



HOSPITAL CLOSURE GUIDELINES PART II

A Bankruptcy Primer



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A Bankruptcy Primer

Developed by
the New Jersey Hospital Association
Health Planning Department and General Counsel's Office

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INTRODUCTION

Today's economic environment means that filing for bankruptcy becomes less of an idea in the abstract and more a real strategic consideration for financially distressed hospitals. But the bankruptcy process is complex and the factors a hospital considers in determining whether to proceed are nuanced.

Recognizing that hospitals need more information to help evaluate the bankruptcy process and other options (e.g. out-of-court-workout, closure, sale, affiliation, restructuring, etc.), NJHA met with officials from the New Jersey Health Care Facilities Financing Authority and the Department of Health and Senior Services to gather information related to bankruptcies across the state. Ultimately we teamed with a cross-section of experienced lawyers from leading New Jersey law firms to produce these guidelines which are designed to assist hospitals in becoming more knowledgeable about the bankruptcy process.

The guidelines that follow, *Hospital Closure Guidelines: A Bankruptcy Primer*, provide a comprehensive review of the bankruptcy process, the myriad considerations involved in the decision, and the various options and strategies that hospitals may undertake to best position their institutions to weather their current financial difficulties. (Last year, NJHA released the first phase of its guidelines for hospitals considering closure, *Hospital Closure Guidelines: Best Practices from the Field*.)

As part of its efforts to improve hospitals' ability to respond to a changing marketplace in an effective and timely way, NJHA continues to advocate with DHSS for improvements to the Certificate of Need process to reduce the administrative burden and make it more responsive to the unique situation of closing rather than establishing a hospital. Specifically, NJHA has recommended that DHSS develop a CN application form that is specific to closures, as the current application does not capture all the information needed by DHSS when considering a hospital closure, necessitating the department to return with "completeness" questions, thereby delaying the application review process. As important, there should be deadlines by which DHSS must complete its review of an application.

The Commission on Rationalizing New Jersey's Healthcare Resources reached the same conclusion about the CN process in New Jersey, recommending in its report that the closure process "should be streamlined and refocused to permit a more rational closure and realignment process," and that a 60-day deadline for DHSS's completeness review be established.

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SECTION A

PRE-BANKRUPTCY ISSUES AND PLANNING

FIDUCIARY DUTIES OF THE BOARD OF TRUSTEES

Most New Jersey hospitals are organized as nonprofit corporations managed by a board of trustees. While the rules governing management of nonprofit and for-profit corporations are similar insofar as the board of directors of a for-profit corporation and the board of trustees of a nonprofit corporation both have general fiduciary duties to act with care and loyalty on behalf of their corporation, there are significant differences in management accountability that inform those duties. Directors of a for-profit corporation are accountable to the corporation's shareholders and discharge their duties with the priority of maximizing revenues, asset values, and generating a positive return for shareholders. By contrast, a nonprofit board is accountable directly to the institution and the community it serves, and trustees' duties are discharged in light of the purposes for which the corporation was formed, with government regulation serving as a substitute for shareholder oversight. As a fiduciary, a nonprofit hospital board trustee must act in the interests of a number of stakeholders and parties in interest, including the community at large, patients, donors and, if insolvency approaches, creditors/ bondholders.

When a business is experiencing financial difficulty, a substantial, if not entirely settled, body of law holds that fiduciary duties of directors and trustees expand or shift in favor of creditors, on the theory that it is the creditors who "own" the business at the point of insolvency. As discussed in greater detail below, in the not-for-profit hospital context, this can lead to acute tensions in the decision-making process, as the interests of creditors must be reconciled with the hospital's charitable purposes.

OUT OF COURT WORKOUT VS. BANKRUPTCY

A financial restructuring or workout accomplished consensually outside of bankruptcy court will generally be less expensive and less time consuming than a restructuring under Chapter 11 of the Bankruptcy Code (discussed in more detail below). Chapter 11 can be a costly process in terms of both monetary and non-monetary resources. A workout will typically involve concerted negotiations to restructure bond debt or other secured debt, and may also involve efforts to obtain refinancing or additional financing and alternate credit terms with vendors.

An out of court workout lacks some of the advantages of a bankruptcy proceeding, however. The automatic stay can provide significant relief to a hospital that is experiencing difficulty managing its creditors. In addition, suppliers will be prevented from refusing to fulfill terms of existing contracts because of pre-petition claims.

PRE-BANKRUPTCY PLANNING

■ **RETENTION OF PROFESSIONALS.** At the earliest signs of financial stress, the hospital should retain experienced legal and financial professionals to help assess the hospital's situation and explore viable bankruptcy and non-bankruptcy or "workout" options. The hospital should retain both attorneys experienced in health care bankruptcy and workout matters and financial consultants experienced in distressed healthcare situations, as these types of cases present unique challenges and there is little time for "on the job training" in a hospital insolvency context. Together, these professionals will work to assist management in identifying and implementing strategies to reduce costs, increase revenue, maximize asset values, obtain financing and iden-

tify potential strategic partners or purchasers. They will also be able to assist management in interacting with governmental entities, creditors, doctors, employees, and the general public. These professionals will also lend essential credibility to the hospital in its negotiations and dealings with creditors, regulatory authorities, unions and various other constituencies in both out-of-court workouts and bankruptcy cases. Once a decision is made to file a bankruptcy petition, the hospital will also need assistance cataloguing and managing claims, giving notices to creditors, and filing the required bankruptcy schedules. Experienced bankruptcy professionals can assist management with these tasks as well.

- **EXIT STRATEGY.** In the event a hospital chooses to file for bankruptcy, management must work with its professionals to develop a strategy for emerging from bankruptcy. Such an exit strategy might include a sale, merger or stand-alone reorganization, and may involve a number of sub-strategies. It will be helpful in developing the exit strategy to have a complete picture of the hospital's assets and liabilities. Although management cannot predict all of the events that may occur during a bankruptcy case, the importance of planning for the hospital's emergence from bankruptcy cannot be overstated. For every month that the hospital is in bankruptcy, the hospital will incur professional fees and costs and will be required to devote extraordinary internal resources to the reorganization effort. Thus, the success of a reorganization often depends upon the ability to minimize the internal and external costs associated with bankruptcy by avoiding a prolonged period of time in bankruptcy. To the extent practicable, developing strategies before filing bankruptcy will aid in reducing the costs and disruption associated with a bankruptcy filing.
- **DETERMINE STATUS OF GOVERNMENT LICENSES AND PERMITS.** In contemplation of any bankruptcy filing, the hospital should assess the status of all of its licenses (including certificates of need), permits, registrations and other governmental authorizations (collectively, "Licenses") and determine which Licenses will need to remain in place after the bankruptcy. The hospital should consider the impact that a bankruptcy filing could have on its Licenses, and whether specific action will be required after the bankruptcy filing in order to preserve or relinquish such Licenses. Although governmental entities are prohibited from revoking licenses, permits and charters solely because a debtor files for bankruptcy, a bankruptcy filing will trigger increased scrutiny by regulators.
- **STATE NOTIFICATION AND COMMUNICATION.** Because of the State's special interest in the regulation of hospitals within its borders, a hospital should consider notifying the State that it intends to file for bankruptcy protection before it files. (See *Appendix I* to these Guidelines for contact information for the relevant State agencies.) Open and candid communication by the hospital can facilitate future cooperation and avoid strained relations with the State. Indeed, certain New Jersey legislators have introduced legislation requiring advance notice to the State and local governments of an impending hospital bankruptcy.
- **DETERMINE WHICH CRITICAL CONTRACTS AND LEASES MUST BE PRESERVED.** As discussed in greater detail below, bankruptcy will allow the hospital to keep contracts and leases that are beneficial and reject those that are burdensome. Prior to a bankruptcy filing, an initial analysis should be undertaken to identify contracts and leases that will be critical to ongoing operations and that are also transferrable.
- **OTHER CONSIDERATIONS/NON-BANKRUPTCY APPROVALS.** The hospital must also consider relevant state and federal laws with which it must comply in connection with the bankruptcy case.

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- ◆ **THE WARN ACT.** The Worker Adjustment and Retraining Notification (“WARN”) Act is a federal statute that requires employers with one hundred or more full-time employees to notify employees at least sixty days in advance of an intended plant closing or mass layoff. The purpose behind the WARN Act is to protect employees, their families and communities by allowing workers and their families some transition time to adjust to the prospective loss of employment, to seek and obtain alternate jobs, and, if necessary, to seek training or retraining so that these workers can compete in the job market. The hospital may be liable to each employee for back pay and benefits for each day that advance notice required by the WARN Act was not provided.

There are three exceptions to the WARN Act: the “unforeseeable business circumstances” exception, the “natural disaster” exception, and the “faltering company” exception. A struggling hospital should not assume that it will be able to rely on these exceptions. A recent case of note, *In re APA Transport Corp. Consolidated Litigation*,¹ dealt with the faltering company exception. In that case, the court held that a company that requested extension of its financing from a loan provider, but failed to follow up on those requests, had not been “actively seeking” financing at the time the 60-day notice was required to be given by the WARN Act, a key element of the exception. This case demonstrates that hospitals should not expect the exceptions to be applied liberally. Because WARN Act liability can affect greatly a hospital’s ability to emerge successfully from bankruptcy, it is strongly recommended that hospitals avoid such liability by complying with the Act’s notice requirements. In a bankruptcy proceeding, the Bankruptcy Court may be helpful in moving the regulatory process to a prompt conclusion, in order to allow the bankruptcy case to be resolved.

- ◆ **CERTIFICATE OF NEED.** Prior to closing or transferring a general acute care hospital, a certificate of need (“CN”) must be obtained from the New Jersey Department of Health and Senior Services (“DHSS”). The CN process is discussed in more detail beginning on page 34. Failure to obtain a CN prior to closure or transfer may be viewed as a violation of hospital licensing regulations and may result in substantial fines and penalties. In a bankruptcy proceeding, the Bankruptcy Court may be helpful in moving the regulatory process to a prompt conclusion, in order to allow the bankruptcy case to be resolved.
- ◆ **CHAPA AND ATTORNEY GENERAL/COURT APPROVAL.** In addition to certain Bankruptcy Court approvals involved with the disposition of a hospital’s assets, other government approvals will be necessary, such as Attorney General and New Jersey Superior Court approval under the Community Health Care Assets Protection Act or “CHAPA” (N.J.S.A. 26:2H-7.10 et seq.), and under the Attorney General’s common law jurisdiction over the disposition of charitable assets (both of which are discussed in **Section C**). Although the Bankruptcy Code allows for the sale of assets, it generally does not override applicable non-bankruptcy laws that may restrict or place certain conditions on the transfer of a hospital’s assets. For this reason, a hospital should inform itself of the procedures for obtaining all of the necessary governmental approvals for the disposition of its assets, and, to the extent practicable, initiate

¹ 541 F.3d 233 (3d Cir. 2008).

the paperwork and communications with the appropriate State agencies to begin the approval processes early in the bankruptcy case. (See *Appendix I* for contact information for the relevant State agencies.)

- ◆ **PATIENT MEDICAL RECORD LAWS.** The hospital will also have to continue to comply with any applicable state medical records retention requirements (discussed in more detail in **Section C**).
- ◆ **PBGC.** The hospital will need to analyze the status of any pension plans for its employees and prepare to notify the PBGC.

PRE-BANKRUPTCY UNION ISSUES

During the pre-bankruptcy phase, hospital management will want to consider whether and how to approach its non-management employees, whether they are a part of a collective bargaining unit or not. For example, in an effort to avoid a bankruptcy filing, hospital management may be seeking wage, benefit or other concessions from employees, and whether all or part of a the workforce is covered by a collective bargaining agreement (“CBA”) will have a significant impact on those deliberations. As discussed on pg. 23, CBAs and other employment contracts can be rejected or modified as part of the Chapter 11 process, and that possibility can provide a powerful negotiating tool for hospital management in pre-bankruptcy discussions with unions and employees. It is also not too early for the hospital to consider whether the CBA has a “successor” clause, and the conditions under which such a clause is or is not binding on any purchaser of the hospital.

It is also important for management at this stage to conduct a thorough evaluation of the status of employee benefits, whether pursuant to a CBA or otherwise. Issues including defining the scope of benefits provided (e.g., medical malpractice insurance, health insurance and pension and/or deferred compensation plans), whether the benefits are provided through the employer or the union or jointly through a fund, and whether the hospital is current in its payments under the existing benefits package. If the hospital is not current in its payments to a union-sponsored health or pension plan, for example, the union or joint labor-management benefits fund may well end up being a member of the Creditors Committee if a bankruptcy proceeding is commenced.

SECTION B

THE BANKRUPTCY CASE

CHAPTER 11 VS. CHAPTER 7

If a hospital has decided to seek bankruptcy protection it must decide which chapter of the Bankruptcy Code it will file under – Chapter 11 or 7. A Chapter 7 case mandates an orderly wind down (which may include a sale) and closure of the hospital. The primary difference between a Chapter 7 liquidation and a Chapter 11 liquidation is that, under a Chapter 7 case, hospital management will immediately be replaced by a trustee who will be authorized to operate the hospital for only a short period of time (if at all). Figuratively, former management loses “possession” of the hospital’s assets, since only the Chapter 7 bankruptcy trustee has the authority to act on behalf of the hospital once a Chapter 7 petition is filed.

