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SO MANY TROUBLED CALIFORNIA HEALTH CARE DISTRICTS, SO MANY HAVE FILED CHAPTER 9--LESSONS TO BE LEARNED

I. Introduction [2]

A. Health Care Districts in California

Near the end of World War II, California faced a severe shortage of hospital beds. The situation, especially in rural areas, was exacerbated by the return of thousands of U.S. soldiers in need of regular medical care and hospitalization. To respond to the inadequacy of acute care services in non-urban areas, the legislature enacted the Local Hospital District Law in 1945. [3] The intent was "to give rural, low-income areas without ready access to hospital facilities a source of tax dollars that could be used to construct and operate community hospitals and health care institutions in medically underserved areas, to recruit physicians and support their practices." [4]

The Local Hospital District Law allowed communities to create a new governmental entity, independent of local and county jurisdictions, that had the power to impose property taxes, enter into contracts, purchase property, issue debt, and hire staff. In general, the process of creating a hospital district started with citizens in the community identifying the need for improved access to medical care that was not being met by existing facilities. A petition for formation was filed by the community to the county board of supervisors, and residents of the proposed district then voted in favor of the measure to create the hospital district. In 1963, the Knox Nisbet Act created Local Area Formation Commissions (LAFCOs) and ***190** clarified and formalized the process for establishing, consolidating or dissolving hospital districts. [5]

From the start, hospital districts have had the power "to do any and all things that are necessary for, and to the advantage of," any type of health promoting service or health care facility. In addition to establishing, maintaining and operating hospitals, hospital districts can support outpatient, retirement and chemical dependency programs, operate ambulance services, operate or support clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and "any other health care services provider, groups, and organizations that are necessary for the maintenance of good physical and mental health in the communities served by the district." [6]

Typically, district hospitals created under the Local Hospital District Law were small, independent facilities, and many had "difficulty keeping up with industry changes." [7] Many district officials felt, however, "that their mission [was] changing; as hospitals move away from acute care towards health maintenance, their statutes need[ed] to change too." [8] In recognition of the broad variety of healthcare services being provided outside of hospital settings, as well as the need of hospitals to diversify and stay competitive, the legislature changed the designation "hospital districts" to "health care districts" in 1994. [9]

According to information from 2017, there are 79 health care districts in California, of which 54 are in rural areas. Of the total number of districts, 38 own and operate a hospital, five own but do not operate a hospital, and 36 do not own or operate a hospital.

Of the 36 districts that neither own nor operate a hospital, 19 provide direct services, seven provide ambulance services, three have clinics, one provides ambulance services and has a clinic, four have skilled nursing facilities, and four provide community based services. Seventeen districts do not provide any ***191** direct services and instead administer grant funding as their sole purpose. The districts employ some 32,000 people throughout the state. Their hospitals (comprising approximately 10% of the hospitals in California) provide a significant portion of medical care to minority populations and uninsured in medically underserved regions of the state, and are mainly funded by Medicare, Medi-Cal, and district tax dollars. [10]

Health care districts in California are authorized to incur various types of debt, [11] including general obligation bonds that are paid from *ad valorem* property taxes levied on property within the district. [12] They may also incur debt secured by district revenues, including revenue bonds, [13] certificates of participation (COPs), [14] and Cal-Mortgage insured revenue bonds. [15]

B. The Ability of Health Care Districts to Obtain Bankruptcy Relief

A health care district is a "municipality" within the meaning of section 101(40) of the Bankruptcy Code. [16] As a result, it may only obtain relief under the Bankruptcy Code by filing a voluntary petition for relief under chapter 9 and demonstrating that it is eligible to be a "debtor" under that chapter within the meaning of Bankruptcy Code section 109(c).

***192** Under Bankruptcy Code section 109(c)(2), a key requirement for a municipality to obtain chapter 9 relief is that it must be permitted to seek such relief under state law. [17] Prior to 2012, local public entities in California, including health care districts, were freely authorized to file chapter 9 petitions. In 2012, the statutory permission was tightened to require the local public entities to either engage in a pre-filing "neutral evaluation" with their major creditor constituencies or, alternatively, to declare a fiscal emergency by majority vote at a public hearing. [18]

Chapter 9 of the Bankruptcy Code was designed to provide a mechanism under which a financially distressed municipality may obtain bankruptcy relief without violating the Tenth Amendment of the United States Constitution. The Tenth Amendment states that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." Thus, Bankruptcy Code section 903 provides that chapter 9 "does not limit or impair the power of a State to control, by legislation or otherwise, a municipality of or in such State in the exercise of the political or government powers of such municipality, including expenditures for such exercise ...." Similarly, under Bankruptcy Code section 904, bankruptcy courts are not permitted to "interfere with (1) any of the political or governmental powers of the debtor; (2) any of the property or revenues of the debtor; or (3) the debtor's use or enjoyment of any income-producing property."

