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Financing Healthcare Providers: The Lender's Perspective

By Rossi Felix

WHAT'S INSIDE

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June 3-6, 2015

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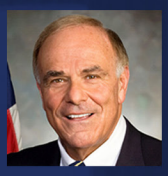

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THOMAS MORROW, CIRA
AlixPartners

On taking over as President from Matt Schwartz. What an act to follow! Matt did such great job as President it will be my honor if I can accomplish 80 percent of what Matt did. During his term he led one of the most successful Annual Conferences we have ever had. He also has restructured the committees that AIRA uses to get things done and provided important leadership to the Grant Newton fund to keep this important charity growing. Thanks for your many contributions to the Association, Matt!

AIRA's Mission. In addition to "uniting and supporting professionals providing business turnaround, restructuring and bankruptcy services; and developing, promoting and maintaining professional standards of practice, including a professional certification program," the AIRA is about education. We have a lot to offer. Here is a quick list of what is coming up. More information is available on the website, www.aira.org.

- CIRA classes. We offer the CIRA courses in New York, California, Puerto Rico and online. Please refer to the schedule on the website for specific dates and locations.
- CDBV classes. We also offer the CDBV courses in New York and California. Again, please refer to the schedule on the web site for dates and locations.
- Energy Summit. This successful regional program is in its fourth year, with an afternoon agenda focusing on issues related to the energy industry, on September 16, in Dallas.
- AIRA at NCBJ. In conjunction with the National Conference of Bankruptcy Judges, AIRA hosts the Opening Reception and a breakfast program Saturday morning. This year the NCBJ is September 27-30, in Miami. I hope to see you there!
- New York POR conference. On November 2, we will host the 14th edition of this outstanding all-day program focusing on advanced restructuring issues.
- 32nd Annual Conference. Next year the annual conference will be held June 8-11, at the Coronado Island Marriott in San Diego—mark your calendars now so you join us at this world class venue for our biggest event of the year.

Being a volunteer organization The AIRA is primarily a volunteer organization. We need your help to create the material and serve as panel members for AIRA's educational conferences and other programs throughout the year. AIRA's monthly webinars have proven to be a very popular way to cover current topics in the industry and are an excellent medium for member involvement. We also are currently seeking and value member contributions to AIRA Journal, which is published quarterly. Reach out to me or any of the board members and we will get you involved.

A small but experienced staff. The work of all the volunteers would not accomplish as much as it does without the support of the staff in Medford, Oregon. This group makes AIRA their passion and they are the glue that holds everything together. In future articles I will shine more light on this talented group.

Meet AIRA's New President

At the close of AIRA's 31st Annual Conference in Philadelphia, Tom Morrow, CIRA, assumed the responsibilities of President, following Matthew Schwartz, CIRA, who now serves as Chairman. Tom has been a member of AIRA for [_] years, a Director for [_] years, and active in many roles including [_____, _____, and _____]. He received his CIRA certificate in 19[_].

Tom has spent more than 20 years at AlixPartners helping companies solve financial and strategic challenges. At AlixPartners he has held the position of Managing Director and his work has focused on helping companies improve profitability through better management of their cash flow, cost structure and human resources. He provides expertise in financial, operational and business analysis; loan workouts and restructurings; and creditor negotiations.

Prior to joining AlixPartners, Tom was Director of Franchise with Wendy's International where he was responsible for franchisee restructurings. At present, Tom continues working on the General Motors bankruptcy case as Trustee for one of the trusts that is resolving certain legacy assets.

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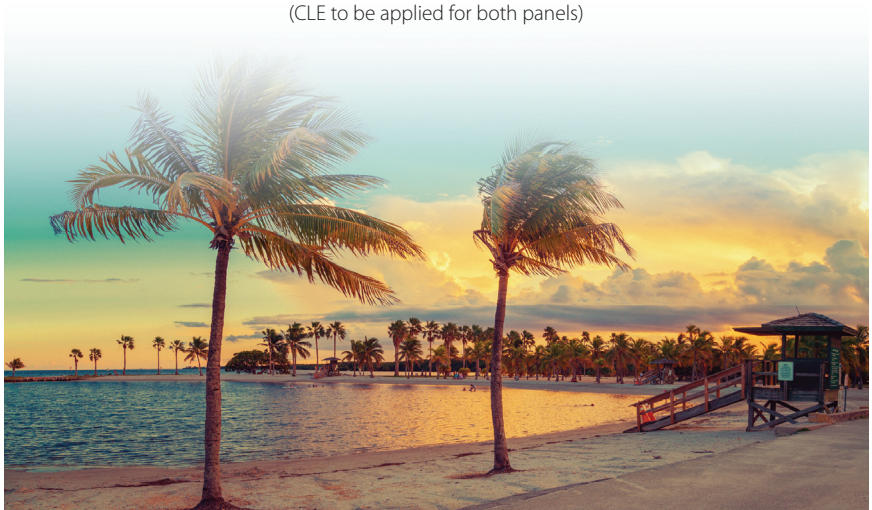
(CLE to be applied for both panels)



Financing Healthcare Providers: The Lender's Perspective

ROSSI FELIX
Wells Fargo Capital Finance

Most lenders spend weeks and even months underwriting a company's credit worthiness. They analyze years of financial statements, pour over collateral reports that include accounts receivable agings, accounts payable agings, inventory listings, equipment schedules and even real estate appraisals to ensure the loans they make are solid. Field interview management and "kick the tires." Depending on the size and type of loan being provided, the lender may also require third parties to provide quality of earnings reports or quality of care analysis.

Then it is time for the underwriting team to amass all the information into a single report and present the deal to the Credit Committee for final approval. At this point one might think, it is a done deal, right? Hardly. Now the legal process, which can sometimes take as long as the underwriting process, gets underway. There are teams of attorneys, countless meetings and conference calls, and many volumes of legal documents to review and negotiate so the process can finally be completed and the borrowers receive their long awaited loan.

Why does it take so much time and hard work just to lend a company a few million bucks? It's simple: Lenders want to be certain they are offering a loan to a reputable company with a solid management team and the debt can be repaid at the end of the term. They also want to make sure that from a legal perspective all their rights and remedies are protected in the event of default. Nevertheless, good loans sometimes go bad, and liquidations, foreclosures and bankruptcies are an unavoidable part of being a lender. And when it comes to financing healthcare providers, things get even more complicated.

Challenges of Lending to Healthcare Providers

Lending to companies that are reimbursed by governmental payors such as Medicare and Medicaid adds an extra layer of reimbursement and regulatory complexities to underwriting and legal processes that have to be considered as part of the underwriting and legal processes. According to the National Health Expenditures Accounts (NHEA) in 2013 U.S. healthcare spending topped $2.1 trillion or $9,255 per person. As a share of the nation's Gross Domestic Product, healthcare spending that year accounted for 17.4 percent.

The healthcare industry is so large, providers operate in a number of different sectors each with its own unique way of providing care for a full spectrum of health-related conditions. Correspondingly, lenders may choose to consider loans across all sectors of the healthcare continuum while others prefer to specialize in one or more specific sectors. In any given sector, these lenders typically provide a number of different types of senior debt financing options including asset based loans, cash flow loans, factoring, equipment leasing, tax free bonds and high yield bonds. In some cases, borrowing needs of healthcare providers might require more than just senior debt; and so, usually at a higher cost, junior capital such as sub-debt, mezzanine debt or second lien financing can be made available. In addition, there are the public markets that in good times are always eager to provide capital, but these are typically reserved for larger healthcare providers.

Although a wide variety of different lending products may be offered, there are fewer lenders interested in healthcare than in other, more traditional industries and businesses. This stems from the fact that there is considerable uncertainty surrounding reimbursement by governmental payors, which stems from changes in reimbursement and governmental regulations. If Washington decides it needs to slow the pace of government spending or if the politicians in DC want to find a way to fund a new program or project, it always seems to lead to cuts in the amount of money they are willing to allocate to reimbursement of healthcare companies providing care to the sick and elderly.

Over the years there have numerous cuts to funding for nursing homes, physicians, home health care providers, medical products companies and others. Sometimes these companies have been able to reduce expenses and weather the storm; but at other times they have been forced to sell, liquidate, file for bankruptcy or simply close their doors. However, these changes in reimbursement, although always difficult to digest, can also create opportunities for providers and lenders alike.