Hospital bankruptcies are often filed under Chapter 11 of the Bankruptcy Code because it enables the hospital to continue to operate while developing a plan to maintain operations and restructure debts through a global resolution with all creditor constituencies. A Chapter 11 debtor is known as a debtor-in-possession (or “DIP”) because the debtor’s pre-bankruptcy management continues to operate the hospital during the bankruptcy case and the hospital remains in possession of its assets. No bankruptcy trustee is appointed; it is the debtor-in-possession’s responsibility to operate the hospital and develop a plan for restructuring its debts. A Chapter 11 case may result in a reorganization through which the hospital emerges as an operating entity with a restructured balance sheet, or it may result in liquidation, whether through an orderly wind down and/or a sale or merger with another entity.

Because many nonprofit hospital bankruptcies are filed under Chapter 11 of the Bankruptcy Code, these guidelines focus on the bankruptcy process under Chapter 11.

CHAPTER 11

■ OVERVIEW OF OPERATING IN CHAPTER 11

- ◆ **THE HOSPITAL IS STILL SUBJECT TO APPLICABLE NON-BANKRUPTCY REGULATION.** Chapter 11 offers various benefits to a struggling business, but it is not a cure-all. When contemplating whether to file for Chapter 11, it is important to understand that Chapter 11 generally will not supplant the various state and federal laws and regulations that govern the hospital’s existence. Section 959(b) of Title 28 of the United States Code requires a bankruptcy debtor-in-possession to manage and operate its property “according to the valid laws of the State in which such property is situated . . .”² Section 959(b) has consistently been read to “require[] a debtor to conform to federal, state and local law in conducting its business.”³ (See **Section C** for a more detailed discussion of the interplay between the state and federal authorities in the context of a nonprofit hospital bankruptcy case.)
- ◆ **THE NEED FOR BANKRUPTCY COURT APPROVAL OF VARIOUS TRANSACTIONS.** Chapter 11 brings with it a heightened level of scrutiny with respect to both finances and operations. This scrutiny comes not only

² 28 U.S.C. § 959(b).

³ *Norris Square Civic Ass’n v. St. Mary Hospital (In re St. Mary Hospital)*, 86 B.R. 393, 398 (Bankr. E.D.Pa. 1988).

from the Bankruptcy Court, but from the creditors as well. Once in bankruptcy, it is important that management appreciate that all transactions outside the “ordinary course of business” will require notice to creditors, negotiations with creditors and, ultimately, Bankruptcy Court approval. Transactions outside of the “ordinary course of business” for which Bankruptcy Court approval is required generally include, among others:

- financing transactions
- purchases or leases of major equipment
- entering into contracts
- modifying employee benefits
- implementing new administrative procedures and programs
- hiring professionals, such as lawyers, auditors, real estate brokers, and bankruptcy consultants
- sales of major assets

■ THE AUTOMATIC STAY

- ◆ **OVERVIEW OF THE AUTOMATIC STAY.** One of the primary and most immediate benefits of filing for bankruptcy is the so-called “automatic stay.” Generally speaking, the filing of a bankruptcy case will immediately and automatically stay a broad range of actions against the hospital and its assets. While there are exceptions to the stay (most notably in the regulatory enforcement area), creditors are generally stayed from actions to collect debts or enforce judgments against the hospital, and pending lawsuits in which the hospital is a party are generally stayed. Furthermore, as discussed in the next section, the other parties to hospital agreements are generally stayed from terminating contracts and leases – at least until the hospital has had reasonable time to decide whether it will assume (i.e., continue to perform) or reject (i.e., terminate) such contracts through the bankruptcy process. This provision can have a positive effect on a hospital’s operations: suppliers will be required to perform (i.e., deliver needed equipment and other supplies), which can result in the hospital’s physicians having access to supplies that have been scarce or non-existent, as the hospital’s credit dried up pre-bankruptcy.
- ◆ **THE AUTOMATIC STAY PROHIBITS IMMEDIATE TERMINATION OF PROVIDER AGREEMENTS AND OTHER CONTRACTS AND LEASES.** The automatic stay will have a number of stabilizing benefits. Not only will actions by creditors be stayed, but immediate termination of provider, supplier and other vendor contracts for non-payment will be prohibited. Such contracts may include:
 - Medicare and other federal or state health care provider contracts
 - Physician contracts
 - Radiology or other specialized professional services agreements
 - Ambulance company contracts
 - Contracts to supply OR supplies or blood

◆ **AUTOMATIC STAY AND EXCLUSION FROM OR TERMINATION OF MEDICARE AND MEDICAID.**

- **The Automatic Stay Does Not Prevent Exclusion from Medicare and Medicaid.** Section 362(b) of the Bankruptcy Code contains various exceptions to the automatic stay, including a provision stating that actions by a governmental entity to enforce its police or regulatory power are not stayed by the filing of a bankruptcy petition. Some cases have held that attempts to exclude a debtor from a federal health care program – at least for reasons based solely upon the debtor’s nonpayment (for example, Medicare overpayments, False Claim Act liability,⁴ or civil penalties) – are not proper efforts to enforce regulatory powers and, thus, are prohibited by the automatic stay.

However, the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (the “2005 Amendments”) added a new section 362(b)(28) to the Bankruptcy Code. That section expressly provides that the automatic stay does not prevent the Secretary of Health and Human Services from excluding a health care business “from participation in the Medicare program or any other Federal health care program (as defined in section 1128B(f) of the Social Security Act pursuant to title XI or XVIII of such act).”⁵

For many, if not most, hospitals, exclusion from a federal health care program such as Medicare will have disastrous consequences. In situations where the government seeks to terminate an existing health care program contract or exclude a health care provider from continued participation in a federal health care program, it is critical to understand how the new section 362(b)(28) works, as well as its relationship to section 525 of the Bankruptcy Code. The interplay of these statutes is described below.

- **Stay of Termination vs. Exclusion.** Exclusion and termination are separate and distinct concepts under the Medicare statute and are governed by different sections of the Medicare statute. Federal law allows HHS to exclude a provider from the program only if certain specified grounds exist. Exclusion is typically reserved only for the most egregious offenders – generally providers who have a criminal conviction for violations of the Medicare Act, such as a felony, health care fraud, patient abuse, or who have displayed other indicia of untrustworthiness and pose a risk to the Medicare/Medicaid program or its beneficiaries (e.g., a provider whose professional license has been suspended or revoked due to incompetence or poor professional performance). Section 362(b)(28) of the Bankruptcy Code does not change the grounds that must exist before HHS can exclude a provider; it merely states that if exclusion is otherwise authorized, HHS does not violate the stay by the pursuit of that remedy after a provider files for bankruptcy.⁶

Notably, section 362(b)(28) of the Bankruptcy Code refers only to “exclusion” from a federal health care program, not “termination” of an existing health care program contract. If the factors in the

⁴ Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government’s damages plus civil penalties of \$5,500 to \$11,000 per false claim.

⁵ 11 U.S.C. §362(b)(28).

⁶ As a practical matter, the 2005 Amendments merely accelerated the timing within which the provider must address the problems that put it at risk for exclusion. Nothing contained in the Bankruptcy Code, either before or after the 2005 Amendments, changes the remedial actions a provider will have to take to avoid exclusion. Prior to the 2005 Amendments, the automatic stay arguably required the government to wait until the conclusion of the bankruptcy case before commencing the exclusion process. After the 2005 Amendments, HHS can begin the process immediately, since Section 362(b)(28) provides that the automatic stay does not stay the exclusion process. After the 2005 Amendments, a provider at risk for exclusion should commence negotiations with the government as early as possible, even before a bankruptcy filing, in order to begin the substantive remedial tasks necessary to remain in the Medicare or other federal health care program.

exclusion statute are not met, HHS will not be able to employ Section 362(b)(28), since that section does not address termination from Medicare or other health care program. HHS is required to seek an order from the Bankruptcy Court granting relief from the automatic stay before it may terminate a provider's participation in Medicare or other federal health care program.

“Termination from participation in the [Medicare/Medicaid] Program . . . is a less serious remedy than exclusion. Termination is a discontinuation or refusal to renew a provider's Program contract. Unlike exclusion, termination is not permanent and the provider may immediately reapply for a new contract. CMS should grant a new contract if the reasons for the termination have been remedied and the provider gives reasonable assurance that they will not recur. Unlike the serious criminal convictions required for exclusion, a provider's contract may be terminated for a variety of reasons including, for example, failure to maintain substantial compliance with Program requirements.”⁷

- **Interplay with Section 525.** In some cases decided prior to the 2005 Amendments, the government refused to renew, or sought relief from the stay to exclude, provider participation simply because the provider was in bankruptcy or had failed to pay pre-petition penalties or to satisfy Medicare overpayment liability. In *Health Care Financing Admin. v. Sun Healthcare Group, Inc. (In re Sun Healthcare Group, Inc.)*,⁸ the Delaware district court affirmed the bankruptcy court's holding that the government's refusal to issue a new provider agreement until a pre-petition debt was paid violated section 525 of the Bankruptcy Code, which provides that a governmental entity may not deny, revoke, suspend or refuse to renew a license or other similar grant solely because an entity is or has been a Chapter 11 debtor or has failed to pay a debt that is dischargeable in bankruptcy. In so holding, the *Sun Healthcare* court concluded that the provider agreements at issue constituted “a license or other similar grant” within the meaning of section 525(a).

The lesson from *Sun Healthcare* is that, even if exclusion or termination is not barred by the automatic stay, it will be prohibited by section 525(a) if the government's action is motivated *solely* because the debtor is in bankruptcy or has not paid a pre-petition debt. Of course, the government will likely offer ostensible non-bankruptcy related reasons why it is terminating or excluding a provider. However, the bankruptcy courts will look beyond superficial pretexts to determine whether the government is improperly discriminating for purposes of section 525(a).

- ◆ **AUTOMATIC STAY AND SETOFF OR RECOUPMENT OF MEDICARE AND MEDICAID OVERPAYMENTS.** A major issue in health care bankruptcies over the years has been whether the government can recover pre-bankruptcy Medicare or Medicaid overpayments by reducing (i.e., offsetting against) payments coming due to the hospital during the bankruptcy case under a provider agreement that has not been assumed⁹ by the provider. Such efforts are essentially attempts to collect on a pre-petition debt, which are barred by the automatic stay and the general prohibition against paying pre-petition debts outside of a plan of reorganization. While mutual pre-petition obligations can generally be offset in bankruptcy, the setoff of pre-petition over-

⁷ Lacktman, N. & Owens, K., “*Health Care Providers and the Automatic Stay, Is Medicare Termination Different Than Exclusion?*” American Bankruptcy Institute Journal (November 2006), p.72.

⁸ 2002 U.S. Dist. LEXIS 17868 (D.Del. Sept. 4, 2002).

⁹ For a discussion of “assumption” and “rejection” of contracts, see page 19 and Glossary.

payments against the government's post-petition debts to a hospital is expressly barred by the automatic stay. In other words, if a hospital receives Medicare overpayments for a pre-bankruptcy period, the government may not withhold post-bankruptcy payments in order to recoup those overpayments.

In an effort to circumvent these prohibitions, the government has traditionally argued that it may recover such overpayments by virtue of the common law doctrine of recoupment. "Recoupment is the setting up of a demand arising from the same transaction as the plaintiff's claim or cause of action, strictly for the purpose of abatement or reduction of such claim."¹⁰ The doctrine of recoupment is an equitable exception to the automatic stay. Unlike setoff, recoupment is not barred by the automatic stay, because the funds subject to recoupment are not the debtor's property. Recoupment and setoff are similar from a conceptual standpoint, but a primary difference is that recoupment must be based on a single transaction, whereas setoff may involve mutual debts arising from separate transactions.

Litigation in the area of recoupment of Medicare overpayments has focused on the question of whether the mutual obligations at issue have arisen from the same transaction or series of transactions. In the *University Medical Center* case, the United States Court of Appeals for the Third Circuit adopted what is known as the "integrated transaction" test and held that each yearly payment to a Medicare or Medicaid provider constitutes a separate transaction. In denying the government's effort to recoup overpayments, the Third Circuit explained:

[T]he relationship between HHS [now CMS] and a Medicare provider entails transactions that last over an extended period. However, each of these transactions begins with services rendered by the provider to a Medicare patient, includes payment to the provider, and concludes with HHS's recovery of any overpayments. Recovery of the 1985 overpayment, therefore, is the final act of the transactions that begin in 1985. UMC's 1988 post-petition services were the beginning of transactions that would stretch into the future, but they were not part of the 1985 transactions. To conclude that these claims arose from the same transaction for the purposes of equitable recoupment would be to contort that doctrine beyond any justification for its creation.¹¹

The Third Circuit in *University Medical Center* was the first circuit level appeals court to consider the question of whether the government can recoup pre-bankruptcy Medicare overpayments after the provider files for bankruptcy, and it ruled that recoupment was not permitted.¹² Although decisions of the Third Circuit Court of Appeals are binding on New Jersey bankruptcy courts, it is worth noting that the Third Circuit's rationale has been rejected by other circuit level appeals courts that have considered the question of recoupment of federal health care program overpayments. The First, Ninth and D.C. Circuits have each held that the Medicare system provides for a single, ongoing, integrated transaction for the purposes of recoupment analysis.

- ◆ **THE AUTOMATIC STAY FROM THE SECURED CREDITOR PERSPECTIVE.** A secured creditor is a creditor who has the benefit of a security interest in some or all of the assets of its debtor. In the event of bankruptcy of the debtor, the secured creditor can enforce its rights in the assets of the debtor that were given as collateral and thereby avoid competing with unsecured creditors for payment.

¹⁰ *University Medical Center v. Sullivan (In re University Medical Center)*, 973 F.2d 1065, 1079-80 (3d Cir. 1992).

¹¹ 973 F.2d at 1081-82.

¹² In *University Medical Center*, the Third Circuit stated that HHS could recoup the overpayments if the provider agreement is assumed by the debtor hospital. 973 F.2d at 1075, 1082 n.20. For a discussion of "assumption" of Medicare provider agreements, see page 23.