The authority of bankruptcy courts to act in chapter 9 cases is therefore far more limited than in cases under chapter 11 or chapter 7. Among other things, bankruptcy court approval is not required for a chapter 9 debtor to use, lease or sell property, obtain new unsecured financing in the ordinary course with administrative expense priority under Bankruptcy Code section 364(a) or (b), or retain and compensate professionals. [19] Effectively, the bankruptcy court's authority is limited to (1) determinations of eligibility under ***193** Bankruptcy Code section 109(c), (2) approving secured or superpriority administrative expense financing, (3) approving the assumption or rejection of executory contracts and unexpired leases, including collective bargaining agreements, (4) confirming or denying confirmation of the debtor's plan of adjustment, and (5) dismissing the bankruptcy case. [20]

C. The Challenges Facing California Health Care Districts

The financial pressures on California health care districts reflect the pressures on rural hospitals throughout the United States. The most commonly mentioned cause is the "steady decline in patient volume" (due to a material shift of patient care from hospital care to outpatient settings), usually coupled with the "pressure on operating income from bad-debt write-offs, increased charity cases and Medicaid and Medicare underpayments." [21] Commentators also point to the domino effect of the "2008-2009 recession, followed by 2% Medicare payment cuts in 2011, a 30% to 35% reduction in reimbursement for Medicare patients who can't cover their out-of-pocket expenses in 2012, and the 2013 across-the-board 2% budget sequestration." [22] Commercial

payers' linking of their reimbursement rates to Medicare and Medicaid rates (usually reimbursing at the same level or a small percentage above it) has also become a factor. [23]

***194** Another challenge is the shift from fee for service (where each procedure is paid for separately) to a capitation or bundled payment system "where the hospital receives one fixed payment for the entire 'episode of care' regardless of the number of procedures or length of stay." [24] This requires providers to "develop or participate in efficient and effective care delivery networks that focus on preventative health and chronic disease management across the care continuum, from primary care clinics through skilled nursing facilities." [25] The capitation system also requires a "more sophisticated technology system to track metrics to qualify for value-based care," and smaller hospitals typically do not have that type of funding available. [26]

Staffing and recruitment are particularly troublesome, as it is difficult to keep a smaller, usually rural hospital fully staffed. [27] "Efforts to recruit and retain nurses, such as sign-on bonuses and generous fringe benefits, are an increasing expense." [28] The nurse shortages hit rural hospitals harder than urban hospitals because "large urban hospitals generally are closer to nursing schools, can pay higher wages and offer more job opportunities for spouses." [29]

Recent developments present additional challenges to economic stability. With the passage of the Affordable Care Act, the growing emphasis on wellness and preventive care will most likely support the drive toward less hospitalization. [30] Problems associated with the implementation of electronic health records or electronic medical records systems are surfacing. These systems have proven time consuming (with possible lead times of 18 to 24 months) and expensive to implement, disrupt revenue and collection activities, and drive up operating expenses. [31] Hospitals must also maintain or upgrade aging equipment and ***195** infrastructure and find construction funding to meet California's seismic safety requirements for hospitals. [32] Finally, a large percentage of California hospitals are reportedly being hit by Medicare reimbursement penalties "due to underperformance on 30-day readmissions." [33]

California health care districts continue to suffer the consequences of these deep-seated structural problems. As set forth in *Appendix I*, health care districts in California have filed 25 chapter 9 cases since 1991. Of these, five districts have filed twice.

The outcomes of these cases have not favored continuation of district hospitals in their original form. As summarized in *Appendix II*, only ten (or 50%) of the 20 hospitals that filed for chapter 9 protection remained in operation as acute care hospitals. Of those ten, five are being operated by third parties through sales or other transfers, leaving only five still operated by their districts. Interestingly, all of the five surviving district operated hospitals are designated "critical access hospitals," thereby entitling them to increased Medicare reimbursement rates for services rendered. [34]

Of the remaining ten districts, five closed their hospitals completely and now limit their operations to providing ambulance services (one district) or community grants (two districts) or have left their hospital properties vacant (two districts). The rest closed their hospitals, and the facilities were re-purposed for another health care use (a rehabilitation center or skilled nursing facility), usually through a sale to a third party.

