

Private Ownership and Long-Term Care Facilities

July 1, 2025

Presented by Suzanne Koenig and Janus Pan

1

Presenters



Suzanne Koenig
Founder & CEO
SAK Healthcare
SKoenig@sakhealthcare.com



Janus Pan
Attorney
Greenberg Traurig, LLP
Janus.Pan@gtlaw.com



2

Presentation Topics

Private Ownership does not yield worse care than nonprofit ownership.

- Recent Enforcement Trends and Governmental Scrutiny on Standards of Care in Long Term Care
 - CMS Staffing Ratios – vacated by U.S. District Court for Northern District of Texas on 4/7/25.
 - Government scrutiny of private-owned (including private-equity) backed care.
 - False Claims Act and lack of medical necessity in submitted claims, including substandard care.
- Comparison of Nonprofit Care vs. Private Ownership-Backed Care (Private Equity or Direct Ownership)
 - Definition of Private Equity: Pooling together capital from investors to be managed by a professional advisor, to eventually sell for a profit.
 - Definition of Private Ownership: Direct ownership of a private company that owns or operates healthcare facilities.
 - When compared to nonprofit care, private ownership-backed care often has more training and teaching, better operations.

Comparison of Nonprofit Care vs. Private Ownership-Backed Care

Abstract

Since the 2000s, private equity (PE) firms have been actively acquiring nursing homes (NH). This has sparked concerns that with stronger profit motive and aggressive use of debt financing, PE ownership may tradeoff quality for higher profits. To empirically address this policy concern, we construct a panel dataset of all for-profit NHs in Ohio from 2005 to 2010 and link it with detailed resident-level data. We compare the quality of care provided to long-stay residents at PE NHs and other for-profit (non-PE) NHs. To account for unobservable resident selection, we use differential distance to the nearest PE NH relative to the nearest non-PE NH in an instrumental variables approach with and without NH fixed effects. In contrast to concerns of the public regarding quality deterioration associated with PE ownership, we find that PE ownership does not lead to lower quality for long-stay NH residents, at least in the medium term.

Similarly, previous research has found that 86 percent of nonprofit hospitals did not provide more charity care than the value of their tax exemption.⁴ Moreover, nonprofit hospitals have been found to have lower ratios of charity care to total expenses than for-profit hospitals.⁵ In this study we compared the changes in charity care spending versus cash reserve balances associated with changes in profits from 2012 to 2019. We found that increases in profit at nonprofit hospitals were not correlated with increases in charity care (exhibit 1).

- Various studies indicate that private ownership does not lead to lower quality of care in nursing homes and hospital systems.
- Steward Health Care System LLC, Prospect Medical Holdings: hospital chain bankruptcy case examples.

Provider Example: Sabra Health Care REIT and Regulatory Hurdles



Also, unattractive for acquisitions are SNFs that are losing a lot of money.

"[That] is a good starting point, and we see a fair amount of those, because oftentimes what we're seeing is a nonprofit ... divesting, because they're bleeding cash on the asset," Nevo-Hacohen. "And we're not doing managed assets in the SNF space."

Regarding a \$50 million skilled nursing facility (SNF) sale pending from last quarter, Matros said it was still expected to close, the delayed timing not changing the pricing for its sale.

"It's just in a state where there's a lot more regulatory hoops to come through, and there won't be any change on the proceeds that we're expecting," said Matros. "So it's going to just be one of those – it'll happen when it happens."

- Sabra Health Care REIT owns large portfolio of skilled nursing assets.
- Nonprofit skilled nursing facilities are recently bleeding cash and may not be operationally strong enough to overcome regulatory hurdles, including licensure applications.

Provider Example: Duly Health and Care and Private Equity Cash Infusion

Duly is among the many health care providers in the U.S. that have received capital infusions from private-equity firms – a trend that has sparked growing controversy and debate.

Private-equity firms say they provide a financial boost to health care providers, but critics argue the structure of the deals, which are often funded with loads of debt, can destabilize the balance sheet of otherwise healthy enterprises, making them more vulnerable to financial ruin down the line. The deals also often shift majority control of essential clinical services to private-equity firms, allowing financiers – not doctors – to dictate how patient care is provided and how much to charge for it.