The assurance that a secured creditor has in its ability to be repaid is limited to the value of the collateral that secures the claim. After all, if the debtor defaults and has no other assets from which to repay the debt, the secured creditor can only recover the amount it is able to realize from the sale of its collateral. If the collateral is depreciating in value, the time it takes for the secured creditor to take possession of and sell its collateral is crucial.

As described above, whenever a debtor files a bankruptcy petition, the “automatic stay” prohibits creditors (secured and unsecured alike) from seizing assets or taking other action to collect the debt from the debtor. Secured creditors cannot be expected to sit idly in the face of the automatic stay. Secured creditors can and will file a motion for “relief from the stay” (often called a “lift-stay” motion) post-petition if either (1) the debtor does not provide “adequate protection” of the lender’s interest in the subject collateral (discussed in more detail beginning on page 25, or (2) it is established that the debtor (the hospital that filed for Bankruptcy) has “no equity” in the subject collateral (meaning that the lender is owed more than the value of its collateral) and that the collateral is not “necessary” to an “effective” reorganization of the debtor.

Debtors and creditors can benefit both from the stay and from relief thereof. By way of example, even if the debtor has no equity in a PET/CT scanner because it is worth less than the associated indebtedness, if the debtor hospital can establish that the equipment is “necessary” to its provision of medical services, the debtor can block the lender from “lifting the stay” post-petition, so long as the debtor makes payment to the lender to compensate the lender for post-petition depreciation. Equipment of this nature is often supported by service contracts provided by affiliates of the lender. If the debtor does not pay on those contracts, it may be subject to a lift-stay motion by the lender or its affiliates, who will seek to terminate the subject contract on grounds that failure to pay for post-petition services constitutes a lack of “adequate protection.”

Where grounds exist to lift the stay, secured creditors can file a motion seeking such relief post-petition. In a motion of this nature, the secured creditor will seek a bankruptcy court order that lifts the automatic stay and allows the creditor to repossess and recover its collateral. Usually, the secured creditor will then sell the collateral through state law foreclosure proceedings, pursuant to the hospital’s security agreement with the creditor. If the court denies the motion, the secured lender can still demand continued adequate protection of its interest in the collateral as a cost of keeping the automatic stay in effect. In the case of equipment collateral, this may take the form of monthly post-petition payments from the debtor to the lender in order to cover the depreciation that results from post-petition use of the equipment.

Secured creditors may file motions with the bankruptcy court seeking various forms of adequate protection. They often negotiate with the hospital-debtor to ensure that interim payments protect the lender’s interest in the collateral. The secured creditor should recognize that the hospital wants to continue operating and will try to come to an agreement regarding adjusted payments during the bankruptcy period in order to continue operations. The secured lender will also seek adequate protection for the debtor’s use of the lender’s “cash collateral.”

Finally, it bears mentioning that the automatic stay does not extend to any third-party guarantors of the hospital's indebtedness absent a bankruptcy court order extending the protection of the automatic stay to such persons. Lenders can be expected to object to extension of the automatic stay to non-debtor guarantors, and to pursue payments from such guarantors.

- **CREDITORS' COMMITTEE.** To enhance unsecured creditor participation in the Chapter 11 process, the Bankruptcy Code requires that the United States Trustee (part of the Department of Justice empowered to supervise bankruptcy cases) solicit the debtor's largest unsecured creditors to participate in a meeting shortly after a bankruptcy case is filed to appoint an official committee of unsecured creditors (the "Committee"). Unsecured creditors chosen to serve on the Committee are normally representative of the unsecured creditors at large and, once appointed to the Committee, hold fiduciary duties to all unsecured creditors as a group, without regard to the types of claims the individual unsecured creditors hold against the debtor. In hospital bankruptcies, Committee members often include the PBGC, labor union benefit funds, various vendors, including, but not limited to, public utilities, food service providers, unions, medication and technology providers, nurse staffing services and ambulance service providers.

The Committee does not "run the business" or otherwise control the assets of the debtor's estate. Instead, the Committee consults with the debtor concerning the bankruptcy case, investigates the debtor's acts, conduct, assets, liabilities and financial condition and participates in the formulation of a plan of reorganization. The Committee's principal role is to represent the interests of all unsecured creditors in attempting to maximize the recovery for all unsecured creditors. In order to aid the Committee in accomplishing these goals, the Bankruptcy Code specifically sets out certain duties and powers of the Committee, which include the following:

Review the progress and status of the case and communicate with the debtor and other stakeholders on these issues. The Committee reviews the detailed monthly operating reports that the debtor is required to file with the Court and the Office of the United States Trustee. These reports generally provide valuable information to the Committee.

Investigate the financial condition of the debtor, the operation of the debtor's business and the desirability of the continuance of the business.

Participate in the formulation of a plan.

Request the appointment of an examiner in the case when appropriate. An examiner is a professional (often a CPA) with the expertise to investigate the business and file a report drawing conclusions regarding the viability of the business, and the competence and integrity of past or current management. Request the appointment of an operating trustee to displace the debtor's management if appropriate. A trustee is an independent third-party fiduciary charged with the responsibility of controlling assets of the estate and operating the business.

Request dismissal of the case or conversion of the case to a Chapter 7 liquidation, if appropriate. One cause for dismissal or conversion is unreasonable delay in formulation of the plan that is prejudicial to creditors.

The Bankruptcy Code further provides that the debtor must meet with the Committee to transact such business as may be necessary and proper, and that the debtor must furnish to the Committee, upon request, information concerning the debtor's business and its administration. Normally, to aid it in the performance of its duties, the Committee retains its own professionals, who must be approved by the Bankruptcy Court, and who include attorneys, accountants, and appraisers. Compensation to all professionals, including those retained by the Committee, is subject to Bankruptcy Court approval, and importantly, is paid from unencumbered assets of the debtor's estate, not directly by individual Committee members.

The hospital's relationship with the Committee is extremely important to the progress of the bankruptcy case. If the relationship is adversarial, valuable time and resources, as well as the good will of the Bankruptcy Court, can be squandered by litigating disputes. On the other hand, if the relationship is collegial, the Committee can help the hospital by supporting its reorganization plan and otherwise assist the hospital to emerge from bankruptcy.

- ◆ **AVOIDANCE OF PREFERENTIAL AND FRAUDULENT TRANSFERS AND OTHER POTENTIALLY-IMPROPER TRANSFERS OR RELATIONSHIPS.** In many Chapter 11 bankruptcy cases, the Committee is also concerned with avoiding and recovering preferential and fraudulent transfers made by a debtor prior to its bankruptcy filing. The Committee may obtain authority from the Bankruptcy Court to seek to avoid and recover certain transfers, including transfers commonly known as preferential transfers. Preferential transfers are transfers made to or for the benefit of a creditor, concerning a pre-existing debt of the debtor, at a time when the debtor was insolvent, made within 90 days of the filing of the bankruptcy petition (or up to one year before bankruptcy if the creditor is an insider), which resulted in the creditor receiving a larger payment than that creditor would have received if the transfer had not been made and the debtor's assets had instead been liquidated. The purpose of avoiding preferential transfers is to accomplish an equitable distribution of estate property and to prevent the debtor from preferring certain creditors over other creditors.

For example, a hospital in financial distress that is contemplating filing for bankruptcy protection may be in arrears to a key vendor who has threatened to cease providing goods or performing services that are critical to the hospital's day-to-day operations. Under these circumstances, to the extent that the hospital chooses to make a payment to this vendor on account of past-due invoices and then files a Chapter 11 petition within 90 days of making the payment, after the bankruptcy case is filed, the Committee often obtains Bankruptcy Court authority to seek to avoid this transfer and recover the monies for the benefit of the estate. This system prevents disparate treatment among similarly-situated unsecured creditors and serves to ensure equal treatment to all unsecured creditors.

Similarly, the Committee often seeks to obtain Bankruptcy Court approval to avoid and recover other transfers known as fraudulent transfers. A fraudulent transfer is a transfer of the debtor's money or property made with the actual intent to hinder, delay, or defraud a creditor, or made without the debtor receiving something of reasonably equivalent value in exchange for the transfer. To recover a fraudulent transfer made without reasonably equivalent value, the Committee must also establish that the debtor was either insolvent at the time, was undercapitalized, or intended to incur debts beyond its ability to

repay. Under the Bankruptcy Code, the Committee can seek recovery of fraudulent transfers that occurred up to two years before the bankruptcy filing. Under New Jersey law, however, the look-back period is longer, and the Committee can recover fraudulent transfers that occurred up to four years before the bankruptcy filing.

The Committee can also be expected to carefully scrutinize the pre-petition activity of management. Similarly, most Committees and Bankruptcy Courts will scrutinize the professionals retained by the hospital to make sure that those professionals are free from any conflicts of interest, charge appropriate rates, bill appropriate and reasonable hours, and otherwise act in the best interests of both the hospital and its creditors.

- **ASSUMPTION AND ASSIGNMENT/REJECTION OF CONTRACTS AND LEASES.** Another advantage of Chapter 11 is that it allows for the rejection of burdensome executory contracts (i.e., contracts under which performance remains due from both parties) and unexpired leases, and allows for assumption and assignment of beneficial contracts, typically notwithstanding any anti-assignment clauses in the contract. The debtor is allowed a reasonable time within which to determine whether assumption or rejection would be beneficial to its restructuring, during which time the terms of the contract or lease are temporarily unenforceable against the debtor.

If a contract or lease is to be assumed, it must be assumed in its entirety; the debtor must accept the burdens of the contract and may not simply assume the beneficial parts and discard the burdensome ones. In order to assume and/or assign a contract in default, the debtor must first cure all defaults under the contract and provide adequate assurance of future performance. Rejection of a contract or lease during a bankruptcy is treated as a breach that occurred immediately prior to commencement of the bankruptcy case, with the result that damage claims will be treated as pre-petition claims (usually general unsecured claims – although, to the extent that the debtor benefits from the contract post-petition, the resulting damage claim can be treated as an priority claim (which have the highest priority for payment under the Bankruptcy Code; see *Appendix II*)). In many cases, vendors are willing to negotiate to continue their contract on amended terms. Certain issues pertaining to assumption and assignment of executory contracts and unexpired leases in the context of a hospital bankruptcy will be discussed below.

- ◆ **ISSUES CONCERNING ASSUMPTION OF MEDICARE AND MEDICAID PROVIDER AGREEMENTS.** Medicare and Medicaid provider agreements are generally treated as executory contracts in bankruptcy, and as such are subject to assumption or rejection. In many cases, it will be necessary for the hospital to assume its provider agreements to allow the hospital to continue as a reorganized entity or to allow for the transfer of the provider agreements as part of a sale. In some cases, it may be necessary to preserve the option of assuming or rejecting provider agreements until a full financial analysis can be performed and a viable exit strategy can be identified. Even in cases where the need to assume a provider agreement is obvious, consideration should be given to the timing of assumption, because notwithstanding the recoupment discussion on page 19, assumption will allow the government to recover pre-petition overpayments, which will have an adverse affect on cash flow.

In order to assume a provider agreement, a hospital will have to cure all defaults under the agreement. Further, as noted earlier, bankruptcy law requires that contracts be assumed in their entirety; a debtor is

not free to assume some provisions of a contract and reject others. As a result, a hospital must assume not only the benefits of an assumed contract, but also the burdens. As discussed above, the Third Circuit in *In re University Medical Center* held that the government could not recoup overpayments without violating the automatic stay. That case, however, involved efforts to recoup overpayments under a provider agreement that had not been assumed. The result would have been different had the debtor assumed the provider contract at the time the government sought to recover the overpayments. The Third Circuit explained, “if UMC assumed its provider agreement, there is no question that HHS could withhold UMC’s post-petition reimbursement in order to recover pre-petition overpayments without violating the automatic stay. Through executing a provider agreement, a hospital accepts the ‘burden’ of allowing HHS to recover the amount of prior overpayments from Medicare reimbursement currently due.”¹³

In Chapter 11 cases, a debtor has until confirmation of a plan to decide whether to assume or reject an executory contract, although this period can be shortened by the Bankruptcy Court upon request of the counterparty to the contract. In many cases, it will be advantageous for the hospital to delay assumption of the provider agreement, because the amount of overpayment liability associated with the agreement has yet to be quantified, rendering a fully informed business judgment difficult to make, or because cash flow needs dictate that assumption be delayed.

In the event that a provider agreement is ultimately rejected, all pre-petition overpayments not recouped will be treated as general unsecured claims. However, overpayments made during the bankruptcy and not recouped will likely be treated as administrative claims, which will have to be paid in full under any plan of reorganization unless the government (i.e., CMS or state Medicaid agencies) affirmatively agrees to less favorable treatment.

■ **FINANCIAL REPORTING.** Chapter 11 brings with it detailed reporting requirements. Comprehensive schedules of assets and liabilities, and lists of creditors, contracts and leases, as well as monthly operating reports, must be prepared and filed with the Bankruptcy Court. This is in addition to any reporting that lenders might require as a condition to extending financial accommodations, and generally speaking, is presented on official forms and in a manner to which the Bankruptcy Court and the professionals involved are accustomed. While the legal and financial professionals will assist in assembling and presenting this information, the information usually will be gathered initially by hospital personnel. Due the comprehensive nature of the information that needs to be gathered, this project can require considerable time and resources and may distract from operational and restructuring issues.

■ **FIRST DAY MOTIONS.** Two of the most fundamental rules of operating in Chapter 11 are that a debtor-in-possession: (1) must obtain Bankruptcy Court approval for transactions outside of the ordinary course of its business, and (2) is generally prohibited from paying any obligations that arose prior to the bankruptcy filing (“pre-petition”) other than pursuant to a plan of reorganization or liquidation approved by the Bankruptcy Court.