There is, however, one common denominator for nearly all of the health care district bankruptcy cases. Almost all of the districts are located in rural areas of California.

***196** This is not surprising. Rural hospitals are traditionally small, with the increased financial risk associated with small stand-alone hospitals. Those risks include typically weaker "enterprise value profiles," such as a "high dependence on a small number of physicians for patient volumes," operating with a "limited population base served," and "generally weaker demographic and economic characteristics." [35] They rely more on Medicare and Medicaid, so they struggle with reimbursement rates. Patient volumes are more inconsistent, and long-term demographics reflect a shift in population away from rural areas. [36] "[R]esidents of rural communities are typically older and poorer, more dependent on public insurance programs, and in worse health than urban residents." [37]

The difficulties experienced by rural hospitals both in California and nationally are not new. From 1995 to 2016, the total number of rural hospitals in California declined by over 25% (from 79 to 59). [38] Nationally, the rate of rural hospital closures

may be accelerating. According to a study published by the National Rural Health Association (NRHA), from 2013 to 2014 the "number of rural, short-term acute hospital closures was more than twice the number in 2011." [39] A recent study by consulting firm Navigant concluded that one in five rural hospitals is at risk of closure due to financial distress. [40] Although the California Health Care Foundation (CHCF) has reported that the number of rural hospitals in California may have stabilized in recent years (from 2011 to 2016), five California health care districts have filed for chapter 9 protection since 2016. As ***197** observed by the CHCF, the continued existence of bankruptcy filings "underscore[s] the ongoing financial pressure on [rural] hospitals." [41]

It should also be noted that the impact of health care district bankruptcies and hospital closures on surrounding communities reaches far beyond reduced access to critical care. As the NRHA has observed, the community frequently also loses access to primary care, because most physicians are hospital-based. "If the hospital closes, you also lose the physicians, the nurses, the physician assistants. We're getting these complete medical deserts forming," with serious consequences. [42] According to a recent study of hospital closures in California, rural hospital closures increase mortality rates in the affected areas by 5.9%. [43] Moreover, hospitals are often the "economic drivers of rural communities. Per capita income falls 4% and the unemployment rate rises 1.6 percentage points when a hospital closes." [44] The NRHA is reported to have estimated that rural hospitals represent as much as 20% of local salaries and wages. "The average rural critical access hospital alone creates around 195 jobs and generates about $8.4 million in payroll annually." When a hospital closes, physicians leave the area and do not come back, young families will not "move into an area without access to a local emergency room," and "[i]t can really close down that town." [45] Thus, the success of hospitals in all of these communities should be of vital interest not only to those seeking to make ***198** healthcare accessible to all, but also to those who wish to preserve and protect a way of life in rural America.

The fate of each California health care district that has filed a chapter 9 case is described below, together with the reported bankruptcy court decisions issued in each case.

II. Large Health Care District Bankruptcies

A. Valley Health System (C.D. Cal. 2007)

Valley Health System (VHS) was formed in 1946. At the time of the commencement of its chapter 9 case on December 13, 2007, [46] VHS owned and operated three hospitals and a skilled nursing facility in Riverside County: Hemet Valley Medical Center, a 340-bed hospital in Hemet; Menifee Valley Medical Center, a 84-bed hospital in Sun City; Moreno Valley Community Hospital, a 95-bed hospital in Moreno Valley; and Hemet Valley HealthCare Center, a 113-bed skilled nursing facility in Hemet. VHS had sustained a net loss of $7.5 million for the fiscal year ending June 30, 2009, which was an improvement over the $17.8 million loss for the prior year. Bond debt, under two issues of bonds, totaled $84 million.