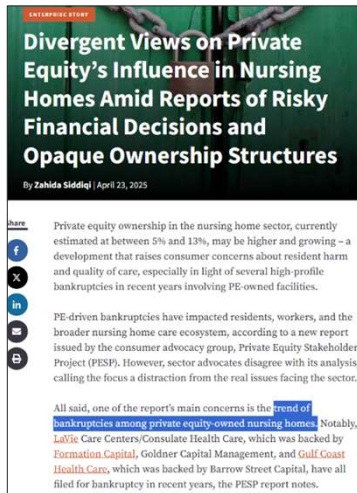
"Ultimately, whoever controls the dollars controls, really, everything," Jentel says. And private-equity firms are "going to have different priorities for where money is put in the company than someone whose priority is taking care of patients."

Duly Chief Physician Executive and Chairman Dr. Paul Merrick told Crain's the group has never required physicians to log more hours or expand caseloads, but says its providers sometimes see more patients than those employed at hospital chains because they are "highly engaged" in clinical care.

"We collaborate with physicians to maximize productivity and enhance patient care," Merrick says. "With support from our financial partner, we've deployed software tools and clinical governance protocols that align with the latest medical research and best practices."

- Duly Health and Care received private equity infusions, allowing it to adopt best practice software tools and clinical governance protocols.

Increased Governmental Scrutiny of Private-Ownership Provided Care



- Recent wave of private equity bankruptcies.
- Previous Biden Administration's and DOJ's focus on private ownership of nursing facilities.

Decreased Federal Governmental Scrutiny of Privately-Owned Care

District court strikes down CMS minimum nurse staffing rule

© Apr 08, 2025 - 04:04 PM



The U.S. District Court for the Northern District of Texas April 7 **vacated** the Centers for Medicare & Medicaid Services' minimum staffing mandate for nursing homes. The rule required all nursing homes to have an RN onsite and available to provide direct resident care 24/7. It also required a minimum of 0.55 hours per day for RNs, 2.45 hours per day for nursing assistants and 3.48 hours per day for total nurse staffing.

- CMS Proposed Minimum Staffing Ratio: On-site RN 24/7; 0.55 hours per day per RN; 2.45 hours per day per Nursing Assistant; 3.48 hours per day per Total Nursing Staffs.
- CMS Minimum Staffing Ratio vacated on April 7, 2025 in Texas court.
- HHS appealing decision to 5th Circuit Court of Appeals.

False Claims Act (FCA)



31 U.S.C. § 3729(a)(1)	Statutory Prohibition
(A)	Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval
(B)	Knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim
(C)	Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government
(G)	Conspires to violate a liability provision of the FCA

The FCA, 31 U.S.C. §§ 3729-3733, is the federal government's primary weapon to redress fraudulent claim submissions to governmental payor programs.

- The FCA provides for recovery of civil penalties and treble damages.
- The FCA requires “knowing” conduct, defined as (1) actual knowledge, (2) deliberate ignorance, or (3) reckless disregard.

False Claims Act, Medical Necessity, and Substandard Care



- “Medical Necessity” in Medicare: “No payment may be made. . . for any expenses incurred for items or services, which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” 42 U.S.C. § 1395y(a)(1)(A).
- “Substandard Care” and “worthless services.”
- Genesis Healthcare example: “unnecessary therapy and hospice services.”
- Philip Esformes’ medically unnecessary services billed through assisted living facilities and skilled nursing facilities.

Genesis Healthcare will pay \$53.6M to settle overbilling, 'substandard' care allegations

By Leslie Small · Jun 19, 2017 12:17pm

False Claims Act Hospice Lawsuits Overbilling

“Healthcare fraud is a hidden tax costing billions of dollars every year and, as in this case, too often threatens the very health of vulnerable patients,” said Special Agent in Charge Omar Pérez Aybar for the Office of Inspector General of the U.S. Department of Health and Human Services (HHS-OIG). “Esformes – who provided shoddy medical care – stands convicted of fraud and is now paying the price. We continue working tirelessly with our law enforcement partners to protect people in government health programs.”

According to the evidence presented at trial, between January 1998 and July 2016, Esformes led an extensive health care fraud conspiracy involving a network of assisted living facilities and skilled nursing facilities he owned. Esformes bribed physicians to admit patients into his facilities. Then, he cycled the patients through his facilities where they often failed to receive appropriate medical services or received medically unnecessary services billed to Medicare and Medicaid. Several witnesses testified to the poor conditions in the facilities and the inadequate care patients receive.