As a result, it will likely be necessary to obtain immediate bankruptcy approval for various transactions in order to finance operations, avoid disruptions in the delivery of services and supplies, and otherwise continue hospital operations uninterrupted by the bankruptcy filing. It is critical for bankruptcy counsel to work

¹³ 973 F.2d at 1075

with management in advance of a filing to identify those payments and transactions for which Bankruptcy Court approval must immediately be sought on an expedited basis, as motion papers must be prepared explaining in detail to the Bankruptcy Court why the requested emergency relief justifies departure from established bankruptcy rules.

Typical “first day” motions include:

Motion to pay employees’ wages and benefits earned pre-petition

Motion to pay pre-petition obligations owed to so-called “critical vendors”

Motion to continue to use cash in the ordinary course of business

Motion to obtain new financing – known as debtor-in-possession or “DIP financing”

Motion to pay insurance premiums

Motion to pay critical vendors

- ◆ **EMPLOYEE WAGE MOTION.** Companies often file a first day motion for authority to pay pre-petition wages and benefit obligations immediately upon filing for Chapter 11. It is also commonplace for courts to approve these motions, because these obligations would be entitled to priority over general unsecured claims in any event, up to a maximum of \$10,950 per employee.
- ◆ **CRITICAL VENDOR MOTION.** The general exception to the rule against paying pre-bankruptcy claims of creditors is embodied in the so-called “doctrine of necessity.” The doctrine of necessity is a judge-made doctrine that originated in the railroad reorganizations of the nineteenth century in order to justify payment of pre-petition debts to parties without whose continued cooperation the reorganization effort would likely fail. In modern day Chapter 11 practice, the “doctrine of necessity” is most commonly used to justify payments of pre-petition debts at the outset of a Chapter 11 case to a limited number of “critical vendors,” i.e., those suppliers and service providers who threaten to withhold critical supplies and services unless and until their accounts are made current and for whom there is no replacement.

Critical vendor motions have come under increased Bankruptcy Court scrutiny in recent years, and payments are limited to those vendors whose continued provision of goods and services is truly critical to continued operations. The Bankruptcy Court might require an evidentiary hearing to determine whether a proposed payment is truly necessary. Creditor committees typically oppose payments to some vendors. Notwithstanding the increased scrutiny of these motions in recent years, for hospitals these motions may be granted with respect to suppliers of blood, pharmaceuticals and other medical supplies that are critical not only to the hospital’s reorganization, but also to proper patient care. Other critical vendors in a hospital case might include food service providers, providers of IT or communication services and providers of building maintenance. The hospital will be expected to show that there is no other vendor who will perform the services, in order to justify payment of these isolated critical vendors. In general, the sooner the critical vendor motion is made in the bankruptcy case, and the more limited are the vendors listed as critical, the greater the chance the motion will be successful.

Similarly, as of the commencement of a bankruptcy, the hospital will likely have numerous pre-petition purchase orders outstanding for goods necessary to the operation of its business. Vendors may refuse to ship these orders unless the hospital issues substitute purchase orders or obtains an order of the Bankruptcy Court authorizing payment or at least affording administrative expense priority to such obligations.

◆ FINANCING ISSUES

- **Cash Collateral.** Cash collateral is the highest and best form of collateral. Cash collateral is defined in section 363(a) of the Bankruptcy Code as “cash, negotiable instruments, documents of title, securities, deposit accounts, or other cash equivalents whenever acquired in which the estate and an entity other than the estate have an interest and includes proceeds, products, offspring, rents, or profits of property and the fees, charges, accounts or other payments for the use or occupancy of rooms ... whether existing before or after commencement of a case under this title.” Clearly, cash collateral can cover a lot of territory. A lien in cash collateral has unique benefits, but it also raises potential problems for secured creditors. The most common form of cash collateral in a hospital’s bankruptcy is the collected cash proceeds of the debtor hospital’s accounts receivables in which a secured lender holds a security interest as collateral for its pre-petition loan(s) to the debtor.

Unlike the case with other debtor assets, a debtor needs express creditor or court approval before any post-petition use or sale of already encumbered “cash collateral.” This is because, even with the extra protection provided by the automatic stay, the inherent intangible nature of cash collateral can pose problems of adequate protection for secured creditors, and cash can easily be dissipated. The value of the lender’s interest in cash collateral and the timing of valuation are critical. Secured creditors will act quickly to determine the value of their interests in cash collateral and to reach an agreement with the debtor and its creditors’ committee on the terms and conditions of “adequate protection” for the lender so that the debtor can be allowed to use cash collateral after the bankruptcy filing.

Many times, the parties can negotiate a proposed cash collateral order pre-petition. If the parties cannot reach agreement, the bankruptcy court can enter an order that allows the hospital to continue to use the cash collateral post-petition over the objection of the lender, provided that the court finds that the terms and conditions of the court order are sufficient to adequately protect the lender. In all Chapter 11 cases, the debtor hospital generally files a motion for permission to use the lender’s “cash collateral” with the debtor’s other “first day” motions on the first day of the debtor hospital’s bankruptcy case.

If cash collateral is used by the debtor hospital, secured creditors with an interest in it have the right to “adequate protection” as provided by section 361 of the Bankruptcy Code. Adequate protection provided by a hospital debtor to a secured creditor, for use of the creditor’s cash collateral, generally includes, among other things, (i) the debtor’s grant of a replacement lien to the creditor on post-petition accounts receivable, equal in amount to any decline in the lender’s interest in pre-petition receivable collateral from use of the cash collateral; (ii) cash payments to the lender by the debtor hospital, post-petition, often in the amount of interest on outstanding fully secured debt that accrues at the non-default rate and, in some cases, principal payments also; (iii) the hospital-debtor’s

agreement to use cash only as set forth on, and allowed by, court-approved budgets that are acceptable to the lender; (iv) the debtor's commitment to continue to provide insurance over assets in which the lender holds a security interest; and (v) in some cases, the pledge of substitute collateral to the lender.

If projections show that the Debtor hospital is likely to lose money and patients post-petition, such that, over time, the level of post-petition patient receivables will be lower than the level of receivables that existed as of the Petition Date, the debtor hospital can expect that a secured lender with a lien on the accounts will argue that a "replacement lien" (i.e., a lien in post-petition receivables to 'replace' the lender's lien in pre-petition receivables) will not be sufficient to adequately protect the lender for the debtor's use of the lender's cash collateral. In these circumstances, the lender will likely demand, and the bankruptcy court may require, that the hospital provide adequate protection of the lender's interest in cash collateral by turning over a significant amount of cash collections on pre-petition receivable collateral to the lender as the collections comes in, or by requiring that the debtor escrow the cash in a segregated account, pledged to the lender, which cannot be used to pay operating expenses.

When a debtor hospital uses the cash collateral of a pre-petition lender as outlined above, the debtor simply gets use of the collected cash proceeds of the pre-petition accounts so that it can use them to pay bills, make payroll, etc., and generate new receivables going forward. However, the pre-petition lender does not make further, additional loans, post-petition.

Once the cash collateral is dissipated, it is gone. Therefore, it is essential for a secured lender to protect its interest in cash collateral. If the debtor hospital spends more money in its post-petition operations than the money it is collecting – and thus operates at a deficit – it is likely that the secured creditor's interest is being diminished without recompense. Thus, secured lenders, as well as other parties, including the debtor, will want to obtain a quick read on whether or not the hospital can realistically operate long-term and reorganize as a "going concern," and emerge from Chapter 11 under a confirmed plan, or whether, instead, Chapter 11 is simply a means to a quick sale of the hospital's assets to a third-party.

- **Debtor-in-Possession Financing.** Cash collateral is often used as a tool for financing the debtor post-petition, but as noted, because the lender is not making fresh advances, use of cash collateral alone may not be sufficient to support continued operations of a troubled hospital. The debtor hospital often has a difficult time obtaining sufficient unsecured debt post-petition, because vendors become wary. Therefore, the hospital will likely also consider two other alternatives, either: (i) raise cash post-petition by selling off assets under section 363 of the Bankruptcy Code or (ii) obtain a post-petition loan, either from the existing lender(s) or from a new lender, through a post-petition debtor-in-possession (DIP) financing facility that provides the hospital with additional borrowing capacity. A new loan of this nature can be secured by a pledge of previously unencumbered assets (if they exist), a junior lien on existing collateral, or an administrative priority claim superior in priority to other post-petition administrative expenses, as the circumstances warrant.

If the debtor cannot obtain financing on any other terms, section 364(d) of the Bankruptcy Code allows a post-petition lender to take a lien on property that is already encumbered, and that lien may have either equal or superior priority for repayment with the pre-existing lien. If the new lender receives first priority for payment over the existing lien, the new lien is said to “prime” the pre-existing lien. The hospital can expect that any effort to prime an existing secured lender over its objection will be vigorously opposed.

Generally, the most common source of post-petition debtor-in-possession financing to a hospital debtor comes from a fresh loan made by the principal existing pre-petition secured lender(s). It is not uncommon for the parties to agree that the proceeds of the post-petition loan will “roll-up” and repay existing pre-petition secured indebtedness, either immediately or through pay-downs when post-petition collections are received on pre-petition collateral which are treated as paying down the pre-petition indebtedness and being re-advanced, subject to borrowing base limitations, as new, post-petition indebtedness.

It is common for a hospital debtor to stipulate to the validity, extent, and priority of a pre-petition lender’s liens as a condition of either obtaining consensual use of cash collateral or the debtor’s receipt of §364(d) financing from the pre-petition lender. In either case, the Committee will generally require 60 days or so to investigate the validity, extent, and priority of the lender’s pre-petition lien(s) as a condition of the deal.

- **Post-Petition Financing via Factoring of Receivables.** Factors today play an increasing role in providing post-petition financing to clients in a wide variety of industries, including that of debtor hospitals. This is all the more true as the “credit crunch” intensifies. Essentially, a factor purchases the hospital’s healthcare receivables in consideration of a “discount” (i.e., a “commission”), which can be either a flat fee or, in block-time pricing, a fee that rises with the time it takes to collect a purchased account. Medical factors typically “advance” 70-80% of the contractual purchase price of the account, set at their net realizable value as determined by the parties at the time of purchase, with the balance payable to the hospital upon collection of the purchased account, net of discount fees and expenses due to the factor. Oftentimes, the hospital also agrees to serve as “servicer” for the factor on accounts sold to the factor.

In connection with any factoring arrangements or other transaction including the sale or assignment of a hospital’s Medicare or Medicaid receivables, careful attention should be given to assure compliance with the federal anti-assignment rules of Medicare and Medicaid.

- **Unconventional Financing.** Unconventional financing may also need to be considered. This might include filing a *cy pres* petition in state court to allow use of restricted gifts and donations for general corporate purposes. Although there is little reported case law in this area, there is historical precedent in the New Jersey courts for allowing hospitals and other charitable institutions to borrow such restricted funds on a secured basis on the ground that a donor’s charitable purpose is furthered by efforts to ensure the institution’s survival.

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- ◆ **ACTIONS OF THE CREDITORS' COMMITTEE WITH RESPECT TO FIRST DAY MOTIONS.** As discussed above, in virtually all Chapter 11 cases, a debtor files various "first day" motions with the Bankruptcy Court, simultaneous with or immediately after its bankruptcy filing. Under most bond and other asset-based financings, a bond trustee or another secured creditor will have a pre-bankruptcy lien on all present and future gross receipts of a hospital, which include, among other things, accounts receivable, contributions and other contractual rights to payment, and the proceeds thereof. As set forth above, the Bankruptcy Code prohibits a debtor's use of cash collateral unless the secured party consents or the Bankruptcy Court authorizes the debtor's use of cash collateral upon determining that the secured party is furnished with "adequate protection." As a result, first day motions usually include requests to use encumbered cash in the normal course of business and to obtain post-bankruptcy financing. While the Committee generally supports these motions, which are critical to a debtor's ongoing operations, the scope of the relief can substantially impact the unsecured creditors' interests. Consequently, one of the first steps taken by the Committee upon its appointment is to review and respond to these motions.

In connection with a motion to use cash collateral and/or a motion for post-petition financing, the Committee normally negotiates a "carveout" to pay certain of the Committee's professional fees and also requests a window of time to obtain and review the loan documents and other documents evidencing the secured creditors' liens upon assets of the debtor's estate. The Committee may have a legal basis to challenge a secured creditor's pre-bankruptcy lien because the Bankruptcy Code allows for the avoidance of pre-bankruptcy liens under various circumstances, including where the lien has not been properly perfected prior to the bankruptcy. Upon successful challenge of an asserted lien, the unsecured creditors of the debtor are entitled to share in the distribution of those now unencumbered assets on a pro rata basis, subject to the unsecured administrative and priority scheme set forth in the Bankruptcy Code.

In connection with a motion to obtain post-bankruptcy financing, the debtor is often required to grant liens on previously unencumbered property as security for the loans. The Committee often finds it necessary to object to a debtor's attempts to encumber otherwise unencumbered assets, as these unencumbered assets may be the principal or sole source of recovery for the unsecured creditors. This will often create challenges, as the debtor might need to obtain financing in order to continue operating or allow time to proceed with a sale. The Committee must balance the debtor's operational needs with the long-term objective of maximizing the return to the unsecured creditors.