The Asset-Based Lending Perspective

From an asset-based lending perspective, it is important that lenders to healthcare providers and others closely monitor the collateral against which they are lending at all times, so that when changes in reimbursement occur, they know exactly where they stand. Unlike other forms of financing that rely on cash flow and enterprise value, the key to asset-based lending is centered in knowing where the loan balance stands in relation to the liquidation value of the assets one is lending against. Cuts to reimbursement can severely impact cash flow and enterprise value and, as a result, repayment

of the loan or sale of the business can become problematic. Asset-based loans are not as susceptible to large swings in cash flow or enterprise value when these types of changes in reimbursement occur—the reason is that an asset-based loan is focused on the *quantity of collateral* and the *quality of that collateral*.

The *quantity* of collateral can be determined as follows:

- How much of a particular asset class (receivables, inventory, equipment, real estate, etc.) is available to be pledged as collateral?
- How predictable is the value of that collateral in a liquidation scenario?

As one might guess, the more collateral securing the loan, the more likely it will be possible to sell the assets in a foreclosure or distressed sale and come out whole. However, in today's lending environment many healthcare providers want to maximize the amount of loan proceeds they can obtain and are therefore requesting that lenders be more aggressive on advance rates and loan-to-value ratios. In addition (and unfortunately for lenders), there is currently an abundance of capital which is driving lenders to be more competitive and, in some cases, to "stretch" the collateral to get to the borrower's requested proceeds amount.

In situations such as these, where there is not an overabundance of collateral, the quality of the assets becomes extremely important. Two measures for evaluating the quality of the asset are as follows:

- How liquid is the asset and thus how quickly can it be converted to cash?
- What outside forces might impact the conversion of less liquid assets to cash?

As mentioned earlier, the healthcare industry is highly regulated and subject to government regulation which can significantly impact collateral values. Consequently, a thorough analysis of the collateral must be performed during the underwriting process to make certain that advance rates and loan-to-values are established at levels that will ensure the liquidation and/or sale of assets will generate enough cash proceeds to fully repay the loan.

With the foregoing as a backdrop, the various asset classes will be examined more closely. The discussion starts with what are perceived to be the most liquid assets and works through the various classes to arrive at those most likely to be impacted by outside forces and take the most time to convert to cash.

Accounts Receivable

Asset-based loans come in several basic forms with the most basic being a revolving line of credit secured by receivables. The following discussion is relevant to a variety of healthcare providers and distributors of healthcare products, including the following:

Home Health	Physician Groups	Rehab Therapy
Skilled Nursing	Behavioral Health	Hospice
Diagnostic Labs	Specialty Pharmacy	Dental Practice Management
Imaging	Product Distribution	Medical Devices

Generally speaking, anyone who provides a healthcare service or sells a healthcare product and bills a governmental entity, an insurance company, a managed care organization or even other healthcare providers for the provision of those products and services could potentially qualify for a revolving line of credit secured by these accounts receivable.

Lenders will typically lend up to 85 percent (the "advance rate") against what is commonly referred to as the Expected Net Value (ENV) of the eligible accounts receivable. The ENV is usually calculated during a field exam and analysis of the company's billing and collection procedures. ENV's can vary greatly from lows in the 20 percent range (usually a hospital) to highs in the mid to upper 90 percent range (typical for a nursing home operator). Simply stated, the ENV calculation uses the net receivable (less any contractual adjustments) and compares it on a historical basis to the percentage of collections ultimately received. This takes into account amounts that are NOT collected such as bad debts, discounts and offsets, to name a few.

Eligible accounts receivable would include amounts due and payable from some of the following payor classes:

Medicare	Medicaid	Commercial Insurance
Managed Care Organizations	HMO/PPO	Veterans Administration
State/City Agencies		Other Healthcare Providers

Note that because government agencies and insurance companies often try to find reasons to delay payment, the days sales outstanding for healthcare providers, especially hospitals, is considerably longer than for most other industries.

In addition to receivables included in the borrowing base, there are also receivables that lenders intentionally exclude due either to the low probability of collection or the cost associated with collecting in a liquidation scenario. Examples of ineligible receivables include the following:

- Receivables aged greater than the standard number of days (varies by sector) from the date of service or invoice date for a medical product or device supplier.
- Private pay receivables; i.e., those due directly from the patient including co-pays.
- Litigated worker's compensation claims which are generally those under a letter-of-protection (LOP) from an attorney and have an extremely long collection cycle that can take years.
- Other litigated claims whereby payment of the receivable is contingent upon the outcome of a court proceeding.

In an effort to track the quality of the receivables, lenders typically require standard receivable reports that generally include receipt of accounts receivable agings ("agings") categorized by 1) the number of days the receivable is past its due date (e.g., 1-30, 31-60, 61-90, etc.), and 2) by payor class or by customer if applicable. Agings are used to calculate a borrowing base that determines how much the provider could borrow given, a) the amount of eligible collateral, and, b) the established advance rate which might range anywhere from 75 percent on the low end to as much as 85 percent on the high end. For example, $5,000,000

of net eligible A/R collateral might produce a borrowing base of $4,250,000 given an 85 percent advance rate.

Borrowers are also required to "roll the collateral forward" each time they wish to borrow funds under the line of credit. Rolling the collateral is a simple calculation that takes beginning collateral, adds in new sales/claims, and subtracts out collections to arrive at a new, more current collateral amount. Funds may be requested as often as daily, but generally follow a weekly or biweekly schedule depending on the individual cash flow needs of the business.

It is important for the lender to know where the revolver loan stands in relation to the amount of collateral they have securing the loan. In a liquidation scenario, the lender would ideally like to see the collections from accounts receivable retire the loan in full in roughly 30-45 days.

Inventory

In a variety of healthcare sectors, companies maintain considerable levels of inventory that allow a lender to incorporate into the borrowing base advances against that inventory and include it as eligible collateral. Some examples are as follows:

Pharmaceutical Companies	Medical Device Manufacturers	Disposable Medical Products
Generic and prescription drugs	Implants for hip/ knee/back, etc.	Incontinence and catheters
Specialty pharmaceuticals	Insulin pumps	Infusion and hypodermic
Mail order items	Pacemakers	General supplies such as bandages, surgical gloves, etc.

All of the above inventory products could qualify as eligible inventory collateral and therefore be included in the borrowing base. Advances against the net orderly liquidation value (NOLV) of inventory ranges anywhere from 50 to 75 percent depending on the type of inventory and the ease of which it could be sold. The more commodity-like a product is, the more readily it can be converted to cash.

Lending against inventory complicates the relationship with the borrower because it adds a class of collateral that is less liquid and whose quality is less predictable in liquidation. Additionally, inventory of a medical nature will often require the lender to adhere to regulatory restrictions and may limit the options available to, as a third party, sell that inventory. For example, some inventory can only be sold by a licensed provider while other inventory may have a limited shelf life. There is also the risk of customer rebates that can offset or reduce value. Some inventory may be protected by intellectual property rights or royalty streams which can often create unique obstacles that become magnified should the business fail and a distressed sale or liquidation occur.

Another consideration for lenders is the location of the inventory. If possible, inventory should be centrally located so the lender can perform the sale from a single site versus multiple locations which increase costs. Also important is the lender's ability to gain access to the building or warehouse from a landlord. This is typically achieved through a landlord waiver typically negotiated as part of the upfront legal documentation process.

Lenders will also need to have a good understanding of the company's inventory reporting capabilities and whether the inventory is tracked using a perpetual versus a periodic system.

As with accounts receivable, the inventory report is used to determine which inventory would be considered eligible and therefore how much borrowing capacity would be generated based on the assigned advance rate. The advance rate is usually determined by the lender after completion of a third party appraisal that is used to establish the NOLV. Most often, inventory reports are submitted and the borrowing base calculated on a monthly basis since these asset levels tend to remain more stable than accounts receivable.

In a liquidation scenario, it would be ideal for the lender to find a single buyer to purchase the inventory for an amount sufficient to retire the inventory portion of the revolver in full. Alternatively, the inventory could be sold to the existing customer base either at a discount for cash or at the customary price and converted to a receivable which would convert to cash based on stated terms. The latter approach would require the lender to retain essential employees in order to ship the inventory and collect the receivables generated as a result. This is obviously a more expensive approach and one that, if not handled efficiently, could result in a loss for the lender.

Machinery & Equipment

In many cases, machinery and equipment (M&E) can also be included in the pool of eligible collateral that an asset-based lender is willing to consider when making a loan. In most instances, loans against M&E are set up as separate term loans outside of the revolving line of credit which allows this portion to be amortized over time. Healthcare providers and companies that generally take advantage of machinery and equipment loans include the following:

- Acute care hospitals
- Specialty and multi-specialty hospitals
- Imaging centers
- Durable medical equipment (DME) suppliers
- Manufacturers of equipment, implants, medical products, etc.