False Claims Act Focus on Nursing Homes

Among the 2023 cases highlighted by the federal government Thursday was a settlement in which the owners of [Saratoga Center for Rehabilitation and Skilled Nursing Care](#) and its owners agreed to pay \$7.1 million. The New York nursing home operators were accused of providing "worthless services" to residents over four years of mismanagement marked by what the government deemed patient safety violations and fraudulent billing.

EDITORS' PICKS

[VIEW ALL >](#)

Supply side economics?



- Healthcare providers paid government \$1.67 billion to resolve healthcare claims in 2024 and paid \$2.7 billion in 2023.

Special Notes on Receiverships



In a real-estate default, lenders/landlords can foreclose against property.



Receivers can be appointed in State or Federal court.



The Receivership Estate includes all assets, and only liabilities incurred after the Receiver's appointment.



Receivership involves both the healthcare business and the healthcare real property.



Pitfalls of receiverships include: license loss, management, funding, staff, patient/resident retention, bankruptcy filings and Tenant avoiding liabilities.



A Receiver takes control of property and related businesses pending results of foreclosure.



Receivership allows for orderly transition to new operator or new buyer.



Receivership insulates lender / landlord from risks associated with operating a healthcare business.



Receiverships are cost-effective.

Special Notes on Receiverships (continued)

McKnight's
Long-Term Care News

NEWS • COLUMN • RESOURCES • WEBINARS/EVENTS • MAGAZINE • TOPICS •

Search

DAILY UPDATE NEWS

Success, not distress, with these steps, NIC panel advises LTC operators

JAMES M. BERKMAN
MARCH 11, 2025
SHARE

Mike Flanagan and Suzanne Koenig addressed attendees about operational best practices at the 2025 NIC spring conference in San Diego. (Photo: Tori Seger)

TOP STORIES

NEWS

Providers fighting for better Senate budget bill after 'cold-hearted' House version passes

NEWS

Illinois providers split on fighting new bed tax

DAILY UPDATE NEWS

This polypharmacy initiative moved one-third of nursing home residents away from dangerous

Regulatory compliance problems require giving managers and staff the resources they need to improve care, she added. If occupancy is a major problem, a detailed market study should be undertaken to best understand the competition, pay rates and levels of care that are needed — and not needed. "Make difficult decisions on service lines if you have to."

Fellow panelist Suzanne Koenig, the CEO of SAK Management services, also emphasized personnel issues as a way to avoid distress.

"Make sure you have somebody [qualified] in leadership, especially in receivership or bankruptcy," she advised. "You have to have a leader who can work with the people because your staff in there are freaking out. They don't understand what the stress is."

She reminded, too, that a principle critical to many business, whether for-profit or nonprofit, is still vital: "Cash is queen — you have to know what your current cash is."

"You have to have somebody who knows how to put together your projections. That's the key," she added. "And it has to be somebody who knows senior care and housing. Your people who are doing these projections have to know when this money is coming in, and how it is coming in, and project out a 13-week cash flow."

- Current cash position; future cash projections.
- Smooth transition of operations, to oversee staff.

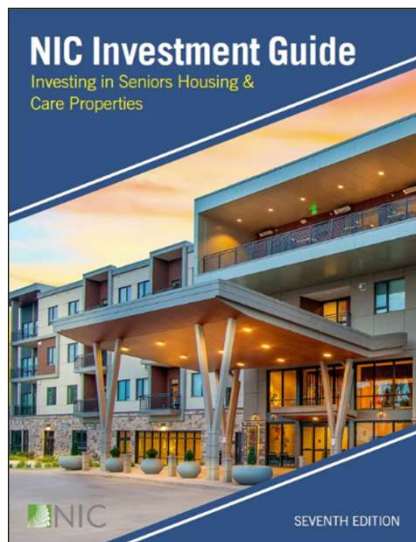
Issues Checklist for Troubled Assets (including Receiverships)

