.
- Being sued by Yale New Haven Health for failure to disclose accurate financial in connection with sale of CT hospitals.

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## Regulation Aimed at PE in Healthcare

- Effective January 16, 2024, a new rule promulgated by the Centers for Medicare & Medicaid Services (CMS) expanded disclosure requirements for skilled nursing facilities participating in Medicare (SNFs) and nursing facilities participating in Medicaid (Medicaid Nursing Facilities) with respect to direct and indirect ownership, oversight, managerial, and other information to increase transparency and provide families with necessary data for evaluating such facilities.
- Senate report released January 2025 finds PE compromises patient care to maximize profits.
- New Massachusetts legislation (effective January 2025) requires increased disclosures regarding hospital ownership and finances and mandates higher penalties for failure to disclose. Law also bars the MA Dept. of Public Health from granting a license to establish or maintain an acute care hospital that has leased its main campus from a REIT.



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## Distressed Healthcare Alternatives



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## Foreclosure

### Pros

- Get control of asset; become owner of asset
- Completely push borrower out

### Cons

- License not transferrable— need a new CHOW
- HIPAA concerns
- Regulatory concerns
- Employment issues
- Insurance issues
- Immediate closure not an option

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## Receivership

### Pros

- Costs lower
- Speed
- Fewer filing requirements
- Licensing/regulatory
- Public policy/perception
- Record retention
- Automatic stay
- Sale process

### Cons

- More filing requirements
- Not true automatic stay
- Less structure/clarity than bankruptcy
- Free and clear sales?
- Creditor/service provider confusion over receiver role
- May lead to bankruptcy anyway

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## Chapter 11

### Pros

- Opportunity for release
- Can exert control over the timeline and process — to a point

### Cons

- No conversion to chapter 7 with not-for-profits
- Influence of other case constituents — court, creditors' committee, UST

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## Key Issues in Court Actions



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## Definition of a Health Care Business

- Section 101(27A) defines a health care business as follows:

(A) means any public or private entity . . . that is primarily engaged in offering to the general public facilities and services for (i) the diagnosis or treatment of an injury, deformity, or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care; and

(B) includes – (i) any – (I) general or specialized hospital; (II) ancillary ambulatory emergency, or surgical treatment facility; (III) hospice; (IV) home health agency; ...; and (ii) any long-term care facility, including any (I) skilled nursing facility; (II) intermediate care facility; (III) assisted living facility; (IV) home for the aged; (V) domiciliary care facility; ... or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.

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## Additional Bankruptcy Health Care Provisions

The Bankruptcy Code has three additional provisions relevant to a health care business:

- Section 503(b)(8) allows an administrative expense claim for the actual, necessary costs and expenses of closing a health care business.
- Section 704(a)(12) requires a trustee to use all reasonable and best efforts to transfer patients from a health care business to nearby facility offering substantially similar services and reasonable quality of care.
- Section 351 requires a trustee authorizes destruction of patient records within one year of publishing notice of intent to do so under certain circumstances.

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## Patient Care & Patient Care Ombudsman

- The 2005 amendments require the bankruptcy court to appoint a Patient Care Ombudsman (PCO) to represent the interests of patients, **unless there is cause not to do so**. 11 U.S.C. § 333(a).
- The PCO monitors quality of care, may interview patients and staff, and issues reports to the court. This is paid for by the debtor.
- The common trend is for debtors to file motions to avoid the appointment of a PCO or to consent to appointment of a PCO subject to scope and budget limitations or other constraints.



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## Sale Process

- Subject to regulatory approval
- Highest “or” best (not “and”)
- Post-sale/pre-closing funding
- Opco v. Propco
- Operations transfer agreements and management agreements
- Provider agreements



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## Regulatory Issues

- Medicare and Medicaid Provider Agreement
  - Contract subject to section 365 or license without cure requirements?
- State Approvals:
  - Suitability/CHOW process
  - Transfer of health care assets
  - Transfer of nonprofit assets
  - Medicaid Provider Agreement
  - Anti-trust
- Federal Approvals:
  - Medicare Provider Agreement
  - Other?