Loans against M&E can equal up to 85 percent of NOLV or 100 percent of net forced liquidation value (NFLV). Amortization periods range from three to seven years depending on the useful life of the equipment and other obsolescence factors. Providing a term loan typically requires the lender to analyze historical cash flow to determine the borrower has the ability to service the debt and still generate some amount of free operating cash flow. Even a minimal amount of excess cash flow provides the lender comfort that if financial performance declines for some reason; a cash flow cushion will remain and allow the company to service debt.

These items represent a move down the liquidity chain with the ability to convert M&E to cash being more difficult than for receivables and inventory. In a healthcare setting, the preferable make up of M&E would be in major movable equipment such as MRI machines, CT scanners, and X-Ray and ultrasound equipment. These larger items are more readily sold to buyers at higher values than other equipment such as oxygen machines, computers and phone systems.

Real Estate

Finally, certain lenders will consider loans against real estate, either on a stand-alone basis or in conjunction with any or all of the products above. There are a number of different types of healthcare real estate properties such as:

Independent Living	Assisted Living	Skilled Nursing	Medical Office
In-Patient Rehab	Long Term Acute Care	Acute and Specialty Hospitals	In-Patient Behavioral Health

Lenders tend to specialize when it comes to healthcare real estate, due to the single-use nature of some of the properties and the varying enterprise value component of each. If healthcare real estate lenders were lumped into two categories, they could be separated according to low acuity and high acuity. The lower acuity properties would include facilities where very little care, if any, is provided to the residents; such as, independent living and assisted living. These property types have little to no government reimbursement as part of their revenues. The higher acuity properties are facilities where patients require some-to-an-abundance of care; such as nursing homes and hospitals.

Typically, loan values range from 50 percent of fair market value (FMV) on the higher acuity properties (i.e., hospitals) to 85 percent of FMV on properties with a high frequency of trading activity and/or lower acuity facilities. Also impacting loan to value ratios are type and location of the facility and sales of comparable properties in the same geographic region.

Amortization on real estate loans typically ranges from 15 to 25 years depending upon the property type. Standard maturities range from three to five years depending upon the use of proceeds and any number of additional factors. In certain sectors, HUD or other governmental agency guaranteed and subsidized loans ("Agency RE Loans") may be available. Obtaining financing through HUD and other governmental departments can be a long and arduous process. In addition, the terms are very restrictive including lockout periods and termination fees. However, many people choose these types of loans due to favorable long term fixed rates and in some cases 30-year amortization schedules.

Other Lender Monitoring and Ongoing Requirements

As noted earlier, when current assets such as accounts receivable or inventory make up the collateral base, lenders require weekly and/or monthly reporting to track quantity and quality of the collateral. These loan types also require monthly and annual financial reporting (income statements and balance sheets) to track operating performance of the healthcare provider.

In addition to reporting, many lenders require borrowers to establish lockbox accounts that are controlled by tri-party agreements among the bank, the provider and the lender. This allows the lender to track and analyze collections and the quality of receivable performance.

Finally, the lender reserves the right to send in its own field examiners/auditors at least once per year. This allows the lender a firsthand look at the borrower's operational and accounting procedures to make sure the company is performing in a manner that provides for accurate and timely reporting of its financial condition.

Financial Covenants

Financial covenants are a means by which operational performance can be tested. In the case of a simple revolving line of credit secured by receivables, a lender may only have a couple of financial covenants, such as minimum liquidity and cash velocity or loan turnover.

To the extent the credit facility provides for inventory loans and/or term loans, the financial covenants may also include a minimum fixed charge coverage ratio and a maximum leverage ratio. All covenants are established and agreed upon up front and are based on the borrower's projected future financial performance.

In some cases, unforeseen issues may arise that can cause the borrower's financial performance to deteriorate. If this occurs and the borrower defaults on one or more of its covenants, the lender then has the opportunity to discuss the problems and determine what course of action both parties will pursue going forward. In some cases, the lender will amend the covenants and continue in the relationship and in other cases the lender will require that the loan be moved to another bank or finance company assuming those options are available. In severely distressed situations where there are no other financing options available, foreclosure and liquidation or bankruptcy may be the only course of action.

Conclusion

Even in distressed situations, asset-based lending is generally available to all types of healthcare providers. There is a fair amount of work on both sides that must be done to enter into a lending agreement. It is the lender's job to make sure the proper analysis is performed in underwriting, and reasonable advance rates and loan to collateral values are established to ensure repayment at the end of the term or in the unlikely event of a liquidation. Likewise, proper structure and legal documentation are essential to minimizing losses if loans that appeared good at the outset end up going bad.

ABOUT THE AUTHOR

ROSSI FELIX

Managing Director | WellsFargo

In May 2013, Rossi Felix joined Wells Fargo Capital Finance, part of Wells Fargo & Company as managing director within its Healthcare Finance Group. Based in Dallas, Texas, Rossi's efforts are focused on providing senior secured financing to middle market healthcare providers and ancillary service companies operating across a variety of sectors, including hospitals, skilled nursing, home healthcare, hospice, medical device, pharmaceutical and other healthcare companies. Rossi has over 30 years of lending experience, with a majority of those years specifically focused on the healthcare sector. He has held notable senior management positions with responsibility for credit, operations and business development at GMAC Health Capital, GE Healthcare Financial Services, FINOVA Capital Corporation, Heller Financial and Foothill Capital. Rossi holds a BBA from Austin College in Sherman, Texas.

Unique Aspects of Physician Practices

ANDREW MASINI, CIRA
CohnReznick LLP

Private practices cast 50% of the physicians in the U.S. into the dual role of healthcare provider and small business owner and, often, with only the slightest of training for the latter.

As a small business owner, a physician has to contend with an industry dominated by third-party payment — a complication that few other small businesses face. The rigid schedules of reimbursements encourage throughput of patients and discourages spending time on the business strategizing, analyzing results or re-designing workflow. The third-party payer system imposes two more conditions on the practices: 1) the lengthy and varying lag times between bill submission and reimbursement; and 2) the vagaries of collecting all reimbursements due to the practice. Thus, physicians with too little business training are putting too little time into doing the technical analyses of Days Sales Outstanding and revenue leakage among others.

Old Problems Exacerbated

The recession amplified these weaknesses in the physician practice model. Households strapped for cash took a look at their portions of healthcare payments, copays, and deductibles — relatively small amounts compared to the portions covered by insurance — and decided to do the unprecedented: they rationed their visits to the doctors. Physicians, of course, found themselves missing out on both the patient-paid portions *and* the larger insurer-paid portions. Thus, practices that were already inadequately addressing revenue leakage were faced with the additional problem of revenue loss.

In addition to making slow-payers even slower to pay, the recession turned more patients — even prosperous ones — into slow-payers. This added a new segment of revenue to the Days Sales Outstanding issue.

Bankruptcies of physician practices get a disproportionate amount of attention because, for so long, being a physician was synonymous with being financially secure; bankruptcies turn that notion on its ear. Yet, there is no measure that tells us definitively if the rate of bankruptcy among physician practices is increasing. What we can observe is:

- practices facing increases in pressures — pressures that often lead to business failure,
- the rise of concierge medical practices, and
- the flow of both new and established physicians to hospital settings or large practices that more closely resemble hospitals than the traditional single physician or small partnership practices.

Business Characteristics

Physician practices have idiosyncrasies, both subtle and stark, that set them apart from other types of businesses and inform their operations.

Two Entities

Physicians identify so closely with their practices that they can easily lose sight of the distinction between the person and the business. Motivated by well-deserved pride in operating their own practices, physicians do not seriously consider that:

- the *person* can work anywhere and that the *business* is just one choice of employment,
- any one business may not turn out to be a fruitful venture for any number of reasons while the *person* moves on to success.

The personal drive to hold onto the practice tends to delay the business decision to open or join another practice or move to a hospital environment.

The strong identification with the practice may lead the physician to too quickly offer to guaranty the debt of the practice. This ties the person to the fortunes of the business. If the worst happens and the business goes into bankruptcy, the person may be forced into bankruptcy also.

Finally, that strong identification with the practice too often causes the physician to be slow to admit needing concessions from creditors or advice.

Burdens

Malpractice has long been recognized as a driver of cost both in terms of premiums for insurance coverage and, sometimes, the cost of judgments that exceed the coverage. Also, a settlement of a malpractice suit may have a hidden cost that is only revealed when the physician later seeks hospital privileges or listing with an HMO and is denied.

Very much in the news now is the fact that rates of reimbursements paid by private insurers, Medicare, Medicaid, and HMOs have not kept pace with the costs faced by physicians. These are effectively decreases in physicians' revenue. These decreases were in evidence prior to the recession and the downward pressure on reimbursement rates will continue even in recovery.