During the chapter 9 case, (a) the bankruptcy court approved the sale of the Moreno Valley hospital to Kaiser Hospital Foundation for approximately $53 million, and (b) VHS closed the skilled nursing facility. VHS also successfully renegotiated payor contracts and its collective bargaining agreements with the Service Employees International Union (SEIU) and California Nurses Association (CNA). Pursuant to its plan of adjustment, confirmed on April 26, 2010, VHS sold its remaining two hospitals to Physicians for Healthy Hospitals (PHH), a nonprofit corporation, for total consideration of more than $75 million. The sale was subject to voter approval, which they overwhelmingly gave by an affirmative vote of 87.07%. After the sale of substantially all of its assets, VHS continued to support community healthcare projects through the administration of grants. [47]

The bankruptcy court issued three reported decisions in the VHS chapter 9 case. In the first decision, the court overruled an objection to the chapter 9 petition ***199** by U.S. Bank, as indenture trustee for the bondholders. [48] According to U.S. Bank, VHS was ineligible for chapter 9 relief because it failed to satisfy the eligibility requirements of Bankruptcy Code section 109(c)(5), which required that VHS prove that it was "unable to negotiate with creditors" prior to filing the petition "because such negotiation [was] impracticable."

In determining that VHS had satisfied section 109(c)(5), the bankruptcy court observed that VHS had more than 5,000 creditors and had attempted to resolve its financial problems prior to the filing of its petition, through either a restructuring of its debt or the sale of assets. Both of these efforts were unsuccessful due to rejection by voters of two ballot measures--one to

issue $485 million in general obligation bonds, secured by property tax revenues, to retire VHS's special revenue bond debt, finance capital improvements and provide VHS with the time and capital to return to profitability, and the other to approve the sale of substantially all of its assets to Select HealthCare Solutions. Under these circumstances, the bankruptcy court concluded that meaningful negotiation "is infeasible, if not impossible" absent a plan of adjustment under chapter 9.

In the second reported decision, the bankruptcy court ruled that the appointment of a patient care ombudsman under Bankruptcy Code section 331(a)(1) was not necessary under the specific facts of the case. [49] Among the factors considered by the bankruptcy court were that: (a) VHS had sought relief under chapter 9 primarily due to the burden of servicing its bonds and problems stemming from its capitation relationships, and there were no allegations of deficient patient care or privacy concerns; (b) VHS was already subject to substantial monitoring by federal and state regulatory agencies and independent accreditation associations; (c) VHS had adopted extensive and redundant internal procedures to ensure the highest level of patient care and resolve any complaints relating to same expeditiously; and (d) a patient care ombudsman could result in substantial administrative expense to the debtor.

The third reported decision overruled numerous objections to confirmation of VHS's plan of adjustment. [50] Of particular interest was the objection by Prime Healthcare Management, who sought to prevent consummation of the sale to PHH on the ground that the VHS Board of Directors had granted PHH an exclusive right ***200** to negotiate sale terms with VHS for a period of 90 days, thereby blocking Prime from negotiating a competing offer and violating the Board's fiduciary duty to maximize the sale price. In overruling this objection, the bankruptcy court focused on the difference between chapter 9 and chapter 11. While a "no shop" provision would not be permitted under chapter 11, where the debtor-in-possession has a fiduciary obligation to maximize the estate's value, chapter 9 is different. There is no concept of a debtor-in-possession in chapter 9, and neither Bankruptcy Code section 541 (defining "property of the estate") nor Bankruptcy Code section 363 (regulating the use, sale or lease of property) is incorporated in chapter 9. By virtue of Bankruptcy Code section 904, the debtor retains title to, possession of, and complete control over its property and its operations. Thus, it is not restricted in its ability to sell, use or lease its property and may implement buyer protections that would not be permissible in a chapter 11 case.

The bankruptcy court further observed that VHS was a health care district, with its powers enumerated in California Health & Safety Code section 32121, including the power "[t]o transfer, at fair market value, any part of its assets to nonprofit corporations to operate and maintain the assets." [51] The bankruptcy court found that there is nothing in that section, or any other provision of the Local Health Care District Law [52] that imposes fiduciary obligations on the board of directors of a local health care district. Moreover, the statutory authorization to transfer assets, by its terms, does not require competitive bidding. [53] Thus, the "no shop" agreement with PHH violated no fiduciary duty, and the Board had no obligation to submit the proposed sale of assets to a competitive bidding process. [54]

B. West Contra Costa Healthcare District, dba Doctors Medical Center (N.D. Cal. 2006 and 2016)

West Contra Costa Healthcare District was formed in 1948. It completed construction of a hospital in San Pablo (Contra Costa County), known as Brookside Hospital, in 1954. The hospital operated at a significant loss until 1997, when the District leased the hospital to Tenet Healthcare Corporation. Tenet changed the ***201** name of the hospital to Doctors Medical Center and combined it with a second Tenet-operated Doctors Medical Center in Pinole (Contra Costa County). Tenet operated the two hospitals until August 1, 2004, when it terminated its agreement with the District and returned control of both facilities to the District.