- **VALUATION OF LENDER COLLATERAL AND FILING A PROOF OF CLAIM.** When a hospital files for bankruptcy protection, a secured creditor will gather and review its loan agreement, its security agreement, its UCC-1 financing statement(s), and any other documents evidencing its rights. If the creditor is willing to assent to bankruptcy court jurisdiction, as is often the case, it will prepare a proof of claim. A proof of claim, which must be filed before any applicable "bar date", asserts the amount owed as of the petition date, as well as the creditor's interest in the debtor's property. If the secured creditor is fully secured, it can opt not to file a proof of claim, and its debt will "ride through" the bankruptcy unless restructured via the debtor's Chapter 11 reorganization plan. If, however, the secured creditor is "undersecured" (see below), it will need to file a timely proof of claim in order for its "deficiency" claim, treated as a general unsecured claim, to share in any

“dividend” paid by the debtor on pre-petition claims, whether through a Chapter 11 plan or, if no plan can be confirmed, the administration of assets by a Chapter 7 trustee following conversion of the case.

Valuation of collateral is critical to determining whether a secured creditor’s claim is fully secured. This is because, in bankruptcy, only claims that are fully secured as of the date of the bankruptcy filing continue to accrue post-petition interest and other charges and fees, such as late charges, default interest, and legal fees for the lender’s counsel. For purposes of determining entitlement to post-petition interest and fees, the value of the lender’s collateral is set at either its liquidation value (forced sale or orderly liquidation), if the bankruptcy filed is a Chapter 7 liquidation case, or at the going-concern fair market value of the collateral in a Chapter 11 case. Disputes over the valuation of collateral sometimes arise, and are adjudicated by the bankruptcy court. Appraisal testimony will be necessary unless the parties, including the other creditors, can stipulate to collateral values. Section 506 of the Bankruptcy Code provides that “such value shall be determined in light of the purpose of the valuation and of the proposed disposition or use of such property, and in conjunction with any hearing on such disposition or use or on a plan affecting such creditor’s interest.” That is to say, the bankruptcy court, with input from the parties, uses its discretion in determining what valuation methodology is best suited to the case at hand.

Medical equipment can depreciate fairly quickly in today’s world of rapid technology development. For example, a new MRI machine or CT/PET machine is very valuable to the operation of the hospital. However, if the hospital files for bankruptcy when the machine is several years old, the fair market value on the petition date will reflect the depreciation in value that occurred pre-petition as the equipment was used.

Medical receivables are inherently hard to value, because of the wide variation between “billed charges” and the lesser contract rates negotiated with insurance companies, HMOs, and other payors. Some hospitals do not “book” sufficient reserves necessary to reduce the receivables to their estimated net realizable value on a frequent basis. In some cases, such reserves are not booked until the subject receivables are actually collected, at which time the discount is recognized. Therefore, the hospital can expect that secured lenders with a lien on receivables will take an active interest in this question and seek electronic interface with, and close review of, the hospital’s billing and collection records.

Secured creditors generally want to value their collateral at the highest legally justifiable value. Debtors, on the other hand, generally seek to value the lender’s collateral at the lowest legally justifiable value. Under bankruptcy law, if the lender’s claim is “underwater,” meaning that the valuation of the secured creditor’s collateral on the petition date (or thereafter) is lower than the balance owed as of that time, the claim is generally bifurcated into: (1) a secured claim to the extent of the market value of the lender’s collateral and (2) an unsecured “deficiency” claim for the shortfall. Unsecured claims of this nature are generally paid out at a discount by the debtor along with other pre-petition general unsecured claims.

Valuation is also important due to the priority of disbursement. Secured claims are paid first. After secured creditors are paid, post-petition administrative claims and “priority” general unsecured claims receive disbursement. Then the “general” unsecured claims split the residual assets of the debtor according to the terms of the reorganization plan or through the liquidation process. General unsecured claimants are lucky to receive even a third of their original claim. In some large bankruptcies – U.S. Airways, for example – the

dividend on general unsecured claims is only pennies on the dollar, and in some cases can be “0”. Thus, creditors are vigilant in safeguarding the value of collateral and monitoring to be sure that the debtor does not dissipate the lender’s interest in “cash collateral” (see above).

- **HIPAA; RECOUPMENT CLAIMS.** Pre-petition secured lenders will generally already be parties to a Business Associate Agreement with the hospital debtor that allows the lender reasonable access to patient receivable information and, as needed, the underlying patient medical records under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If the debtor hospital obtains new post-petition financing from another lender, then it should be sure to enter into a HIPAA Business Associate Agreement with the new lender as a condition of the deal.

Secured lenders and factors with security interests in hospital receivables will take a keen interest in determining whether or not their interests in medical receivables will be offset and reduced by either set-off or recoupment claims by payors, such as commercial insurers and Medicare and Medicaid, who seek to recover any pre-petition overpayments they have made by setting off against monies due to the hospital for post-petition patient care. In this regard, most circuit courts of appeal have held that a Medicare or Medicaid contract is a unitary contract, and that overpayments from one cost year can be offset against monies owed to the hospital for another cost year. In the Third Circuit, however, as noted above, recoupments of this nature can only be made on a year-by-year basis.

- **EMPLOYEE RETENTION PLANS.** A key employee retention plan (a “KERP”) may be necessary to prevent employee departures during the bankruptcy. Highly skilled and trained employees can prove invaluable during the course of reorganization, and a key employee retention plan offering incentives to remain through the restructuring is an effective way to keep current valued employees and avoid the difficulties their losses would cause.

Historically, KERP’s were usually structured as retention bonus plans, under which a debtor would propose to pay bonuses to designated key personnel who remained in the employ of the debtor through a given period of time. While the Bankruptcy Code did not expressly provide for the implementation of KERPs, courts often approve KERPs as a proper exercise of the debtor’s business judgment – even where substantial bonuses were proposed for management. In response to perceived abuses, the 2005 Amendments changed the Bankruptcy Code to allow for retention payments to insiders only under circumscribed conditions, including where such insiders have a bona fide job offer from another employer for at least the same rate of compensation as the insider is receiving from the debtor. Following the 2005 Amendments, debtors have usually successfully structured insider KERPs as incentive, rather than retention, plans. Since the 2005 Amendments, bankruptcy courts have approved incentive plans for insiders under which, among other things, bonuses were to be paid only if certain performance objectives are met, including, for example, if a sale price were to exceed a stalking horse bid for the debtor’s assets.

- **PROFESSIONALS**

- ◆ **THE BANKRUPTCY COURT MUST APPROVE RETENTION OF ALL PROFESSIONALS**

- **Legal and Financial Professionals.** It is necessary for the Bankruptcy Court to approve all outside professionals retained by the hospital. This includes all outside lawyers, financial advisors and con-

sultants, regardless of whether they were in place prior to the filing of the bankruptcy. Bankruptcy lawyers and many financial advisors in the restructuring arena are aware of this requirement. However, while the hospital's general bankruptcy counsel might be a firm that will be able to handle various non-bankruptcy aspects of the restructuring, chances are that some of the lawyers who performed work for the hospital pre-petition, e.g., regulatory counsel, labor counsel, malpractice counsel or corporate counsel will have specialized expertise or institutional knowledge that makes their continued retention desirable. It is also possible that general bankruptcy counsel will need to retain conflicts counsel for certain matters. If any of these professionals work prior to obtaining Bankruptcy Court approval of their retention, they proceed at peril of receiving no compensation for their pre-petition services. To avoid unpleasant surprises in this area, it is essential that the hospital coordinate all professional retentions with general bankruptcy counsel.

- **Public Relations Firm.** While a detailed discussion of professional retentions is beyond the scope of this guide, the importance of public relations to a hospital needs to be mentioned. Given a hospital's special purpose within a community, it is essential that the hospital cultivate and maintain good community relations in both good times and bad. In bad financial times, it is in the interest of all constituencies – the hospital, creditors, employees, patients, regulatory agencies and the public – that the hospital's operations continue as smoothly as possible, and that uncertainty surrounding operational or financial difficulties be minimized. To that end, it is essential that a coordinated program be implemented to communicate a coherent and consistent message to the hospital's various constituencies.

Patients and doctors are essential to any hospital. If the public or doctors perceive a lack of resources or confidence in the hospital's ability to deliver quality care, patients may voluntarily go to other facilities or be directed elsewhere by doctors who have privileges at other hospitals. A hospital should consider hiring a public relations firm before or soon after it files for bankruptcy to draft press releases, handle media relations, and supervise the dissemination of information regarding a bankruptcy filing, including internal communications and the release of information to the media and the public.

- ◆ **THE HOSPITAL MUST PAY THE FEES OF ITS OWN PROFESSIONALS AND THE THOSE OF PROFESSIONALS RETAINED BY CERTAIN OTHER PARTIES.** Chapter 11 can be an expensive process for a hospital. A hospital must pay the legal fees and expenses of a number of professionals, including lawyers, accountants, financial advisors, and a variety of other professionals and consultants. While it may not be unusual for these types of professionals to be retained by a hospital outside of bankruptcy, a Chapter 11 filing will escalate the level of professional activity because each aspect of the hospital as a business entity must be dissected and presented to the Bankruptcy Court for administration. All of the hospital's assets and liabilities must be analyzed in detail so that they can be properly administered in the Bankruptcy Court in one fashion or another. Hospital operations must be analyzed from top to bottom, whether in connection with the implementation of cost-cutting measures or to properly fulfill reporting requirements imposed during a bankruptcy. All of this must be done with the assistance of legal and financial professionals. Because of the need for Bankruptcy Court approval for a multitude of hospital actions and transactions, a Chapter 11 case will

be motion-intensive, involving frequent court appearances by the professionals involved.

Professionals employed by the hospital must also spend considerable time negotiating with professionals representing other constituencies. As noted above, the Bankruptcy Code calls for the appointment of a committee to represent the interests of unsecured creditors and, in some cases, committees to represent the interests of other creditors. The Committee will retain its own lawyers and financial advisors, and perhaps other professionals. Another reason why Chapter 11 can be expensive for a hospital is that the Bankruptcy Code requires a debtor's bankruptcy estate to pay not only the debtor's professionals, but also the professional fees and expenses of the Committee.

In addition to the various professional fees and expenses described above, the hospital will also have to pay quarterly statutory case administration fees to the United States Trustee, which are based upon disbursements made by the hospital and which can amount to \$10,000 or more per quarter.

- ◆ **THE PATIENT CARE OMBUDSMAN.** A hospital will also likely have to bear the costs associated with the appointment of a "patient care ombudsman." Under section 333 of the Bankruptcy Code, added pursuant to the 2005 Amendments, the Bankruptcy Court must order the appointment of a patient care ombudsman within thirty (30) days after commencement of a hospital bankruptcy filing, unless the Court finds that an ombudsman is not necessary for the protection of patients under the specific facts of the case. The fees of the ombudsman, which may include fees of any professionals retained by the ombudsman, are paid by the bankruptcy estate.

An ombudsman appointed under section 333 is required to monitor the quality of patient care, represent the interests of the patients during the bankruptcy case, and protect confidential patient records and property. The ombudsman must report to the Bankruptcy Court every sixty (60) days (with a copy to all parties in interest), regarding the quality of patient care at the debtor facility. If the ombudsman determines that the quality of patient care is declining or otherwise being materially compromised, he or she must detail that determination in a written report that must be filed with the Court immediately after the determination is made.

While the Bankruptcy Court need not order the appointment of an ombudsman if it determines that an appointment is unwarranted, an ombudsman has been appointed in most of the recent New Jersey hospital bankruptcies. In the Passaic Beth Israel case, the Bankruptcy Court approved the appointment of New Jersey's Long-Term Care Ombudsman to act as patient care ombudsman, an action expressly permitted by the Bankruptcy Code. In the Bayonne Medical Center case, a private ombudsman was employed and the ombudsman sought to retain counsel. There was a dispute regarding whether the ombudsman could retain professionals, and ultimately, a settlement was reached allowing the ombudsman to retain an attorney with a limited budget.

During the bankruptcy process, employees will be interviewed by the Patient Care Ombudsman, so it is beneficial for the debtor hospital to explain the Ombudsman's role in a town hall meeting with its employees. If employees are properly briefed, their interviews with the Ombudsman will be productive. If there is no cause for concern with respect to patient care, it will be borne out in their conversations with the Ombudsman.

In the Pascack Valley case, the hospital objected to the United States Trustee's motion for the appointment of a patient care ombudsman, claiming that an ombudsman was unnecessary in light of the hospital's imminent closure and the fact that the New Jersey Department of Health and Senior Services was carefully monitoring the daily activities at the hospital. The hospital argued that appointment of an ombudsman would only create additional and unnecessary administrative expense for the already burdened bankruptcy estate. Nonetheless, the Court approved a Consent Order allowing for the appointment of an ombudsman for a thirty (30) day period while Pascack Valley completed its closure plan. The ombudsman was permitted to re-apply to the Court to continue for an additional period of time in the event closure was delayed.

Even in cases where the hospital continues to operate, the hospital often resists the appointment of an ombudsman because it does not want to pay the ombudsman's fees and expenses. However, the board of trustees must give careful thought to the position it takes on this issue. Care must be given to appropriately balance fiduciary duties to fulfill the hospital's mission of providing quality patient care to the community against fiduciary duties to creditors. In this regard, it should be kept in mind that Bankruptcy Courts appear likely to order the appointment of an ombudsman in cases where a hospital continues to operate because they will not want to be seen as being complicit in jeopardizing or compromising patient care.

■ ADDITIONAL STATE APPROVALS

- ◆ **CERTIFICATE OF NEED.** As discussed previously, a CN is needed before a hospital can be transferred or closed. The CN process for a hospital closure or sale follows the "full" review process, under which a closing hospital must submit its CN application to DHSS on the first day of the month. Prior to filing, DHSS encourages CN applicants to contact DHSS to obtain additional guidance on its proposed CN application. As an alternative to full review "expedited" review can be requested by the hospital when: (a) an emergent situation demands rapid action; or (b) the proposed transaction has minimal impact on the healthcare system as a whole.