Changes in regulations, such as the recent mandate to implement electronic patient records storage, impose the cost of compliance on the practices.

We are used to primary care physicians stocking, dispensing, and billing for vaccinations or other medicines and we rightly think of this as a relatively small part of a primary care practice's cash flow; however, some specialties call for the physician to stock and dispense a very significant amount of costly medications.

A Special Responsibility and Cost: Patient Records

When a practice closes, the physician has the responsibility to transfer patient records to a custodian and ensure patients will have access to their records. The custodian could be another practice but it may also be a commercial storage facility. If a practice is facing closure because of a business failure, this responsibility may be at odds with the ability to pay for storage and access.

In 2003, when the issue of what a failed or failing practice could and should do with patient records was new and murky, a case arose that eventually revealed an array of risks. Eight physicians in the practice who could not pay a records custodian had their licenses suspended. They were viewed as posing a danger to their patients. As that drama unfolded, the landlord locked up the building that housed the practice and, with it, the scanning equipment of the records custodian doing on-site work. Also, some records had been placed in a self-storage facility. When the owner of that facility failed to collect on back rent for a unit, he destroyed the records.

The Bankruptcy Reform Act of 2005 provided some amount of help in these cases by giving priority to the cost of preserving these records and access to them. Also, state regulators of physicians and the storage facility industry started adapting to accommodate cases of failing practices in a practical manner. The result is that commercial storage facilities are increasingly able to fund access through fees that they charge patients. In turn, those search and access fees are increasingly being regulated.

Assets and Ownership

Because of the large costs of the equipment needed by a practice, the obligations and the value of the practice will hinge on whether the equipment and premises are sublet, owned and fully paid for, or owned but with payments still due.

If a physician has started or joined a new practice and the new practice attempts to use any assets associated with the old practice — the premises, the equipment, the name of the practice, the phone number, the web domain, the email address — the question arises as to whether the new practice is trading on the goodwill of the old practice. If the old practice is in new hands, whether through sale or bankruptcy, that goodwill has value that belongs to the owners or the creditors of the old practice.

The patient list is a special asset. A physician who is closing a practice for any reason has the responsibility to transfer patients and notify them of the transfer. Depending upon the state, there can be limits on the physician's ability to solicit the former patients for a new practice. In the case of bankruptcy, two special considerations are those of whether the trustee will allow the physician to use the list during the proceedings and whether the trustee intends to abandon the list and allow it to revert to the physician.

Collections

Physician practices have several avenues for collections. Medical liens can be attached to the proceeds of any personal injury settlements or verdicts in favor of patients or any workers' compensation awards. Physicians can make claims against the estates of deceased patients. Wrongful death awards do not pass to the estate, but state law may dictate that portions of these awards be made available to satisfy medical expenses of the deceased.

Small claims courts are available, of course, but they limit the amount that can be collected in an action. For claims greater than the small claims limit, arbitration is less costly than litigation. In most cases, arbitration is specified as a remedy in a financial responsibility agreement or an accompanying document that the patient signs when seeking services from the practice. In general, the arbitration specified is binding arbitration.

There are a number of reasons for medical practices not offering "prompt-pay discounts" in advance of rendering services. For example, a prompt-pay discount may run afoul of a federal anti-kickback statute or it may call into question what the "usual charge" is for Medicare and Medicaid purposes. However, discounts may be offered *after* rendering services. These discounts can be used to encourage partial payment to settle outstanding balances.

Personally-Guaranteed Debt

As mentioned above, physicians identify personally and very closely with their practice. For that reason, physicians may have a greater tendency than do other small business owners to guarantee the debt of the practice. Also for that reason, physicians may guarantee a loan when it is more appropriate to consider an orderly shutdown or to seek an out-of-court agreement or bankruptcy protection.

In any case, it is very likely to find the debt of a practice personally guaranteed by the physician. The physician may also be compelled to file for personal bankruptcy in the event the practice requires bankruptcy protection.

Valuation

Physician practices will typically be valued using an excess earnings approach, a version of the income approach:

- The balance sheet is "fair valued" to determine a net tangible asset value.
- Earnings are normalized and reasonable officer compensation is subtracted to arrive at excess earnings.
- The excess earnings are used to determine the return on the net tangible asset value.
- An appropriate multiple is applied to the return to arrive at the value of the practice.

The Challenges of Running a Business vs. Practicing Medicine

Out of necessity, the hours of medical training limit the amount of business training a physician can obtain. Then, once in private practice, third-party reimbursement schedules tend to reinforce the idea that only billable patient time is productive. Patient and charting hours easily continue to supplant business training. Whereas other business owners may have four-year or two-year degrees in business or years of work experience under their belts, the private practice physician may only be able to measure his or her business training in days.

As the practice continues, patient and charting hours continue to crowd out strategy, design, implementation, and management. Physicians are generally not conditioned to spend up to 30%

of their time on business analysis and strategy nor are they conditioned to view this time as necessary to sustain or increase revenue.

Slow Response to Downturns

As noted above, physicians approach their practices with well-deserved pride. They are masters of the core objective of the practice: diagnosis and treatment. It may be difficult, then, for a physician to admit weakness in what he or she considers lesser business aspects of the practice. Hence, there is good reason to expect to find a physician has been slower than other business owners to seek advice from professionals, concessions from creditors, or bankruptcy protection.

Also, as previously mentioned, physicians in private practice may be too quick to borrow in an effort to buy time even when there is no reason to believe that the borrowed time will be of any help.

Finally, physicians are understandably hesitant to deny a patient care. Hence, a physician may take longer than is reasonable to terminate a physician-patient relationship for failure to pay.

Characteristics of Risk and Success

What types of practices are more prone to risk in this economy? What types are more prone to success? Some patterns emerge.

Among the indicators of risk:

- Primary care physicians and specialists conduct the initial visits of patients. They are very likely to have patients present with multiple, unrelated problems. Consequently, these physicians spend more time conducting examinations and taking histories. They are also more likely to have to consider more conditions than for which they will ultimately be able to bill.

- Physicians are more exposed to stagnant revenue if they are dependent upon reimbursements from Medicare, Medicaid, and HMOs. These payers are resisting increases in their reimbursement rates that would keep pace with rising costs of physician practices.

- Urban markets tend to have higher overhead costs and be saturated with physicians, which increases competition for patients and drives rates down.

- At one time, practices were encouraged to identify the diagnostic and treatment procedures they most often ordered such as x-rays, scans, lab work, physical therapy, and then incorporate these ancillary services into the practices. Now, most of these ancillary services are subject to flat or declining reimbursement rates, so practices that incorporated such services are seeing less revenue enhancement from them.

Among the indicators of success:

- Subspecialists treat discrete illnesses and conditions. Their time and procedures are very specific and fit more easily into the diagnostic and treatment coding used by third-party payers. Hence, subspecialists enjoy the advantages of less unbilled time.

- Physicians that have more cash and PPO (Preferred Provider Organization) patients are generally paid more for their services. The caveat to this is that patients have been forgoing elective procedures since the recession.

- Suburban markets tend to have fewer physicians per capita so each physician faces less competition for patients and enjoys higher billing rates. Also, these markets tend to have lower overhead costs than urban markets.

- Malpractice premiums vary greatly from area to area, even to the point of having as much as three to four times the difference within the same state. Practices located in lower premium areas can have a significant advantage.

Emerging Challenges: Competing Business Models and Trends

Concierge Medicine

Concierge medicine calls for an annual premium to be paid by the patient in return for greater access to the physician. Because of the premiums, the physician can concentrate more time and effort on a smaller collection of patients.

The concierge model focuses on prevention and the coordination of care across specialties and ancillary services. The model had been aimed at more affluent customers but the new focus on prevention and coordination helps patients avoid much in the way of healthcare costs. The "extra" cost tended to not be extra at all but instead resulted in more effective and ultimately more affordable care. The concierge model turned out to be appropriate for middle-class consumers.

Concierge medicine represents a very small slice of the healthcare industry, but that was notably the case with HMOs and PPOs when each was introduced. HMOs and PPOs now dominate the healthcare payment market. It is not a stretch to envision concierge medicine shaping a more effective way to afford healthcare.

Patient-Centered Medical Home

With some tweaking, there has been success in applying the concierge model to poor patients as well. This spawned a new but related model, the patient-centered medical home (this model also goes by the monikers of "primary care medical home," "advanced primary care," and "healthcare home."). The patient-centered medical home is aimed at the treatment of at-risk patients, namely, children and the poor. Because of this, it stands more ready than the concierge model to treat multiple illnesses and conditions and coordinate care across specialties.