The District suffered a loss of $29.7 million during the first nine months of 2006 and filed a chapter 9 petition on October 1, 2006. [55] This was the first of the District's two chapter 9 cases. At that time, the San Pablo hospital had 189 beds, and the Pinole hospital had 70 beds. Immediately after the commencement of the chapter 9 case, the bankruptcy court approved a stipulation with Tenet that terminated the District's liability under a sublease for the Pinole hospital, and the Pinole facility was closed. The District also entered into a joint powers agreement with Contra Costa County that created the Doctors Medical Center Joint Management Authority (JPA). Concurrently with the creation of the JPA, the District received an intergovernmental transfer of $10 million from the County that enabled the District to receive matching funds resulting in a $20 million cash infusion. With approval of the bankruptcy court, the District agreed to repay $11.5 million to the County by transfer from *ad valorem* tax

revenues pursuant to a tax allocation agreement between the District and the County. The District's plan of adjustment, which established the DMC Trust for payments to creditors, was confirmed on August 19, 2008. [56]

The bankruptcy court issued a reported decision during this chapter 9 case in connection with a complaint by the trustee of the DMC Trust to recover $980,000 in allegedly fraudulent transfers made to Tenet of pre-petition sublease payments for the Pinole hospital. [57] The bankruptcy court granted summary judgment in favor of Tenet on the ground that the District was not insolvent on the date it incurred its obligations to Tenet by entering into the sublease. The definition of "insolvent" for a municipality under Bankruptcy Code section 101(32)(C) is that the debtor is either (i) generally not paying its debts as they become due, or (ii) unable to pay its debts as they become due. The balance sheet test for insolvency, which applies to other types of entities, does not apply to municipalities. Thus, although the District's financial condition was deteriorating, the District was successfully ***202** reducing its expenses and able to pay the bulk of its debts as they became due. Accordingly, the District was not "insolvent."

By 2011, the funding secured during the first chapter 9 case had been reduced by 93%, and the District again faced a significant financial shortfall. District voters approved an additional parcel tax, and the District used the future proceeds to secure an additional $35 million in long-term municipal financing through Certificates of Participation (COPs). The COPs were used to refinance a portion of an earlier issue of COPs issued in 2004 and for general operating expenses of the District. With the San Pablo hospital continuing to lose money, and the District unable secure additional financing, the District closed the hospital on April 21, 2015.

In January 2016, the District accepted an offer to sell the hospital property to Royal Guest Hotels, a boutique hotel operator, for $13.5 million. Royal Guest rescinded the offer in September 2016, and the District filed a second chapter 11 petition on October 20, 2016. [58] Pursuant to Bankruptcy Code section 928(b), the bankruptcy court authorized the District to use "special revenues" (the *ad valorem* parcel tax revenues securing payment of the COPs) to pay the continuing expenses of the closed hospital.

The District continued its efforts to sell the San Pablo hospital property, and on January 2, 2018, the bankruptcy court confirmed the District's second plan of adjustment. The plan provided for sale of the hospital property to Lytton Rancheria of California (LRC) for $13 million. LRC is a casino owned by the Lytton Band of Pomo Indians that is located adjacent to the hospital property. The sale, which did not require approval by the voters because the buyer will not use the property for providing medical services that the District could provide itself, closed on April 3, 2018. LRC plans to demolish the hospital building and use the site for casino parking. [59]

***203 C. Tulare Local Healthcare District, dba Tulare Regional Medical Center (E.D. Cal. 2017)**

Tulare Local Healthcare District, formed in 1945, owned and operated Tulare Regional Medical Center, a 112-bed acute care hospital in Tulare (Tulare County), and related facilities, including outpatient services and clinics. [60] On September 30, 2017, the District filed a chapter 9 petition on an emergency basis [61] while in the midst of both a complete cash shortage and a dispute with its management company, HCCA, the same company that managed Southern Inyo Healthcare District.