The completed CN application is reviewed by both DHSS and the State Health Planning Board ("SHPB"). As part of the general review process, DHSS and the SHPB consider whether a closure/sale for which the CN was submitted will have an adverse impact on access to health care services. In making these determinations, various considerations are taken into account, such as: (a) the availability of alternate or substitute services/facilities; (b) the need for special equipment/ services in the hospital's community; (c) the possible economies and improvement in services that could result from the closure/sale; (d) the adequacy of the hospital's financial resources and sources of revenue; and (e) the availability of a sufficient level of professional services.

As part of its review of the CN, the SHPB must hold at least one public hearing, no later than 30 days after DHSS deems an application complete, and the public notice must be provided at least 2 weeks in advance (which can be reduced by the Commissioner of DHSS if the closure happens on an expedited basis).

Upon completion of the review process, the SHPB makes its recommendation to the Commissioner, and the Commissioner issues a letter either approving or denying the proposed transaction. DHSS may include – and usually does include – certain conditions in connection with an approval of a CN application. In the event that a hospital’s CN application is denied, the hospital may request a hearing to appeal such decision.

There have been instances in which hospitals have closed before DHSS has approved the CN application for closure. Nevertheless, DHSS continued to follow the same statutory and regulatory requirements, to the extent applicable, in evaluating the CN application as are used for operating hospitals seeking approval to close. Coordination with bankruptcy counsel, the Creditors’ Committee and the Bankruptcy Court is important, so that they are aware of the CN requirements and schedule.

■ **APPROVALS REGARDING DISPOSITION OF CHARITABLE ASSETS**

As part of the bankruptcy case, the hospital will have to comply with various state law requirements regarding its disposition of charitable assets. Specific details regarding these requirements, such as those under CHAPA, are discussed in further detail in **Section C**.

SECTION C

BANKRUPTCY SALE CONSIDERATIONS

Many hospital bankruptcies will be filed for the purpose of effectuating a sale, or will involve a sale if it becomes apparent that the hospital cannot survive as an independent reorganized entity. Sales in bankruptcy have a number of advantages that non-bankruptcy sales do not enjoy; however, there are several critical points to consider regarding bankruptcy sales.

BANKRUPTCY CANNOT BE USED TO EVADE REGULATORY APPROVAL OF HOSPITAL SALES

The Bankruptcy Code offers an expedited means of obtaining requisite sale approvals. Chapter 11 is often used by business corporations to effectuate a sale of substantially all of their assets without the shareholder approval usually required by state statute, and it is not unheard of for a bankruptcy court to approve a sale of substantially all of a debtor's assets within 30 days after a bankruptcy case is commenced. In the past, some nonprofit hospitals have used a Chapter 11 filing to effectuate a sale of substantially all of their assets without obtaining the state and federal approvals required in a sale outside of bankruptcy. Following the 2005 Amendments, however, the Bankruptcy Code now expressly provides that bankruptcy cannot be used to end-run the state and federal approval processes attendant to asset sales by nonprofit businesses, such as obtaining Attorney General ("AG") approval.

■ **CHAPA.** The New Jersey CHAPA law requires any "acquisition" of a New Jersey licensed nonprofit hospital to be reviewed by the AG and approved by the Superior Court of New Jersey. The purpose of CHAPA is to safeguard the value of New Jersey's charitable assets and ensure that the proceeds of any acquisition are "irrevocably dedicated for appropriate charitable health care purposes." An "acquisition" is defined as the purchase, lease, exchange, conversion, restructuring, merger, division, consolidation, transfer of control or other disposition of a substantial amount of assets or operations, whether through one transaction or a series of transactions with one or more persons or entities. The sale of a hospital (or "substantial" assets of a hospital) qualifies as an acquisition and thus will need to undergo the CHAPA review and approval process.

The first step in connection with obtaining CHAPA approval is to submit an application (usually in the form of a letter addressing the various issues discussed below, along with numerous exhibits) to the AG which sets forth the hospital's circumstances and essentially asks the AG to support (or not oppose) the intended transaction. After submitting the application, the hospital must advertise the proposed acquisition in a local newspaper once per week for three weeks. It is likely that the AG will request additional information and documents in connection with the review. Within 90 days of completion of the application, the AG, in consultation with the Commissioner of DHSS, determines whether the acquisition of the hospital is in the public interest, *i.e.* whether appropriate steps have been taken to safeguard the value of the charitable assets and to ensure that any proceeds from the acquisition are irrevocably dedicated for charitable health purposes. The AG and the Commissioner may reduce the period of time for review of a completed application to less than 90 days if they believe the application should be processed on an expedited basis.

In evaluating the acquisition, the AG must consider several factors, including:

Whether the transaction is permitted under the New Jersey Nonprofit Corporation Act, Title 15A of the New Jersey Statutes, and other law applicable to nonprofit corporations;

Whether the nonprofit hospital exercised due diligence in connection with the acquisition;

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- Whether expert assistance was utilized;
 - Whether all conflicts of interests were disclosed;
 - Whether any management contract in connection with the acquisition is fair market value; and
 - Whether the proceeds will be used for charitable healthcare purposes.

In the case of a transfer of assets, if the acquiring entity is a for-profit entity, the AG must consider additional criteria. For example:

- Whether the nonprofit hospital is receiving a fair market value price;
- Whether charitable funds are placed at unreasonable risk;
- Whether the nonprofit hospital used reasonable criteria in deciding to change its charitable purpose to a for-profit purpose;
- Whether a right of first refusal has been retained to repurchase the assets by a successor nonprofit corporation or foundation if, following the acquisition, the hospital is subsequently sold to, acquired by or merged with another entity;
- Whether the conversion is the only or best alternative;
- Whether the nonprofit hospital exercised due care in assigning a value to its charitable assets in proceeding to negotiate the proposed conversion; and
- Whether board members and senior management will receive future contracts with the new hospital or its affiliates.

Further, if the acquiring entity is a for-profit entity, the AG may require the nonprofit hospital to set aside certain assets as a charitable obligation to be placed in a nonprofit charitable trust.

As part of the review process, CHAPA requires the AG to hold a public hearing. However, if the acquisition is also the subject of a public hearing in connection with a CN application (as discussed on page 34), the two hearings may be combined. In the event that the AG or the Commissioner determine that a proposed acquisition should be considered on an expedited basis in order to preserve the quality of health care provided to the community, the public notice regarding the acquisition may be combined with the notice for the CN hearing and such notice period may be reduced.

Upon conclusion of the AG's review, the nonprofit hospital applies to the Superior Court for approval of the transfer. As part of that proceeding, the AG advises the Court as to whether he or she supports or opposes the proposed acquisition and whether any specific modifications should be imposed on the proposed transaction.

Significantly, in various letters relating to hospital closures, the AG has acknowledged that CHAPA applies only to the transfer of a *licensed* acute care hospital. Thus, once a hospital closes its operations and relinquishes its license, CHAPA would not apply to the sale of the real property and other assets which were formerly used to operate the nonprofit hospital. However, the AG has the authority to review such a transfer under its common law duty to protect the public interest in charitable trusts and to oversee the activities of charitable corporations.

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- **ATTORNEY GENERAL'S COMMON LAW CHARITABLE TRUST POWERS AND *CY PRES*.** The AG has a common law (i.e., non-statutory) responsibility to protect, supervise and enforce charitable trusts. A nonprofit hospital holds all of its assets in trust for charitable purposes and a proposed transfer of these assets implicates the AG's common law duties and powers. The AG's common law powers may arise in connection with a hospital bankruptcy where the hospital closes or gives up its license prior to disposing of its assets (in which case CHAPA would not apply, as discussed above), or in connection with the sale of a nonprofit hospital's affiliates/subsidiaries as part of or in connection with the hospital's bankruptcy. Further, to the extent that a hospital is supported by a nonprofit foundation, the disposition of restricted and unrestricted foundation funds held by such affiliate must also be approved by the AG.

Certain transactions which are subject to the AG's common law charitable trust authority is analyzed under the common law doctrine of *cy pres*. Under the *cy pres* doctrine, when a charitable trust can no longer fulfill its intended charitable purposes the funds shall be applied to a similar purpose. Therefore, a nonprofit hospital must apply to the Superior Court for judicial approval of a transfer of charitable assets. In certain circumstances, the AG reviews the proposed transactions and issues a recommendation to the Court. The purpose of the AG's review is to determine whether the disposition of the hospital's assets is in the public interest. Some of the factors which the AG considers in making its recommendation include the following:

Whether the hospital's directors exercised reasonable care in the performance of their duties concerning the proposed transaction;

Whether any conflict or duality of interest of the parties to the transaction was disclosed (including any board members or officer conflicts);

Whether there is a fair valuation for the sale or transfer of the hospital property; and

Whether the proceeds from the sale or transfer of the charitable assets will be used for appropriate purposes.

Note that these factors are similar to the factors which must be considered under a CHAPA application, as discussed previously. Therefore, in the event that a proposed transaction is subject to both CHAPA and *cy pres*, any AG review and judicial proceedings are often combined and dealt with simultaneously.

- **INTERPLAY BETWEEN STATE AND FEDERAL AUTHORITIES.** When a nonprofit hospital files for bankruptcy protection, federal and state regulatory systems can intersect. The bankruptcy court, which is a part of the federal judicial system, has jurisdiction over the bankrupt debtor's assets. The primary goal of a hospital's Chapter 11 bankruptcy case is the financial restructuring of the hospital's debt. Although reorganization takes place under the auspices of the bankruptcy court, Section 959(b) of Title 28 of the United States Code requires a bankruptcy debtor to manage its assets and operate its business in compliance with federal, state and local laws and regulations. To the greatest extent possible, the federal bankruptcy courts and the state regulatory agencies honor the separate responsibilities of each other.

To the extent the Bankruptcy Code and state law conflict, the Supremacy Clause of the United States Constitution provides that the Bankruptcy Code (as a federal law) overrides contrary state law. For example, actions that may be taken by the State (e.g., collection of past due taxes, monetary penalties and fines)

are stayed by virtue of the automatic stay imposed by the Bankruptcy Code. The Bankruptcy Code contains an exception to the automatic stay that permits prosecution and enforcement of injunctive actions by the government enforcing its police power. Under that exception, a State's efforts to compel a hospital to comply with health and safety regulations would not be subject to the automatic stay. Thus, for example, the State could obtain a court order directing a hospital in bankruptcy to correct licensure deficiencies cited by DHSS or to properly dispose of medical waste, without violating the automatic stay.

The State (represented by the Attorney General) is a party in interest in a bankruptcy case. To the extent that the State seeks collection of a debt owed by the hospital to the State, the State acts in much the same way as other creditors. The State may file a proof of claim setting forth the amount that the debtor owes, and in this way, the State makes sure that its claim receives the appropriate priority for payment under any plan of reorganization for the debtor.

The State will take a much more active role in the bankruptcy case when issues relating to the hospital's CN or license arise. For example, the State frequently advocates to the Bankruptcy Court that it has exclusive province to determine who owns the license to operate a hospital. Ownership of a hospital cannot be transferred without a CN. This means that a hospital CN and/or license cannot be assigned without DHSS's consent, and that DHSS will not be bound by any agreement to transfer the CN and license that it did not approve. Although the State has taken the position that licenses are privileges of the State that may not be transferred to others, hospitals have transferred operating licenses, subject to obtaining the necessary regulatory approvals from the State. The regulatory process, however, occurs independently of the bankruptcy case, and the State's determination regarding licensure must be honored by the Bankruptcy Court.

In the *United Hospital* case,¹⁴ United Healthcare System transferred its license and CN to operate a regional children's hospital to St. Barnabas Healthcare System on an emergency basis. This transfer occurred with the full consent and approval of DHSS as well as United. The bankruptcy court vacated the transaction in order to solicit higher bids from other hospitals. The district court overruled the bankruptcy court, holding that the bankruptcy court had no authority to order the solicitation of higher bids or to compel DHSS to accept any prevailing bidder. Regardless of the bankruptcy filing, DHSS continues to have statutory and regulatory authority to review a CN application, and the Bankruptcy Court is without authority to override the Commissioner's determination.

In the ideal situation, a hospital will not close without obtaining a CN authorizing closure. However, in a classic "Catch 22", a hospital that runs out of money cannot operate. The Bankruptcy Code prohibits a debtor from using a lender's cash collateral after the filing of a bankruptcy petition without the lender's consent. For example, if the hospital's indebtedness is secured by its accounts receivable, the hospital may not use the funds it collects on those receivables without the consent of the lender. The Bankruptcy Code does not compel a lender to consent to use of its cash collateral. (See page 26).

¹⁴ *In re United Healthcare System, Inc.* 1997 LEXIS 5090 (D.N.J. March 26, 1997).

Without financing or the ability to use cash generated from receivables, the hospital may be forced to close. The State will play a prominent role in ensuring quality patient care and safety, and the implementation of a plan for the orderly transition of patients to other appropriate facilities. Communication between all constituencies (including the State, the hospital, the patient care ombudsman, the patients and their families, and the public) is crucial throughout this transition period.

A hospital may look to sell its assets as a going concern, implicating CHAPA and CN procedures. As discussed on page 39, CHAPA requires Attorney General and Superior Court approval of a licensed hospital's disposition or transfer of a substantial amount of its assets. If the hospital is no longer operating, and the sale involves only real estate, furniture, fixtures and equipment, and does not include the CN/license of the hospital, the hospital may request a "no action" letter from the Attorney General's Office confirming that CHAPA review is not required. However, whenever the transfer of a hospital's license accompanies the asset sale, the CHAPA and CN procedures must be followed.