Cash-Only Practices

Cash-only practices are not completely disconnected from the third-party payer system. These practices typically offer their patients detailed instruction and assistance in submitting their claims to their insurers. These practices do avoid the overhead costs of administering to third-party payment systems themselves and the lag in time between submission and payment.

Consolidation

Established physicians are increasingly more willing to give up private practice for the hospital environment. These physicians divest themselves of the tribulations of managing third-party payment and the responsibility of operating a business. They gain the opportunity to focus on healthcare delivery and relative

job security. Frequently, these physicians have sold their practices to the hospitals that they joined. Clearly then, hospitals are moving into the delivery of primary care and specialist services once associated with smaller offices.

There are also two other notable trends: new physicians are more open to joining large practices and smaller practices are increasingly merging into larger ones to achieve economies of scale. Even where there may be an office housing what appears to be a one-doctor or small partnership practice, it is increasingly likely that it is part of a larger entity spanning several such practices.

Taken together, the trends in consolidation indicate movement away from one-doctor and small partnership practices.

Thumbnail: Winning Characteristics

From the above observations, there emerges a thumbnail sketch of the characteristics of practices poised to win in today's economy.

Allocation of Time to Business Matters

Taking a realistic view of time constraints into account, physician/owners will exhibit an earnest and practical effort to plug any holes in their business training — the basics of financial statements, forms of credit, and measures of performance.

Physicians will dedicate considerable time — up to 30% — to business matters, including operations and strategy.

Dispassionate Decisions

Pride of ownership is a terrific pay-off that flows out of a well-run practice, but that well-deserved pride should not dictate how the practice is run. The value of locating the practice close to home may be vastly outweighed by savings on malpractice premiums and other costs. Acquiring equipment should be subject to strict lease-or-buy decisions. The personal stake in the practice should not be the reason for a personal guarantee of business debt.

As is the case with any business, a healthy practice will use short-term and revolving credit for operating costs to bridge temporary cash flow mismatches, whereas, long-term debt instruments will strictly finance capital improvements. The practice that does not abide by this distinction is showing a danger signal.

The healthy practice will address difficulties in a timely manner. This includes recognizing when to seek advice from professionals, concessions from creditors or, if necessary, bankruptcy protection. The crucial element is that of the physician/owner being both practically and emotionally ready to seek such help.

Treating Efficiency as Opportunity

Having patient records in shape for transfer to a custodian and minding the measure of excess earnings of the practice sound like preparations for exiting the practice. Certainly, they are, but they also happen to yield efficiencies for the ongoing practice. Hence, storing records with an eye toward ease of transfer to a custodian and ease of access via a custodian translates into an efficient, disciplined approach to managing these assets.

Likewise, constant monitoring of the excess earnings of the practice is not just a valuation technique; it is also an early warning system.

It just so happens that such techniques have the added benefit of keeping options readily available. The disciplined approach to maintaining records keeps a major obstacle out of the way of taking advantage of a favorable exit opportunity. Ready access to an excess earnings figure attracts merger and sale opportunities.

Keeping Ahead of Industry Trends

The best-positioned practices will notice broad and seemingly slow-moving shifts in the industry and get ahead of these.

Prevention and coordination of care has always been integrated into the practice of medicine. Likewise, patients presenting with multiple illnesses and conditions have also always been common. What may elude the practicing physician are the subtle changes. A new emphasis on prevention and coordinating care is shaping changes in billing, networks of referral sources, and the pools of patients to target. The third-party billing environment is conferring an advantage on practices that craft cost-effective responses to patients with multiple conditions to manage.

Takeaway: The Good News

The thumbnail above yields an encouraging observation. However unique a spin there may be on the challenges that physician practices face, they lend themselves to time-tested tactics rather than demanding the invention of new solutions.

ABOUT THE AUTHOR

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Andrew Masini has over 25 years of private accounting and advisory experience. For CohnReznick, he provides bankruptcy, restructure, forensic, litigation and financial advisory services to clients in a variety of industries: manufacturing, wholesale/distribution, professional services, financial services, telecommunications real estate and nonprofits. He has previously published articles on the Foreign Corrupt Practices Act, healthcare and arts management.

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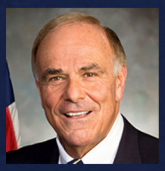

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After 34 years of public service, including 24 years as an elected official, Governor Rendell continues to pursue many of the same issues he was passionate about while in office. He now serves as a consultant or board member for several green and alternative energy firms, including Own Energy, Element Partners and Ocean Thermal Energy. He remains heavily involved in the campaign for government efficiency and strategic cost cutting through his work with entities such as Government Sourcing Solutions, Public Financial Management and Greenhill Advisors; and serves as Co-Chair of the organization "Building America's Future" which focuses on the need for more significant investment in American infrastructure. Rendell served two terms in each of the following offices: Governor of Pennsylvania (2003-2011), Mayor of Philadelphia (1992-2000), and DA of Philadelphia (1978-1985). He currently teaches government and politics at the University of Pennsylvania, and in 2012 his autobiography, A Nation of Wusses, was published by John Wiley.

Professor David A. Skeel

S. Samuel Arsht Professor of Corporate Law at the University of Pennsylvania Law School

David Skeel is the author of The New Financial Deal: Understanding the Dodd-Frank Act and Its (Unintended) Consequences (Wiley, 2011), Icarus in the Boardroom (Oxford, 2005) and Debt's Dominion: A History of Bankruptcy Law in America (Princeton, 2001), as well as numerous articles and other publications. He has been interviewed on The News Hour, Nightline, Chris Matthews' Hardball (MSNBC), NPR, and Marketplace, and has been quoted in the New York Times, Wall Street Journal, Washington Post and other newspapers and magazines.

Osagie Imasogie

Senior Managing Partner & Founder of Phoenix IP Ventures

Osagie Imasogie has over 28 years of experience in the fields of law, finance and business management, healthcare and the pharmaceutical industry. Prior to co-founding Phoenix IP Ventures, an IP based Merchant Bank, Osagie conceptualized and established GlaxoSmithKline Ventures and was its founding Vice President. Osagie led GSK Ventures in concluding over thirty (30) worldwide transactions, within a 3 year period, in which he invested various GSK R&D non-progressed assets into various companies and/or as the basis of starting new companies.

Wednesday, June 3rd - Preconference Program

7:30 am – 8:30 am
Continental Breakfast

8:30 am – 5:15 pm
Concurrent Sessions A & B

10:00 am – 10:15 am
Morning Break

Noon – 1:40 pm
Luncheon Keynote Presentation

3:00 pm – 3:15 pm
Afternoon Break

6:30 pm – 8:30 pm
31st Annual Conference Opening Reception

Concurrent Session A | Bankruptcy Taxation

Panel 1 – Corporate tax update on cancellation of indebtedness and corporate issues including inversions. Panel 2 – Views from the bench; preference actions against taxing authorities; and dealing with tax claims in chapters 7, 11 and 13. Panel 3 – Tax liability discharge with case scenarios. Panel 4 – Criminal tax issues in bankruptcy, employment taxes and the trust fund recovery penalty (TFRP). Panel 5 – Offers in compromise, installment agreements and other exit strategies. Panel 6 – Individual income tax planning and compliance, taxation of foreclosures, individual cancellation of indebtedness issues

Concurrent Session B | Financial Advisors' Toolbox

DIP financing and cash collateral - cradle to grave. This program is designed to educate intermediate practitioners in the skills needed to assist a distressed company through management of cash flow, acquiring financing and obtaining approval through the Bankruptcy Court. Topics include: company research; cash flow modeling; negotiating financing; preparation of first day motions and their relationship to cash flow and borrowing base budgets; DIP financing and cash collateral motion, interim and final orders; and payment of loan on exit (sale of asset or plan).