Issues	Related Items & Notes
Cash Position - Current	<ul style="list-style-type: none"> • Current cash available • Cash projections • Other sources of funds
Cash Position - Longer Term	<ul style="list-style-type: none"> • Existing debt • Owner/lender commitment to fund
Licensure Status	<ul style="list-style-type: none"> • Regulatory filing requirements (Change of Ownership, aka "CHOW" Applications) • Possibility to obtain new license if transitioned • Gap in license coverage and validity
Regulatory Status	<ul style="list-style-type: none"> • Open citations and cycles • Special Focus Facility (SFF) list • Legal diligence (current encumbrances, bankruptcies and litigation)
Legal Transaction Documents for Long-Term Care Facilities	<ul style="list-style-type: none"> • Asset Purchase, Stock Purchase Agreements, Operations Transfer Agreement • Lease and Management Agreements • Resident Agreements
Leadership	<ul style="list-style-type: none"> • Open leadership positions; high-level review of key leaders • Employment of key leaders if transitioning operations
Ownership and Governance	<ul style="list-style-type: none"> • Detailed ownership review including OpCo and PropCo, leases, investors, etc. • Current governance structure and involvement • Commitment to safety of residents
CapEx	<ul style="list-style-type: none"> • Urgent expenditure needs • Existing capital planning • Long-term capital needs to compete
Market Demand Report	<ul style="list-style-type: none"> • Local occupancy and rate comparison • 1-5 year market demand • Asset positioning report
Labor Availability Summary	<ul style="list-style-type: none"> • Current staffing model sustainability • Agency availability and cost • Review of 1-5 year labor market summary • Regulatory staffing ratio requirements

Paths Forward for Troubled Assets:

- Sale (improvement to drive price, fire sale, etc.)
- Closure (all of asset, certain parts of campus, etc.)
- Restructure / Bankruptcy (debt, management, operations, etc.)

Other Reference Resources



National Investment Center:
<https://store.nic.org/collections/frontpage/products/nic-investment-guide-investing-in-seniors-housing-care-properties-seventh-edition>



<https://www.mcknights.com/print-issue-archive/>



<https://www.btgvoice.com/full-episode/379-suzy-koenig-resident-advocacy-in-community-distress-with-suzy-koenig>

15

Takeaways

Private Ownership

Increasing trend of private equity and private ownership acquisition of long-term care facilities, such as nursing homes and assisted living facilities.

Better Care in Private Ownerships

Private ownership of long-term care facilities oftentimes results in similar or better standards of care than nonprofit ownership.

Regulatory Scrutiny

Private owners and private equity entering the long-term care space should watch for regulatory scrutiny and standards of care such as nurse staffing ratios.

16

Takeaway Form – Management Transition Agreement for Sales of Long-Term Care Facilities