The District apparently had a past filled with multiple public disputes over elections, bond measures, and overall management of the hospital. HCCA's relationship with the District began in 2014, when it entered into a management services agreement and was appointed manager of the District and all of its facilities. [62]

At first, HCCA appeared to significantly improve the District's financial performance. [63] However, from March 2016 to March 2017, the District's cash position dropped precipitously from $12,472,924 to $3,622,318. [64] Governance disputes arose between the parties and the District's bond ratings were downgraded. [65] On September 27, 2017, HCCA served the District's board with a lawsuit, alleging breach of contract by the District. The next day, HCCA advised the public and employees that it was unable to make payroll and might need to shut down all operations. The day after that, HCCA told the District that it was out of ***204** cash. As a result, the District's board immediately adopted a declaration of fiscal emergency and authorized the filing of a chapter 9 case. [66]

On September 30, 2017, the District filed its chapter 9 petition. The District then spent the next two months locked in a dispute with HCCA over termination of its management agreement. The bankruptcy court agreed that the agreement would be terminated effective as of November 22, 2017, [67] but by October 26, 2017, the District had voluntarily suspended its license with the State of California to operate the hospital and all healthcare related entities, including clinics and outpatient facilities. [68]

On January 23, 2018, the District filed a lawsuit against HCCA, asserting claims relating to, among other things, allegations of preferential and fraudulent transfers and demanding declaratory relief with respect to a deed of trust that HCCA had recorded against assets of the District. [69] In April 2018, FBI agents and the Tulare County District Attorney's Office seized several electronic devices and documents related to HCCA during a raid on the home of its owner (and the former chief executive officer of the hospital). [70] The litigation between the District and HCCA was short lived but heated, but by August 2018 the District and HCCA had reached a financial arrangement pursuant to which HCCA agreed to reconvey all of its liens against the District's assets, and to release approximately $17,000,000 of claims against the District. This arrangement made it possible for the District to subsequently borrow against its assets in order to fund a plan of adjustment, and otherwise move forward with its reorganization. [71]

***205** The District began its restructuring process by first appointing new management to operate the hospital. Next, the District entered into a series of agreements to partner with Adventist Health to reopen the hospital and other facilities. Among other things, Adventist Health Tulare (AHT), then a newly formed subsidiary of Adventist Health, agreed to provide the District with a $10 million line of credit secured by assets of the District to reopen the hospital before October 28, 2018. [72] Upon reinstatement of the hospital's acute care hospital license by the California Department of Public Health (CDPH), AHT agreed to manage and operate the hospital on the District's behalf pursuant to a management services agreement on an interim basis. AHT also agreed that once all required approvals were obtained (including voter approval) and the transaction closed, AHT would (a) lease the hospital for an initial term of 5.5 years (with rent determined by a fair market valuation performed by an independent expert and an option to extend and renewals for up to 30 years), (b) purchase certain personal property related to the hospital, and (c) assume certain leases and executory contracts (collectively, the AHT Transaction), with the proceeds of the transaction to be applied to the loan. [73] Although the District has no financial obligations to the hospital beyond certain maintenance and construction costs, the District must still complete construction of its stalled hospital tower project and any seismic improvements that are needed. [74]

On August 7, 2018, the bankruptcy court approved the AHT Transaction. The hospital reopened on October 15, 2018, and on November 6, 2018, the transaction was overwhelmingly approved by District voters. [75] The lease thereafter became effective and rent commenced as of March 15, 2019, after the State of California issued a change of ownership letter to AHT. [76]

Once the AHT Transaction closed and the hospital's operations stabilized, the District moved forward to obtain bankruptcy court approval of its plan of ***206** adjustment. On July 3, 2019, the District obtained an order approving its disclosure statement, and on August 16, 2019, the bankruptcy court entered an order confirming the District's plan of adjustment. [77] The plan of adjustment became effective on October 17, 2019. [78] Under the plan, the District will distribute a stream of payments to general unsecured creditors over five years, with distributions commencing approximately five years after the District repays certain loans approved during the chapter 9 case. [79] The District will continue to own and maintain the hospital, but its functions will be limited primarily to monitoring the lease of the hospital to AHT, owning and maintaining the District's other assets (including a health club and other real estate), and otherwise providing healthcare services and programs to the community. [80]

III. Recent Health Care District Bankruptcies

A. Indian Valley Hospital District and Indian Valley Health Care District (E.D. Cal. 1991 and 2003)

Indian Valley Hospital District was formed in 1953 (under the name Feather River Hospital District) and built a hospital, designated a “sole community provider,” in Greenville (Plumas County) in the rural northern Sierra area of Northeastern California near Lake Almanor. At one point before the hospital closed in 2006, it had nine acute beds, 17 skilled nursing beds, an emergency department, and an outpatient laboratory and radiological services. [81]

The hospital struggled financially for years, and the District filed its first chapter 9 case in 1991.[82] In 1993, the District successfully confirmed a plan of adjustment, and the case was closed in November 2000.