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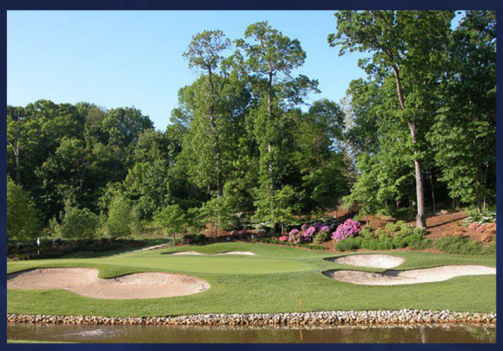
Thursday, June 4 - Conference Excursions



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12:15 pm - Price: $165
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Barnes Foundation Private Tour

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3:00 pm - 5:00 pm - Price: $50

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Philly Food Tour

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Sponsored by **Trenk DiPasquale**
1:30 pm - 4:00 pm - Price: $55

Old Philadelphia Segway Tour

Enjoy a tour of Old Philadelphia on your own Segway! Glide and explore the Old City and Historical/Waterfront Districts as you hear historical stories about how our country was formed. Some of the sites you'll see include: the Liberty Bell, Betsy Ross House, Washington Square, Penn's Landing, Powel House, and so much more! Safety instructions included.
Sponsored by **McCarter & English, LLP**
1:30 pm - 4:00 pm - Price: $75

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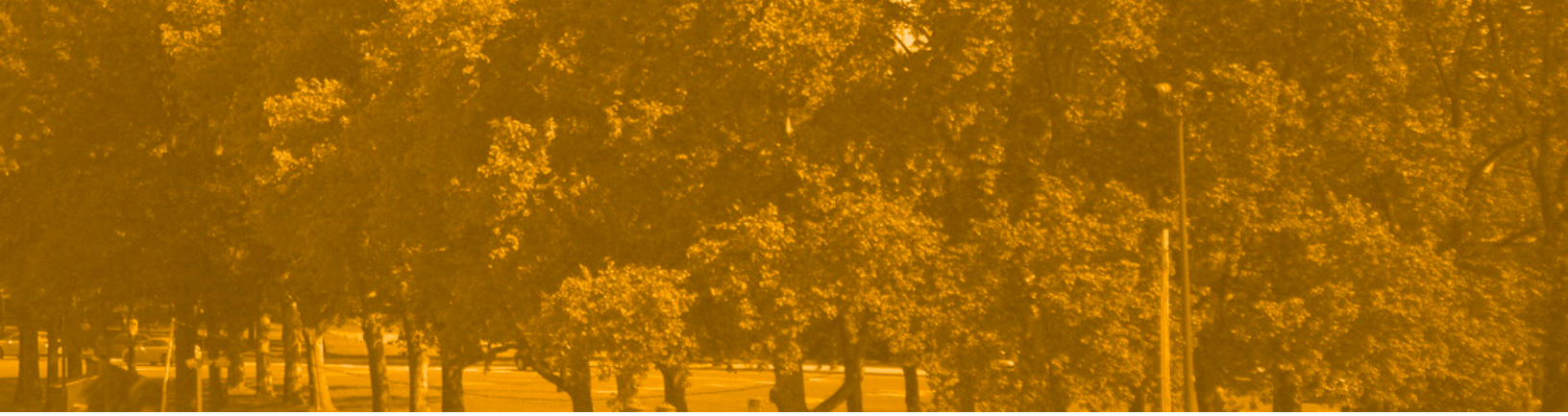

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Nursing Care Facilities: A Care Plan to Address Increasing Financial Pressures

MARTIN CAUZ, CIRA
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The mission statement of any nursing care facility in the United States most likely embodies the underlying theme "to provide the highest quality of care to our residents." While the words may vary from facility to facility, the message is universal.

Nursing care facilities need to have the necessary human and financial capital to deliver the highest quality of care to residents. The human capital is the dedicated healthcare professionals who develop and monitor the residents' care plans and care for the residents. The financial capital is the nursing care facility's economic wherewithal to fund the business.

To say that nursing care facilities in the United States are currently facing tremendous financial pressures would be an understatement. Some of these pressures include: reimbursement rate pressures from Medicare and Medicaid; delayed Medicaid payments caused by poor fiscal conditions at the state level; difficulty attracting and retaining high quality staff; constantly changing technology; and increased regulatory requirements that result in increased spending, to name a few.

Compounding Financial Pressures– Short Term Strategies

When these external financial pressures begin to compound, the nursing care facility, or operator, is at risk for a downward spiral of cash flows. Assuming these pressures begin to compound slowly and the operator's census has not been impacted, what is the operator to do with the reduced level of cash flows? If the operator has sufficient cash reserves and/or availability on a line of credit ("liquidity"), they can tap into those resources. However, if liquidity is tight, the operator will typically resort to one or more of the following strategies:

- Defer capital expenditures
- Defer accounts payable or "stretch" their vendors
- Reduce unnecessary staff at the facility or corporate level
- Reduce marketing spend
- Defer required regulatory or financing related payments

While these strategies may work on a short-term basis, in the long run they will ultimately harm the operator's cash flow. Among the negative long term effects are:

- By deferring capital expenditures, a facility's curb appeal or functionality will begin to deteriorate which may result in survey issues and/or decreased census.
- By stretching vendors, the operator's credibility will decline and the vendors may start charging late fees and/or place the operator on a "cash on delivery" or "cash in advance" status which will further tighten liquidity.
- By reducing staff, the operator may discover these staff members played a critical role in: maximizing reimbursement rates; building census; and/or controlling costs.
- By reducing marketing spend, the facility's census will begin to decline.
- By deferring regulatory payments, the operator will begin to incur fines and penalties.
- By deferring financing payments, the operator will most likely end up in default, start to incur default interest, and/or face loan acceleration.

It should be evident that these short term strategies may address the symptoms but not the cause. Furthermore, the reduced cash flows that stemmed initially from *external* financial pressures may end up being drained even further by both external and *internal* pressures.

Ultimately, the long term effect of external and internal pressures will negatively impact an operator's viability and that operator may find itself looking at an insolvent business that has residents depending on them for care.

"Providing the Highest Quality of Care"

As previously noted, "to provide the highest quality of care to residents" is typically part of a nursing care facility's mission or goal. So how do operators achieve their mission or goal to provide that highest quality of care?

First of all, the Minimum Data Set (MDS) is used to provide a standardized, primary screening and assessment tool of health status for all residents in a Medicare and/or Medicaid-certified facility. The MDS consists of an assessment of each patient's physical, psychological and social functioning, to ensure proper evaluation and care. Assessments are required on a prescribed timely basis and if a resident's status changes significantly, an additional assessment is done at that time.

Leveraging the MDS, successful operators provide the highest quality of care by preparing quality care plans, ensuring their facility is in proper operating condition, having the appropriate systems in place and acknowledging whether they have the proper staff and/or equipment to take care of the residents.

Exhibit 1: Financial Health Minimum Data Set (FHMDS) Categories

- Capital Structure
- Treasury Management
- Financial Reporting
- Financial Planning & Analysis
- Census and Payor Mix
- Census Development
- Clinical Reimbursement
- Referral Hospital Discharge Data
- Cost Control
- Required Staffing Levels & Payroll Management
- Surveys and Corrective Action Plans
- Fines and Penalties
- Risk Management (Regulatory and Legal)
- Physical Condition of Facilities and Equipment

Comparable to providing residents with the highest quality of care, operators must actively pursue a similar approach to cash management and operation of the business. In other words, they need to develop and utilize a care plan and assessment process for the business.

A Care Plan to Address Increasing Financial Pressures

Since operators cannot control external financial pressures, they always need to be prepared – easier said than done! Just as the MDS serves as a standardized, primary screening and assessment tool of a resident's health status by assessing various categories, the operator needs to have screening and assessment tools to monitor its operations and financial health. These screening and assessment tools can be referred to as *Financial Health MDS* (FHMDS). An operator's FHMDS should include the categories in Exhibit 1 (see top of page) among others.

While the frequency and approach to monitoring each category may differ from operator to operator, FHMDS categories must be continuously monitored to effectively inform and equip the operator's preparation for external financial pressures and corresponding internal pressures.

Tools to Assist in FHMDS Monitoring

While there may be multiple individuals and departments involved in monitoring FHMDS categories, the following tools which do not require sophisticated software to implement have been proven very successful in the monitoring process:

- Thirteen week cash flow forecasts
- Key performance indicators
- Heat maps

Thirteen Week Cash Flow Forecasts

A thirteen week cash flow forecast is a tool that provides the operator with a macro or "big picture" view of projected cash flows (inflows and outflows) over a rolling thirteen week period. By implementing this tool, it enables the operator to make better cash management decisions and also enable the operator to see if a liquidity crunch may be on the horizon. In summary, a 13 week cash flow forecast provides a view of the upcoming working capital needs and enables the operator to be proactive versus reactive.

Key Performance Indicators

Key performance indicators (KPIs) are *quantifiable* measurements that an operator can establish to evaluate critical success factors of the FHMDS categories. KPIs by definition provide operators with the most important performance information they need to proactively manage their business. KPIs may be financial or non-financial; however, the definition and accurate measurement of KPIs must be clearly established and consistently implemented. For example, the number of weekly tours may be established as a KPI under the FHMDS category "Census Development."