SALE ISSUES FROM A SECURED CREDITORS' PERSPECTIVE

In today's business world, nearly 80% of companies that file for Chapter 11 reorganization ultimately liquidate, through either: (a) a sale of their assets as a going-concern in Chapter 11, either by a pre-plan sale under sections 363(b) and (f) of the Bankruptcy Code or under a liquidating plan of reorganization; (b) liquidation of assets following conversion of the Chapter 11 case to a Chapter 7 case; or (c) foreclosure after a secured creditor has obtained relief from the automatic stay.

Hospitals are no exception to this rule. In some cases, such as the bankruptcy of St. Vincent Catholic Medical Centers in New York, the hospital sits on valuable real estate that, when the value is unlocked through a sale of assets or Chapter 11 reorganization plan, can provide an asset pool sufficient to pay not only secured claims and administrative claims, but also a significant dividend on pre-petition unsecured claims. Even if this is not the case, most secured lenders will support a sale of the hospital's principal assets as a "going concern" at market value to a better capitalized buyer, with the lender's existing loans either attaching to the sales proceeds and being paid off, or being assumed by the buyer as part of the deal.

If, however, a debtor hospital continues to have negative cash flow post-petition, even with the benefit of the automatic stay (which stops payments on pre-petition indebtedness), the hospital can expect that its secured lender(s) will push for an asset sale under sections 363(b) and (f) of the Bankruptcy Code as a way to pay them off, and if such a sale cannot be negotiated, for dismissal or conversion of the case to a Chapter 7 liquidation.

If a proposed asset sale will not produce enough value to pay off the liens of the secured creditors, the hospital can expect that the lender(s) in question will attempt to block the sale. Some bankruptcy courts, but not all, will allow a debtor hospital to sell assets "free and clear" if the sales price obtained is the best available under the circumstances, even if the sales proceeds will not be sufficient to pay off all liens and encumbrances in full.

SALE ISSUES FROM THE UNION'S PERSPECTIVE

■ **SALE OF THE HOSPITAL.** If the hospital is to be sold, the union will likely want to play an active role in the process. The union will be interested in the buyer's intentions regarding the scope of the hospital's operations post-sale, recognition of the union and honoring the collective bargaining agreement, among other considerations.

■ **SALE ISSUES AND THE COLLECTIVE BARGAINING AGREEMENT.** A sale under section 363 of the Bankruptcy Code implicates Section 1113 of the Bankruptcy Code, which governs the rejection of CBAs. Various federal courts have examined the circumstances under which a CBA may be modified or rejected under Section 1113. For example, there is case law in the Third Circuit (which includes New Jersey) that a debtor or buyer cannot avoid the collective bargaining process by "misusing" the sale process under the Bankruptcy Code. *American Flint Glass Workers Union v. Anchor Resolution Corp.*, 197 F.3d 76, 80-82 (3d Cir. 1999). Other courts have established a number of requirements that must be met before a CBA may be modified or rejected under Section 1113. These include whether the proposed modifications to the CBA are necessary in order to permit the debtor to reorganize and whether the balance of the equities favor the rejection (or modification) of the CBA.

Management can expect that collective bargaining representatives will seek to review any asset purchase agreement ("APA") to determine whether or not it contemplates assumption of the CBA by the purchaser. If it does not, and the CBA contains a successor clause, the representative may seek a Court order blocking the sale. Employed professionals such as physicians and nurses will also seek to review the APA to determine how it addresses the issue of who will assume responsibility for tail insurance.¹⁵

■ **RECOGNIZING THE UNION AND OTHER ISSUES.** If a buyer does not recognize the union but employs substantially all of the employees, the buyer may be in violation of the federal labor law.

The union will be keen to oppose any sale that allows for a payment to secured creditors but leaves union members with priority claims with no potential for distribution. If there is a payment to the detriment of priority creditors, the union may argue that the payment violates the absolute priority rule, which rule requires creditors holding claims of a higher priority to be paid in full before creditors with lower priority claims receive any payment.

The union might also object generally to the sale under what is called the "sub rosa" theory (i.e. asserting that the sale is tantamount to a disguised plan of reorganization or liquidation without the attendant protections granted by the Bankruptcy Code).

BANKRUPTCY SALE MAY SHIELD HOSPITAL TRUSTEES AND OFFICERS FROM BREACH OF FIDUCIARY DUTY CLAIMS

The sale of a hospital's assets through bankruptcy is heavily regulated and generally involves a competitive bidding process held in a public forum with opportunity for objection. This regulated bankruptcy process offers some reassurance to trustees and officers that their decisions in connection with the sale are congruent with their competing

¹⁵ The two basic types of malpractice insurance are "claims-made" and "occurrence-made." "Claims-made" insurance protects against malpractice claims only if the company that insured the hospital, its physicians and nurses at the time of the alleged "occurrence" is the same company that insured them at the time the claim is filed. For example, if company A was the malpractice insurer on the date of an alleged malpractice incident and is still the insurer when the claim is filed, there is coverage for the claim. However, if between those dates the hospital switches from insurance carrier A to insurance carrier B (or obtains no substitute insurance once the policy lapses), there would be no coverage, unless "tail" insurance was purchased.

fiduciary obligations – that is to balance the hospital’s charitable mission with the obligation to maximize value for creditors. In general, courts have acknowledged the existence of these often competing interests and fiduciary obligations in the hospital bankruptcy context. At least one New Jersey court has held that a hospital board properly discharged its fiduciary duties even though it did not accept the highest monetary bid for the hospital’s assets where the lesser bid that was accepted contemplated that the hospital would continue operating.¹⁶

Further, Chapter 11 plans of reorganization or liquidation will usually contain provisions releasing trustees and officers of the debtor from any liability in connection with such sale or any other actions taken in the bankruptcy case. Creditors may challenge these provisions, depending on their terms.

ASSIGNABILITY OF MEDICARE AND MEDICAID CONTRACTS FREE AND CLEAR OF OVERPAYMENT LIABILITY

One important advantage of a bankruptcy sale, at least from a purchaser’s perspective, is that if certain conditions are satisfied, assets can be transferred to purchasers free and clear of liens, claims and encumbrances. In some cases, a purchaser may seek to acquire a debtor hospital’s national provider identifier (“NPI”) and associated federal health care program provider contracts. A bankruptcy sale cannot extinguish recoupment rights, but such rights are limited in the Third Circuit, at least as to Medicare and Medicaid provider agreements. (See page 19).

MEDICAL RECORDS RETENTION

Hospitals are required to comply with various state and federal records retention requirements which may differ depending on the type of record at issue.¹⁷ With respect to institutional medical records, under New Jersey state law, a hospital must retain medical records for the longer of 10 years following the most recent discharge of the patient, or until the patient reaches the age of 23 years¹⁸. In addition, a discharge summary sheet must be retained for a period of 20 years following the most recent discharge of the patient.¹⁹ A hospital undergoing a bankruptcy will need to ensure that its patients are provided continued access to medical records upon the sale or closure of the hospital. For example, the hospital may consider setting up a website with information on obtaining patient records and/or working collaboratively with the local government to ensure that patients are otherwise aware of how they can access their information.

¹⁶ The two basic types of malpractice insurance are “claims-made” and “occurrence-made.” “Claims-made” insurance protects against malpractice claims only if the company that insured the hospital, its physicians and nurses at the time of the alleged “occurrence” is the same company that insured them at the time the claim is filed. For example, if company A was the malpractice insurer on the date of an alleged malpractice incident and is still the insurer when the claim is filed, there is coverage for the claim. However, if between those dates the hospital

¹⁷ The New Jersey Division of Archives and Records Management maintains a records retention schedule for State operated health care facilities. The schedule is not legally binding on private hospitals, and has not been updated since 2002. However, the schedule summarizes relevant federal and State laws and regulations governing record retention and may serve as guide for private hospitals in developing records retention policies. The schedule may be found at: <http://www.njarchives.org/links/pdf/c940000.pdf>.

¹⁸ N.J. Stat. § 26:8-5.

¹⁹ *Id.*

SECTION D

PLAN CONFIRMATION ISSUES

Under Chapter 11, a debtor works to structure and negotiate a global plan to satisfy or restructure prepetition obligations, and to effectuate a sale of assets or emerge as a reorganized entity. A hospital will generally be able to reorganize successfully under Chapter 11, confirm a non-liquidating plan, and emerge from bankruptcy as a going concern and if it is able to: (i) reject unfavorable “executory” contracts; (ii) obtain Chapter 11 post-petition financing and, later, Chapter 11 “exit” financing; (iii) sell surplus assets; and (iv) otherwise reorganize its financial affairs and generate post-petition cash flow sufficient to satisfy its various pre-petition debts and post-petition obligations. As noted above, however, non-liquidating reorganizations are more the exception than the rule. The presence or absence of state financing incentives can sometimes make the difference.

The Bankruptcy Code requires that the plan be voted upon by creditors, who must be grouped into classes of claims for purposes of voting and treatment. A Chapter 11 plan lays out the debtor’s proposed treatment of each class of claims: secured claims, priority unsecured claims and disbursements, and all outstanding claims and liabilities of a debtor. Secured creditors will often have a role in plan negotiations that is adverse to both the debtor hospital and to other creditors, since the debtor hospital and the Creditors’ Committee may attempt to challenge the validity, extent or priority of the secured lender’s liens and security interests. Committees do so because the less assets are encumbered by secured liens, the more there will be left to distribute to the debtor’s unsecured creditors. Therefore, secured creditors must advocate for themselves in plan confirmation negotiations without help from the Creditors’ Committee. During the confirmation process, the secured lender’s collateral is valued once again, and security interests in the property are settled. Secured creditors are usually willing to work with a debtor hospital to determine the parameters of treatment of the lender’s secured claim in the Chapter 11 plan (i.e., to set the collateral value, interest rate, terms and conditions, etc.) for payment of the claim by the “reorganized debtor”²⁰ or how to best liquidate the lender’s collateral for the highest price if a plan cannot be confirmed. Collateral that has been maintained or sold by the estate is subject to a surcharge for costs and maintenance that benefited the lien holder unless this right has been waived in cash collateral negotiations (as is often the case).

If a debtor and a secured creditor are unable to agree on plan terms, the debtor hospital can try to “cram down” a secured lender and “strip” the value of its secured claim to the underlying value of the collateral, reduce the interest on the claim to “market” rates as of confirmation, and stretch out the maturity of the indebtedness. Secured lenders can be expected to resist these efforts. Most disputes of this nature are ultimately resolved consensually, but this is not always the case. In some cases, the secured lender can use an unsecured “deficiency” claim to obtain voting control over the unsecured class of claims.

In a Chapter 11 plan, if the debtor hospital obtains the consent of at least one impaired accepting class of creditors, it can “cram down” the other classes of creditors, provided the plan meets the requirements set forth in section 1129(b) of the Bankruptcy Code. The reorganization plan must also satisfy the various other requirements for plan confirmation set forth in section 1129(a) of the Bankruptcy Code, including, among other things, providing a “dividend” to dissenting members of an “impaired” class of creditors that has, as a class, accepted under the plan at least as much as they would receive in a Chapter 7 liquidation. The bankruptcy court must also, among other things, find that the plan is “feasible.”

²⁰ In fact, if agreement is reached with a secured lender, it can serve as an “impaired” accepting class that opens up the possibility that the debtor hospital can “cram down” other, non-consenting classes, as noted below.

If the debtor loses “exclusivity,”²¹ i.e., the right to propose and confirm a plan without competing plans being filed, secured lenders (and others) will have the right to propose their own plan(s) of reorganization. If a secured creditor files its own plan, it generally calls for liquidation of the debtor hospital’s assets. If the court finds that two competing plans have been proposed and that more than one is capable of confirmation, it will consider which plan is preferred by the hospital’s creditors and equity holders. Oftentimes, that is a non-liquidating plan.

Before circulating its reorganization plan for voting, the debtor hospital will prepare a Disclosure Statement, which provides creditors with the information necessary to either vote on the plan or object to it. The Disclosure Statement should provide clear and comprehensive information regarding the value of the debtor hospital’s assets and liabilities, how it came to file Chapter 11, post-petition financial results, the treatment of the various classes of creditors in the proposed reorganization plan, how the debtor proposes to execute and accomplish the proposed plan, and any alternatives to the proposed plan. The Disclosure Statement must also disclose the details of the proposed exit financing to be employed by the reorganized debtor. Once the bankruptcy court finds that the Disclosure Statements contains “adequate information” to enable creditors to vote intelligently on the proposed plan, it will enter an order to that effect, and the Disclosure Statement and the proposed plan will be circulated for voting. It is not uncommon for a secured creditor to object to the debtor’s proposed disclosure statement, either because it lacks sufficient information or because the secured creditor alleges that it is patently clear that the proposed plan cannot be confirmed as a matter of law.

²¹ A debtor has the exclusive right to propose a reorganization plan within the first 120 days after filing under Chapter 11. Further, other parties in interest may only file a plan if “the debtor has not filed a plan before 120 days”, “a trustee has been appointed”, or “the debtor has not filed a plan that has been accepted, before 180 days after the date of the order for relief under this chapter.”

SECTION E

CONVERSION AND DISMISSAL

If a debtor hospital makes inadequate or unsuccessful efforts to reorganize over an extended period of time, the hospital can expect that its secured lender(s), the Committee and the Office of the United States Trustee will make a motion to convert the case to a Chapter 7 liquidation or to dismiss the case pursuant to section 1112 of the Bankruptcy Code.