MANAGEMENT AND TRANSITION AGREEMENT	
<p>THIS MANAGEMENT AND TRANSITION AGREEMENT ("Agreement"), dated as of _____, is made by and among _____ ("Licensee"), _____ ("Manager"), _____ ("License Parent"), and _____ ("New Operator"), and joined by _____ ("Owner") solely for the purposes of acknowledging its rights hereunder and approving this agreement between the other parties.</p>	
<p>RECITALS:</p> <p>A. Owner owns the real estate, improvements, fixtures, furniture and equipment of that certain skilled nursing facility and related operations known as _____ located at _____ (the "Facility").</p> <p>B. Pursuant to the terms of that [Lease Agreement] by and between Owner and Licensee dated _____ (the "Lease") Licensee previously leased the Facility from Owner on terms more fully described therein.</p> <p>C. On or about _____, Owner terminated the Lease in accordance with the terms thereof and applicable law.</p> <p>D. Licensee currently remains in possession of the Facility as a holdover tenant and tenant in reference and licensed operator of the Facility and is party to certain Medicare and Medicaid Provider Agreements concerning the rendering of goods and services to beneficiaries of the Medicare and Medicaid programs at the Facility.</p> <p>E. On _____, Licensee, along with various affiliated and subsidiary entities (collectively, the "Debtors"), including License Parent and Manager, each filed for relief under Chapter 11 of Title 11 of the United States Code (the "Bankruptcy Code") in the United States Bankruptcy Court for the Northern District of _____ Division (the "Bankruptcy Court") and such court proceedings, collectively, the "Bankruptcy Proceedings" or "Bankruptcy Case" and Licensee continues in business as debtor and debtor in possession under sections 1107(a) and 1108 of the Bankruptcy Code.</p> <p>F. The parties desire, subject to obtaining the approval of the Bankruptcy Court with respect to the Bankruptcy Proceedings, to arrange for the orderly transition of the operation of the Facility from the Licensee to the New Operator and to document certain terms and conditions relevant to the transition of operational and financial responsibility for the Facility.</p> <p>G. In order to facilitate the expedient and efficient transfer of the operations to the New Operator as soon as possible, Licensee and New Operator desire that commencing at 12:01 A.M. in time zone applicable to such Facility, on the Effective Date (as hereinafter defined), New Operator shall manage the operation of the Facility pursuant to the terms of this Agreement on an interim basis until the Closing Date (as hereinafter defined) has occurred. For purposes hereof, the "Closing Date" shall be the later of: (1) the date New Operator secures such acceptable written</p>	
<p>assurances from the appropriate governing authorities as it may deem to be necessary and appropriate to confirm that New Operator has been duly licensed and permitted to operate the Facility under its own operating license (the "New License"), or (2) the date New Operator is duly authorized and certified to participate in the Medicare and Medicaid Programs at the Facility under the assumed and assigned provider agreements (collectively the "License and Certification Approvals"), at which time Licensee will surrender any remaining right, title and interest in, to and under the Facility and its operations to New Operator or its designee and the New Operator shall lease the Facility directly from Owner under the terms of a new lease. The period commencing on the Effective Date and ending on the Closing Date shall be referred to herein as the "Management Period."</p> <p>H. For purposes hereof, the "Effective Date" shall be the later of _____ or that date on which the Approval Order (as defined below) is entered by the Bankruptcy Court. For purposes of this Agreement, "Approval Order" shall mean an order of the Bankruptcy Court, in form and substance acceptable to both Debtors, New Operator and Owner: (a) approving this Agreement, and authorizing and directing the Debtors party hereto to execute and perform this Agreement, as well as any and all additional documents, instruments, notices or waivers that may be necessary in furtherance thereof (collectively due "Related Agreements"); (b) approving the assumption by Licensee and assignment to New Operator of Licensee's Medicare and Medicaid Provider Agreements pursuant to Bankruptcy Code Section 365 on the Closing Date; (c) granting Owner an administrative expense claim against the Debtors' bankruptcy estates pursuant to Bankruptcy Code Sections 365(d)(2) and 559(b)(1)(A) with respect to rent owed in connection with Licensee's post-petition occupancy of the Facility, the amount of which claim shall either be: (i) consented to by both Licensee and Owner or (ii) determined by the Bankruptcy Court after notice and a hearing prior to the entry of such Approval Order (the "Post-Petition Rent Claim"); (d) authorizing and directing Licensee to pay to Owner the full amount of such Post-Petition Rent Claim in cash or cash equivalent on or before fifteen (15) calendar days after the entry of such Approval Order; (e) approving the provisions for indemnification set forth within Section _____ of this Agreement; (f) approving the compromises and settlements between Licensee and Owner that are reflected within this Agreement pursuant to Rule 9019 of the Federal Rules of Bankruptcy Procedure (the "Bankruptcy Rules"); (g) lifting any and all stays or suspensions imposed by Bankruptcy Code Sections 105 or 362 or otherwise as necessary to permit each of Licensee, Owner and New Operator to perform the terms of this Agreement; and (h) waiving application of Bankruptcy Rules 4001(a)(3) and 604(g) with respect to such Approval Order.</p> <p>I. Licensee has agreed herein to assume and assign, under the terms of Bankruptcy Code Section 365, its Medicare and Medicaid provider agreements with the Centers for Medicare and Medicaid Services ("CMS") and the appropriate state agency (the "Existing Provider Agreements") to New Operator as of the Closing Date. In order to ensure the continued reimbursement to New Operator for services rendered and goods sold by New Operator to Medicare and Medicaid beneficiaries from and after the Effective Date until the Closing Date, Licensee has agreed herein to allow New Operator to bill for such services and goods rendered from and after the Effective Date by New Operator under the Existing Provider Agreements and provider numbers and further agree that all revenue billed or received by New Operator under the Existing Provider Agreements for services rendered by the New Operator from and after the</p>	
<p>2</p>	
<p>Effective Date shall be the sole and absolute property of the New Operator, free and clear of all liens of any nature whatsoever.</p> <p>NOW, THEREFORE, in consideration of the foregoing, the mutual</p>	
<p>judgments, liens or sums incurred by Licensee and Owner which are caused by such violation or contents. Such amounts shall be payable by New Operator upon demand of Licensee or Owner. New Operator retains the right to join Licensee in contesting and actions upon providing Licensee with such notice.</p>	

- Allocates Medicare, Medicaid, and other payor payments between Buyer and Seller during the interim period between Closing and payor switches of payments
- Provides for management of facility during any receivership / interim periods
- Allocates rights and obligations associated with healthcare licenses during any interim periods