Heat Maps

The heat map is a tool that is relatively easy to implement and provides the operator with a macro visual representation of data wherein individual values (or ranges of values) contained in a matrix are displayed as different colors. A heat map can be used to help with analysis of many KPIs and categories of the FHMDS. For example, an operator of twenty facilities could develop an occupancy heat map for the FHMDS category "Census and Payor Mix, to show distribution of occupancy levels by facility. In short, a heat map is a very powerful tool to visually summarize a large quantity of data in a single graphic.

Summary

When external financial pressures exist for nursing care facilities, the solution to these externally imposed challenges will not always be short-term strategies; in fact, short-term strategies may ultimately worsen a situation. The solution is for operators to be prepared by having in place an effective "care plan" for dealing with increasing financial pressures. Consistent utilization of effective and efficient screening/assessment tools to monitor operations and financial health can facilitate a proactive stance and support optimum long term outcomes. In this article the reader has been introduced to the Financial Health Minimum Data Set, which provides an operator with a standardized, primary screening and assessment tool of financial health status for the business. Included in this approach are three proven tools to help an operator monitor its FHMDS: thirteen week cash flow forecast, key performance indicators, and heat maps.

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Martin has provided professional accounting and consulting advice to companies ranging from start-ups to Fortune 1000 companies for the last 25 years. Martin is a Certified Public Accountant and a Certified Insolvency and Restructuring Advisor. He currently serves on the Board of Directors for the Association of Insolvency & Restructuring Advisors. Marotta Gund Budd & Dzera, LLC (MGBD) is a financial advisory and restructuring firm that specializes in advising companies, creditors, investors and other parties with interests in companies facing operational and financial challenges. To learn more about developing a Care Plan for Dealing with Increasing Financial Pressures, contact Martin at **mcauz@mgbd.com**

Section 328(a): Professionals Should Be Aware That Obtaining Fee Enhancements Could Be Difficult

MICHAEL J. RIELA
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Investment bankers and other types of professionals for debtors and official committees often request bankruptcy courts to pre-approve the terms and conditions of their retention pursuant to section 328(a) of the Bankruptcy Code. A principal reason for this is that if a professional is retained under § 328(a), the court's authority to reduce that professional's compensation at the conclusion of the engagement is very limited. The reasonableness of the fees of professionals that are retained under section 330(a) of the Bankruptcy Code, on the other hand, is determined at the end of the professionals' engagements. Thus, by being retained under § 328(a) instead of § 330(a), a professional can be quite confident that its agreed-upon fees will not be reduced later.

However, as a number of cases have illustrated, courts' authority to grant fee *enhancements* to professionals retained under §328(a) may be quite limited as well. (In contrast, courts have significantly more leeway to grant fee enhancements to § 330(a) professionals.) This means that, in deciding whether to seek retention under § 328(a) or § 330(a) of the Bankruptcy Code, professionals should consider the benefit of restricting the court's authority to *reduce* their compensation, as well as the associated cost of limiting the court's authority to *enhance* their compensation after the engagement ends.

Sections 328(a) and 330(a) of the Bankruptcy Code

Section 328(a) of the Bankruptcy Code provides (emphasis added):

> The trustee, or a committee appointed under section 1102 of this title, with the court's approval, may employ or authorize the employment of a professional person under section 327 or 1103 of this title, as the case may be, on any reasonable terms and conditions of employment, including on a retainer, on an hourly basis, on a fixed or percentage fee basis, or on a contingent fee basis. Notwithstanding such terms and conditions, the court may allow compensation different from the compensation provided under such terms and conditions after the conclusion of such employment, *if such terms and conditions prove to have been improvident in light of developments not capable of being anticipated at the time of the fixing of such terms and conditions.*

11 U.S.C. § 328(a) (emphasis added).

Under § 328(a), the bankruptcy court determines the reasonableness of the professional's proposed terms and conditions of employment *at the time of retention*, and the court may deviate from the approved compensation terms (either to increase or reduce the professional's compensation) only if those terms were improvident in light of developments that were not capable of being anticipated at the time of the retention. Notably, the language of the statute implies that it is not enough for the subsequent developments to be unanticipated at the time of the retention. Rather, those developments must be *not capable of being anticipated* at the time of retention.

In contrast, professionals that are retained under § 330(a) of the Bankruptcy Code will have the reasonableness of their compensation determined at the conclusion of their employment (*e.g.*, after the effective date of a Chapter 11 plan or after conversion of a case to Chapter 7). As a result, bankruptcy courts have greater latitude to award fee enhancements to section 330(a) professionals. *See, e.g., In re Pilgrim's Pride Corp.*, 690 F.3d 650, 656 (5th Cir. 2012).

Sections 330(a)(1) and 330(a)(2) of the Bankruptcy Code provide, in relevant part:

> (1) After notice to the parties in interest and the United States Trustee and a hearing, and subject to sections 326, 328, and 329, the court may award to … a professional person employed under section 327 or 1103—
>
> (A) reasonable compensation for actual, necessary services rendered by the … professional person, …; and
>
> (B) reimbursement for actual, necessary expenses.
>
> (2) The court may, on its own motion or on the motion of the United States Trustee, the United States Trustee for the District or Region, the trustee for the estate, or any other party in interest, award compensation that is less than the amount of compensation that is requested.

11 U.S.C. §§ 330(a)(1) and (a)(2).

Further, section 330(a)(3) of the Bankruptcy Code provides that in determining the amount of reasonable compensation to be awarded, the court must "consider the nature, the extent, and the value of such services, taking into account all relevant factors," including six factors that are specified in subsection (a)(3).

The *FAH Liquidating Corp.* (Fisker)Decision

In *In re FAH Liquidating Corp. (f/k/a Fisker Automotive Holdings, Inc.)*, Case No. 13-13087 (Bankr. D. Del. Jan. 21, 2015) [Docket No. 1356], the U.S. Bankruptcy Court for the District of Delaware denied the fee enhancement requests of three professional firms that had represented the official committee of unsecured creditors in the case. Although the court acknowledged that the professionals "ably represented the Committee and the other unsecured creditors," it determined that the "requested fee enhancements, if allowed, would result in excessive compensation."

In the *FAH Liquidating Corp.* case, the debtors were founded with the goal of designing, assembling and manufacturing plug-in hybrid electric vehicles. However, the debtors were unsuccessful in their venture, and they filed voluntary chapter 11 petitions after an 18-month period of operational dormancy. The debtors filed their chapter 11 cases to accomplish the sale of substantially all of their assets to their secured creditor Hybrid Tech Holdings, LLC ("*Hybrid*"), which had purchased the secured debt from the United States Department of Energy at a significant discount. The debtors requested that the sale proceed on a very expedited basis (without a full post-petition marketing process), and that Hybrid be permitted to credit bid its secured claim in connection with the sale.

Promptly after the creditors' committee was appointed, its professionals undertook an investigation, obtained discovery and ultimately moved to limit Hybrid's right to credit bid under section 363(k) of the Bankruptcy Code. The bankruptcy court granted the committee's request to cap Hybrid's credit bid, and ordered the debtors to hold an open auction for their assets. A multi-day auction subsequently ensued, at the conclusion of which a different party prevailed with an all-cash bid.

The committee's attorneys and financial advisor, which were all retained under § 328(a) of the Bankruptcy Code, later requested fee enhancements in light of the results they achieved in the case and in light of the risk of non-payment they assumed early in the case. In particular, the professionals noted that at the time the debtors commenced their Chapter 11 cases, general unsecured creditors were expected to receive little or no recovery. They argued that because of their contributions (including their work in conducting the committee's own marketing process for the debtors' assets, identifying the eventual purchaser and securing alternative DIP financing on a subordinated basis), general unsecured creditors ultimately received a 40% recovery in the case. The professionals also noted that they achieved these impressive results during a very compressed timeframe. Both Hybrid and the Office of the United States Trustee opposed the professionals' request.In analyzing the professionals' request for fee enhancements, the bankruptcy court observed that § 328(a):operates as a two way ratchet: it may preclude reduction of compensation that in hindsight appears excessive, but it also may preclude an increase of compensation that in hindsight appears inadequate.

The bankruptcy court also characterized § 328(a) as a tradeoff, where "certainty and predictability come at the expense of flexibility." Professionals that are retained under § 328(a) bear the risk that they would be underpaid if their engagements require more work than they had initially expected.

The bankruptcy court denied the professionals' request for fee enhancements, stating that there was nothing in the record to support an enhancement under the rigorous § 328(a) standard. In particular, the bankruptcy court noted that there was no evidence that the amount of work required was unexpected, and it observed that the abbreviated timeframe of the case was entirely expected at the outset. The committee's professionals did not ask for any extensions of time, despite the bankruptcy court's invitations to do so. The bankruptcy court also observed that the professionals "did not have to look far" to find the buyer that ultimately prevailed during the auction, because that same buyer was the successful bidder in another bankruptcy case in which a major supplier to Fisker was the debtor (and the same professionals also represented the committee in the supplier's bankruptcy case).