Section 1112(b) of the Bankruptcy Code governs dismissal and conversion. The statute mandates dismissal or conversion if “cause” is shown. Cause is defined in a multitude of ways in this section, but most helpful for secured creditors with an interest in cash collateral or other assets is language stating that “cause” includes “substantial or continuing loss to or diminution of the estate and the absence of a reasonable likelihood of rehabilitation.”²² Continued loss to the estate can be shown by a steady decrease in receivables. Deepening post-petition insolvency, coupled with no reasonable prospect for sale of the hospital as a going concern, will likely cause a secured lender to file a motion to convert or dismiss the bankruptcy case.

²² 11 U.S.C. § 1121.

SECTION F

GLOSSARY AND APPENDICES

GLOSSARY

Adequate protection: a phrase used in several sections of the Bankruptcy Code to describe protection afforded to holders of secured claims. The lack of adequate protection of the creditor's interest in its collateral is a basis for relief from the automatic stay. Adequate protection is also the standard for creditor protection from sale or use or encumbrance of the collateral. Although adequate protection is not statutorily defined, the Bankruptcy Code sets out examples of adequate protection, including a cash payment or periodic cash payments, and additional or replacement liens.

Administrative priority claim: claims having the highest priority for payment, including the post-petition costs of operating the debtor's business (employee salaries and wages, medical supplies, equipment lease payments, etc.) and the costs of the bankruptcy case (professional fees, quarterly fees due the Office of the United States Trustee, etc.)

Assume (a contract or lease): a formal act whereby a debtor agrees to continue to perform a contract or lease; assumption of a contract or lease requires the approval of the Bankruptcy Court.

Automatic stay: bar on collection efforts against a debtor or property of the debtor. The automatic stay becomes effective immediately upon filing of a bankruptcy case, and is not dependent upon providing notice to others.

Bar date: the date, fixed by order of the Bankruptcy Court usually on motion of the debtor, by which claims must be filed against a debtor. Failure to file a claim against a debtor by the bar date typically results in the claim being barred.

Claim: right to payment, whether or not such right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, legal, equitably, secured or unsecured; or the right to an equitable remedy for breach of performance, if it gives rise to a right to payment.

Class (of claims): under a Chapter 11 plan, a group of similarly-situated claims (for example, a class of priority unsecured creditors, a class of general unsecured creditors, etc.)

Confirmation: judicial approval of a Chapter 11 plan.

Convert/Conversion: a formal process through which a bankruptcy case changes from a proceeding under one chapter of the Bankruptcy Code to another, it typically signifies a change in kind of the relief to be granted to the debtor. For example, conversion of a case from Chapter 11 to Chapter 7 typically involves a change from a reorganization to liquidation of a debtor's assets.

Cramdown: a colloquial expression that describes confirmation of a Chapter 11 plan, notwithstanding creditor objection.

Creditor: entity that has a claim against the debtor that arose at the time or before the bankruptcy petition was filed.

Creditors' Committee: A committee formed by the Office of the United States Trustee during the first few weeks of a Chapter 11 case that represents general unsecured creditors of a debtor in a Chapter 11 case.

Cure: to rectify a default under an agreement, including the payment of all amounts that are past due in regard to a default in payment or the performance of duties that are past due and unperformed under an agreement.

Debtor: the entity that files a bankruptcy petition; in other words, the "bankrupt."

Debtor in Possession: the debtor in a Chapter 11 case, who remains in control of its business and assets. If a trustee is appointed for a Chapter 11 debtor, the debtor is no longer "in possession," but is simply referred to as the "debtor."

Deficiency claim: a claim for the outstanding balance of a secured debt after the collateral has been sold to satisfy the obligation at a price less than the debt.

Exclusivity: the time period (typically, the first 120 days of a bankruptcy case) within which the debtor has the exclusive right to file a Chapter 11 plan. After expiration of the exclusivity period, other parties in interest may file a plan for the reorganization or liquidation of the debtor.

Executory contract: a contract under which performance remains due from both parties. Executory contracts may be “assumed” or “rejected” during the bankruptcy case.

Factor: A company that lends a certain percentage of each invoice that its borrower issues; it will then collect the invoice when it becomes due, deduct its commission, and pay the balance back to the borrower.

Fiduciary: a person (or a business, such as a bank) who has the power and obligation to act for another (often called the beneficiary) under circumstances which require total trust, good faith and honesty. A fiduciary is held to a standard of care and loyalty, and must avoid self-dealing or conflicts of interest, in which the potential benefit to the fiduciary is in conflict with what is best for the beneficiary. In the non-profit hospital context, a nonprofit hospital board trustee has a fiduciary duty towards a number of stakeholders and parties in interest, including the community at large, patients, donors and, if insolvency approaches, creditors/ bondholders.

Fraudulent transfer: a transfer of the debtor’s money or property made with the actual intent to hinder, delay, or defraud a creditor, or made without the debtor receiving something of reasonably equivalent value in exchange for the transfer. To recover a fraudulent transfer made without reasonably equivalent value, the Committee must also establish that the debtor was either insolvent at the time, was undercapitalized, or intended to incur debts beyond its ability to repay.

General unsecured claim: a claim for which the lender has no collateral which secures the borrower’s repayment. In a non-profit context, these creditors have the lowest priority for payment. [In the for-profit context, equity security holders (i.e., stockholders) have a lower priority for payment than general unsecured creditors.]

Impaired: Under the Bankruptcy Code, a class of claims is “impaired” under a plan unless, with respect to each claim within the class, the Chapter 11 plan leaves unaltered the legal, equitable, and contractual rights of the holder of each claim.

Insolvent: financial condition such that the sum of such entity’s debts is greater than all of such entity’s property, at a fair valuation.

Patient care ombudsman: a person appointed by the bankruptcy court to monitor the quality of patient care, represent the interests of patients during the bankruptcy case, and periodically report to the bankruptcy court regarding patient care issues.

Plan: a proposal for the repayment of debts by a bankruptcy debtor. A plan may be one of reorganization (in which the debtor continues in business) or one of liquidation (in which all assets are sold and the proceeds distributed to creditors).

Post-petition: the time period after a debtor files a bankruptcy petition.

Preference (preferential transfer): a transfer of an insolvent debtor’s property for or on account of a pre-existing debt so that the preferred creditor receives more in satisfaction of its claim than other creditors with similar claims.

Pre-petition: the time period before a debtor files a bankruptcy petition.

Priority unsecured creditor: a creditor having a priority unsecured claim.

Priority unsecured claim: unsecured claims that, by statute, receive more favorable treatment in bankruptcy than other unsecured claims. These claims include certain salaries, wages, commissions and benefits and certain taxes (such as employment taxes).

Reasonably equivalent value: although undefined by the Bankruptcy Code, this phrase means the value that must be received by a debtor in exchange for the transfer of its assets in order for the transfer not to be set aside as a fraudulent transfer. It is often considered to be somewhat less than fair market value (generally, above 70% of fair market value).

Recoupment: if A owes B, and in connection with the same transaction, B owes A, this equitable doctrine allows the amount owed to be reduced by the debt B owes to A. For example, if a hospital owes for utility services, but the utility is holding a security deposit, the doctrine of recoupment would permit the deposit to be applied against the invoices for utility service.

Reject (a contract): a formal act whereby a debtor repudiates (ceases to perform) a contract or lease; rejection of a contract or lease requires the approval of the Bankruptcy Court. Rejection of a contract or lease constitutes a breach of the agreement, but the damages for such breach are treated as general unsecured claims arising immediately before the bankruptcy case was filed.

Reorganization: the goal of a Chapter 11 bankruptcy case through which the debtor emerges as an operating entity with a restructured balance sheet.

Secured creditor: a creditor who has the benefit of a security interest over some or all of the assets of the debtor. In the event of the bankruptcy of the debtor, the secured creditor can enforce its security interest against the assets of the debtor and avoid competing with unsecured creditors for payment of its debt.

Security interest: a property interest created by agreement or by operation of law over assets to secure payment of a debt which gives the beneficiary of the security interest certain preferential rights in relation to the assets, usually including the right to seize and sell the property to satisfy the debt that the security interest secures.

Setoff: if A owes a debt to B, and B owes a debt to A, the procedure whereby the debts are subtracted from one another, yielding a net result. By claiming a setoff, A does not necessarily deny its indebtedness to B, but claims the right to reduce that debt by deducting the amount B owes to A in some other transaction.

Stalking horse bidder: the bidder who places the first bid on a bankrupt company's assets. This bidder has often done due diligence and negotiated the form of purchase/sale agreement. As a result, the stalking horse bidder frequently negotiates for protective measures (e.g., a flat fee – called a “breakup fee” – to be paid to the stalking horse if it is outbid) to ensure that other bidders do not benefit from its work without compensation to the stalking horse bidder.

Tail insurance: a kind of malpractice insurance protecting against claims filed after expiration of a “claims-made” policy. Tail coverage extends the period for reporting covered claims beyond the “claims made” policy period.

Unsecured Creditor: a creditor who does not have the benefit of any security interests in the assets of the debtor. In the event of the bankruptcy of the debtor, the unsecured creditors usually obtain a pro rata distribution out of the assets of the insolvent company on a liquidation, in accordance with the size of their debt after the secured creditors have been enforced their security and the priority creditors have been paid in full.

APPENDIX I

CHAPA REVIEW

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CERTIFICATE OF NEED REVIEW

Office of Certificate of Need and Healthcare Facility Licensure
New Jersey Department of Health and Senior Services
PO Box 358
Trenton, New Jersey 08625-0358
(609) 292-6552 and 292-7228

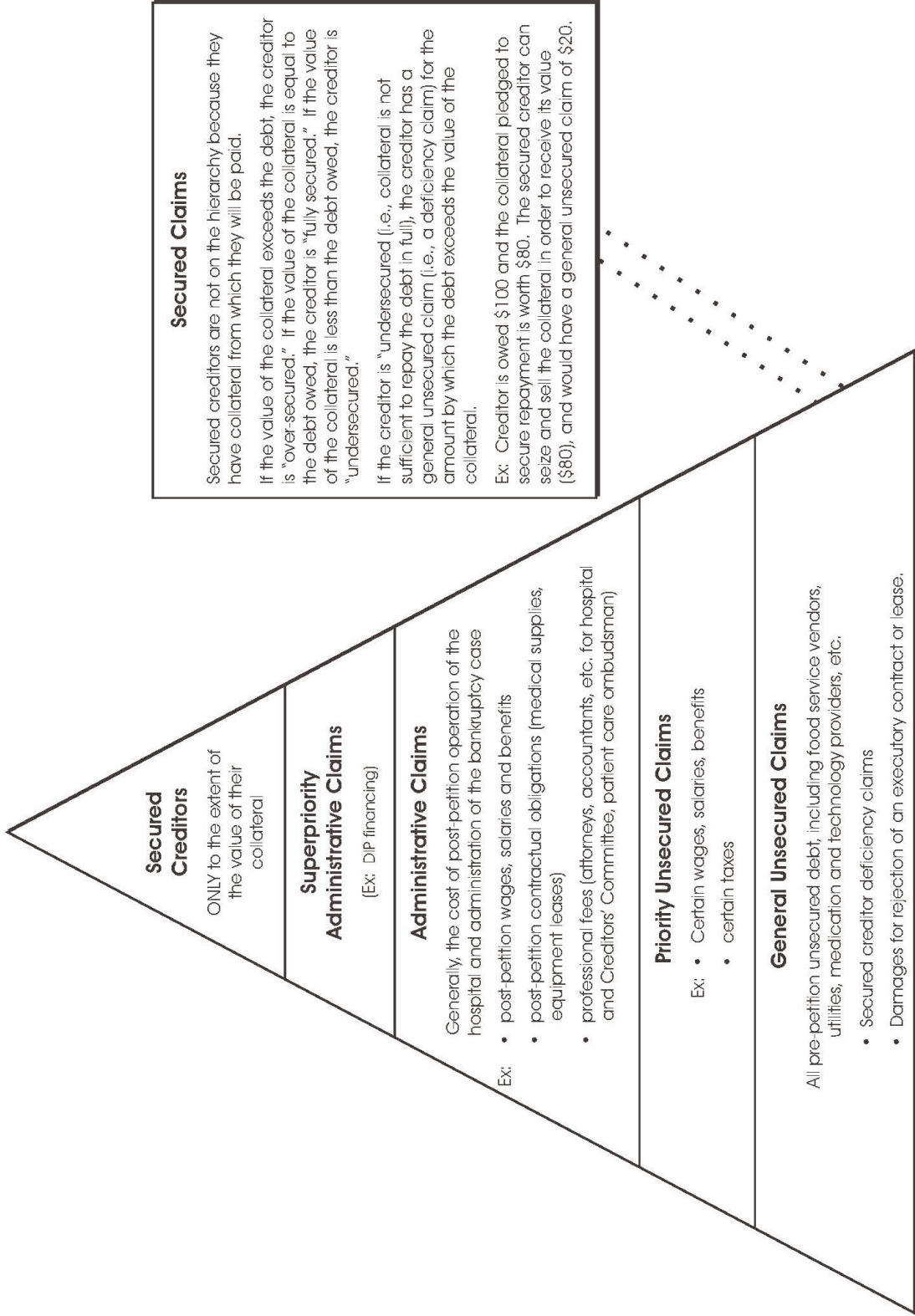
*NOTE: Applications for Certificates of Need must be sent here,
pursuant to N.J.A.C. § 8:33-4.3*

STATE HEALTH PLANNING BOARD

JAMIE HERNANDEZ
New Jersey Department of Health & Senior Services
Office of Legal and Regulatory Affairs
Market and Warren Streets - PO Box 360
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APPENDIX II

Appendix II Distribution Priority for Bankruptcy Claims





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