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# Faculty

**Jeremy R. Johnson** is a shareholder with Polsinelli PC in New York and Chicago, and represents distressed companies and other stakeholders in the insolvency process. Although his restructuring and insolvency practice spans various business sectors from retail to manufacturing, he has experience representing distressed health care businesses or participants in distressed M&A processes. Mr. Johnson's recent engagements in health care include senior living owners and operators (including continuing care retirement communities and skilled-nursing providers) and acute, post-acute and behavioral health providers. Working closely with Polsinelli's health care and corporate teams, he helps provide complete solutions for companies experiencing financial distress. In the last 15 years, Mr. Johnson has led several large company-side engagements and helped managed distressed situations for clients. In addition to company-side and distressed M&A representations, he represents other stakeholders in the restructuring space, including landlords, committees, individual creditors, trustees and other parties in interest. Mr. Johnson received his B.A. in 1996 from the University of Iowa and his J.D. in 1999 from Boston University School of Law, where he served as editor-in-chief of the *American Journal of Law & Medicine*.

**Jim Moloney** is a managing director with Cain Brothers in San Francisco, where he focuses on hospitals and health systems, as well as a range of health care providers. He joined Cain Brothers, a division of KeyBanc Capital Markets, in 1995 and has 35 years of experience in health care mergers, acquisitions, financings and real estate transactions. In addition to health systems and academic medical centers, Mr. Moloney's clients have included public and private companies, as well as real estate investors and developers. He received his B.A. in business in 1988 from the University of Washington Foster School of Business, and his M.B.A. in accounting and finance from the University of Rochester - Simon Business School.

**Cynthia A. Nelson** is a senior managing director with FTI Consulting, Inc.'s Corporate Finance practice in Los Angeles, where she assists stakeholders in evaluating, developing and implementing turnaround plans and restructurings in both judicial and non-judicial circumstances. She has assisted debtors, investors, lenders and creditors' committees in analyzing and developing plans of reorganization, analyzing financing options and market rates of interest, evaluating asset-disposition and development plans to maximize value, conducting due diligence in connection with acquisition and financing, negotiating resolution of troubled credits, and providing litigation support and testimony in adversarial proceedings. In addition, Ms. Nelson has more than 30 years of experience in the real estate industry and specializes in advising stakeholders with interests in real estate. She has experience with development and operating companies, including those with interests in master planned communities, resorts, retail, office, hospitality, multi-family and mixed-use properties. Ms. Nelson has been involved in some of the largest and most notable real estate restructurings of the last decade, including advising the unsecured creditors committee for General Growth Properties, serving as the chapter 11 trustee in connection with South Edge LLC, aka Inspirada, a "New Urbanism" community located in near Las Vegas, and serving as receiver for Talisker Club in Park City, Utah. She is advising the UCC with respect to real estate matters in the Toys "R" Us bankruptcy as well. Prior to its acquisition by FTI Consulting, Ms. Nelson was a partner in PricewaterhouseCoopers' Business Recovery Services group. Before that, she was a senior associate of investment services at Jones

Lang Wootton USA, an associate at Laventhol & Horwath in its Real Estate Advisory practice, and a real estate development assistant at Valencia Company/Newhall Land & Farming. Ms. Nelson is a frequent speaker at conferences and seminars; she has been a panelist at programs sponsored by the ABI, the California Bankruptcy Forum, the Financial Lawyers Conference, the American College of Bankruptcy and other organizations. In addition, she co-chaired the 2016 National TMA Conference and has published articles in the *ABI Journal*, *CPA Expert*, *Daily Bankruptcy Review*, *Turnaround Management*, *Socioeconomic Planning Sciences*, *Location and Stigma*, *Urban Land* and *FTI Journal*. Ms. Nelson received her B.S. in urban planning from California State Polytechnic University and her M.B.A. and M.P.L. from the University of Southern California.

**Paul S. Valentine** is a senior managing director with KPC Advisory Group in Boston and specializes in the management, development and operation of high-quality, fast-growth, small-to-mid-size organizations. He brings a diverse industry background to KPC, including roles in health care services, medical devices, retail products and manufacturing. His formal education in accounting and finance is further enhanced by his corporate roles in sales, operations and product development, as well as a number of officer roles including the chief executive position. Mr. Valentine focuses his case matters on performance improvement and corporate renewal, providing his clients with strategic and marketing advice while maintaining a solid focus on financial structure and operational efficiencies. He has been a crisis management lead for the Commonwealth of Massachusetts COVID-19 Nursing Facility Command Team, a receiver of skilled-nursing, assisted-living and independent-living facilities and a financial advisor of a textile finishing company, and he has been involved in the restructuring of numerous food manufacturers, processors or distributors, restructuring and refinancing of a digital health consulting firm, refinancing and financial advisory services to a medical device company and strategic development and go-to-market strategy for a sleep therapy developer. His industry specializations are in health care services, medical devices/products, food and manufacturing. Mr. Valentine received his B.S. in accounting in 1986 from Babson College and his M.B.A. in finance and entrepreneurial studies from Babson F.W. Olin Graduate School of Business.