Another reason the bankruptcy court decided to deny the professionals a fee enhancement was that unsecured creditors received less than a 100% recovery. In contrast, the bankruptcy court noted that in the vast majority of cases where fee enhancements were granted, unsecured creditors received a full recovery.[1]

The professionals have appealed the bankruptcy court's order to the U.S. District Court for the District of Delaware (Case No. 15-CV-00207). The appeal remains pending as of the date this article was written.

[1] The bankruptcy court noted that even had the professionals been retained under Section 330(a) of the Bankruptcy Code, it still would have denied the fee enhancement requests. In particular, the bankruptcy court noted that the professionals charged their full hourly rates, and that they did not bear a significant risk of non-payment. It also observed that while the professionals performed their services competently, their services were "not extraordinary." In addition, the bankruptcy court also denied the professionals' request for a substantial contribution claim, holding that they had missed the administrative claim bar date and that they were statutorily ineligible to assert such a claim under section 503(b)(3)(D) of the Bankruptcy Code.

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Other Decisions

Like the bankruptcy court in *In re FAH Liquidating Corp.*, the Fifth Circuit in *ASARCO, LLC v. Barclays Capital, Inc.* (*In re ASARCO, LLC*), 702 F.3d 250 (5th Cir. 2012) and the bankruptcy court in *In re Nucentrix Broadband Networks, Inc.*, 314 B.R. 574 (Bankr. N.D. Tex. 2004) both denied fee enhancement requests by professionals that were retained under section 328(a) of the Bankruptcy Code.

In *ASARCO*, the bankruptcy court had awarded the debtors' investment banking firm a fee enhancement of $975,000 (over the reorganized debtors' objection) to compensate the firm for services that had exceeded the scope of the engagement letter, which the firm nevertheless performed.[2] The district court affirmed the fee enhancement, holding that numerous developments had occurred in the case that were incapable of anticipation at the time the investment banking firm was retained. For example, the district court determined that at the time of the retention, the Chapter 11 cases were expected to conclude quickly. Instead, the cases lasted for several years. The district court also observed that the debtors' board members, executives and employees departed at an unusual pace. As a result, the investment banking firm had to recruit new board members and a new CEO, develop an employee retention plan, and perform other services that were outside the scope of the firm's engagement letter.

On further appeal, the Fifth Circuit reversed the fee enhancement award, concluding that the developments that led to the need for the investment banking firm to provide additional services were capable of being anticipated at the time of the firm's retention.[3] Rejecting the investment banking firm's contention that the debtors' stay in Chapter 11 was expected to be short, the Fifth Circuit concluded that the firm "could have and should have anticipated, within the meaning of Section 328(a), that a company in need of a Chapter 11 reorganization might have latent problems lurking under its hood." *In re ASARCO, LLC*, 702 F.3d at 264, citing *In re Home Express, Inc.*, 213 B.R. 162, 165 (Bankr. N.D. Cal. 1997) (stating that "bad management is too often the norm in Chapter 11 cases."). Those latent problems could transform what was expected to be a "pit-stop" in Chapter 11 into a lengthy reorganization process that requires considerably more work than was initially expected. *See id.* The Fifth Circuit also observed that at the time the firm was retained, one of the debtors' labor unions was on strike (and no end to the strike was in sight), and that the debtors' bankruptcy filing was precipitated by billions of dollars in environmental and asbestos liabilities, as well as a decline in copper prices. Thus, a long stay in Chapter 11 was foreseeable at the time the firm was retained. *See id.*Additionally, although the investment banking firm might have not actually anticipated the "extraordinary" level of exodus of executives and employees from the company that had occurred, the Fifth Circuit observed that executive and employee turnover generally is common in chapter 11 cases. The court stated that "[t]he fact that the number of personnel departures was above average, or even extraordinary, does not transform a foreseeable development into one that is incapable of anticipation." *Id. at* 266.

Finally, the Fifth Circuit determined that the terms of the investment banking firm's engagement letter contradicted its assertion that it expected the duration of the debtors' bankruptcy cases to be short. In particular, the engagement letter provided that the firm would receive a $100,000 monthly advisory fee for the first 24 months of the engagement, and that the monthly fee would be reduced to $75,000 thereafter. The Fifth Circuit construed this as evidence that the firm had in fact contemplated that the engagement may last more than two years. *See id.* at 265.

The *Nucentrix Broadband Networks, Inc.* case highlights the different burdens that § 328(a) professionals and § 330(a) professionals bear in obtaining fee enhancements. In that case, the debtors' investment banking firm was retained under § 328(a) of the Bankruptcy Code, while the debtors' law firm was retained under § 330(a). After the conclusion of a very successful § 363 sale that resulted in a 100% recovery for general unsecured creditors and a substantial distribution to equityholders, the debtors' law firm and investment banking firm requested fee enhancements. The investment banking firm argued that the results of the auction (and the resulting full recovery to creditors and distribution to equityholders) was not anticipated, and that those results justified an increase in its previously-approved § 328(a) compensation arrangement. The investment banking firm also noted that it had provided additional services to the debtors in connection with the sale of residual assets in four additional transactions, which were not contemplated at the time of retention.

Although the bankruptcy court characterized the Chapter 11 case overall as an "extraordinary success" and granted the law firm's fee enhancement request, it denied the investment banking firm's request. In denying the investment banking firm's fee enhancement request, the bankruptcy court observed that although no party expected that the section 363 auction process would be as successful to the degree that it was, a successful auction in general was certainly capable of being anticipated. *See*

[2] Although it awarded the $975,000 fee enhancement, the bankruptcy court denied the investment banking firm's request for a $2 million success fee and a $6 million "auction fee."

[3] The Fifth Circuit held that the question of whether subsequent developments were "not capable of being anticipated" at the time of the section 328(a) professional's retention is subject to *de novo* review. Accordingly, the circuit court gave no deference to the district court's determination that the developments in the *ASARCO* case were incapable of being anticipated at the time of the investment banking firm's retention.

In re Nucentrix Broadband Networks, Inc., 314 B.R. at 580. Further, the bankruptcy court rejected the investment banking firm's argument that its additional work with respect to the four residual asset sales justified a fee enhancement, noting that the engagement letter provided that the firm would be engaged for the sale of the debtors' assets "in one or more transactions." *See id.* The bankruptcy court stated that it decided to reject the investment banking firm's fee enhancement request "reluctantly," but that because the firm decided to obtain the protections of § 328(a), it must also live with the conditions of that section. *See id.* at 581.

In contrast to the *ASARCO* and the *Nucentrix Broadband Networks* cases, the bankruptcy court in *In re Uni-Marts, LLC*, No. 08-11037, 2010 WL 1347640 (Bankr. D. Del. Mar. 31, 2010) granted a fee enhancement to an investment banking firm that had been retained under § 330(a) of the Bankruptcy Code. In that case, the firm's compensation was equal to a percentage of the value of the sale of the debtors' assets. The firm requested a fee enhancement because it had to run two auction processes for the sale of the debtors' assets, because the prevailing bidder in the first auction had been unable to consummate the transaction. As a result, the firm spent more than 2,000 additional hours on the engagement, and the firm's blended hourly rate without the fee enhancement would have been less than $165 per hour. Although the bankruptcy court was "initially reluctant" to grant the firm's fee enhancement request because investment bankers are commonly compensated on a percentage basis, it noted that the debtors' and creditors' committee's support for the request was a major factor in its decision to grant the request. *See id.* at *4. In granting the firm's fee enhancement request, the bankruptcy court found it important that the firm had been retained under § 330(a), instead of § 328(a). *See id.* at 2.

Takeaways

Bankruptcy cases are inherently unpredictable, and cases that are initially expected to be short and simple can become protracted and complex. As a result, professionals for debtors and official committees could end up spending much more time on a case than originally expected. However, as illustrated by the cases above, if a § 328(a) professional seeks a fee enhancement upon the conclusion of its engagement, it will likely be held to a difficult-to-meet standard.

Professionals for debtors and official committees can decide whether to seek retention under section 328(a) of the Bankruptcy Code, and they should be aware of this potential drawback of utilizing § 328(a). This is particularly true for professionals that are compensated on a fixed fee or contingency fee basis because they could have to accept the same fee, regardless of whether they end up spending 500 hours or 5,000 hours on the engagement.

Prospective section 328(a) professionals should consider ways to address this issue when drafting their engagement letters and proposed retention orders. It would probably be helpful for those professionals to consult with counsel when drafting those documents.

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