***207** Three years later, in November 2003, the District (which had changed its name to Indian Valley Health Care District) filed its second chapter 9 case.[83] The District had experienced a net operating loss of $2,000,000 in the previous eight years and had a great deal of deferred maintenance and aging equipment. There had been a large turnover in senior management since the early 1990s, and mandatory payment reductions by government and insurance programs, coupled with increased regulatory and nurse staffing requirements, had significantly affected the hospital's financial performance.[84] In fact, the District's cash shortfalls were such that, shortly after the chapter 9 filing, the District used its January 2004 general tax revenue securing certain of its indebtedness to cover ongoing operations of the hospital without the initial knowledge or consent of the secured creditor.[85]

The District sought to fund its plan of adjustment by raising nearly $2,000,000 in 2004 to retire existing debt, repair and refurbish the hospital and equipment for patient care, and implement operational changes.[86] Six months later, however, the District abandoned that plan and began cycling through several options to save hospital operations. It first cut costs by closing the emergency department, reducing staff hours, and retaining a new administrator. The local community realized that the hospital was in danger and began fund raising efforts.[87] By 2006, however, those positive steps could not be maintained. The District was unable to obtain a grant from the California Department of Energy to build a therapeutic spa using the local hot spring that had been providing geothermal heat to the hospital, and was unable to reach agreement with an adjoining health care district for joint operations.[88] Finally, in November 2006, the District's acute care license was suspended and the hospital was closed.[89]

***208** The District was then left with few restructuring options. In 2007, it leased its remodeled clinic building to an adjoining health care district to be operated as a rural health care clinic, and explored converting the hospital building to assisted or congregate living, use by a private healthcare provider, a wellness center, or an off-campus dormitory for the local community college.[90] It even developed a formal Reuse Plan, with access to development funds through the California Department of Housing and Community Development, to promote a sale of the property.[91] Nothing came to fruition. Accordingly, in July 2012, the District reported to the bankruptcy court that there were no realistic prospects of sale until the "national, statewide and local economic conditions improve dramatically,"[92] and the bankruptcy court dismissed the chapter 9 case on October 10, 2012.

Since 2012, a portion of the hospital property has been made available for use as a medical heliport. It also has been designated as "surplus" property by the District and has been listed for sale by a local real estate agent.[93] A consensual annexation of the District's territory by Plumas District Hospital, a neighboring health care district, is in progress.[94]

B. Sierra Kings Health Care District (E.D. Cal. 2009)

Sierra Kings Health Care District owned and operated Sierra Kings District Hospital, a 49-bed hospital in Reedley (Fresno County), and five rural health clinics. The District filed a chapter 9 petition on October 8, 2009, and a plan of adjustment was confirmed on February 2, 2012.[95]

The plan of adjustment was premised on the sale of substantially all of the District's personal property assets and the clinics to Adventist Health, together with a 15-year lease of the hospital real property. District voters approved the transaction by more than 95% of those voting, and the sale and lease to Adventist ***209** Health closed on December 31, 2011. Adventist Health continues to own and operate the hospital under the name Adventist Medical Center--Reedley, and the more than $800,000 per year in rent that Adventist Health pays to the District enables the District to administer grants for community health purposes.[96]

The bankruptcy court issued a reported decision in the chapter 9 case.[97] The decision approved a reaffirmation and settlement agreement with holders of certain general obligation bonds that had been issued only three months prior to the filing of the chapter 9 petition for purposes of improving the District's hospital. Pursuant to the settlement, the District acknowledged and agreed, among other things, that (a) the bonds were secured by an unlimited direct and continuing *ad valorem* tax levied on all taxable property in the District, (b) the *ad valorem* taxes were "special revenues" as defined in Bankruptcy Code section 902(2)(E), and (c) the bonds and the security for the bonds would not be impaired during the chapter 9 case or in the plan of adjustment.

C. Mendocino Coast Health Care District (N.D. Cal. 2012)

Mendocino Coast Health Care District was formed following a successful grass-roots effort to pass a hospital district initiative in January 1967. [98] The District operates Mendocino Coast District Hospital, a critical access hospital licensed for 49 beds in Fort Bragg (Mendocino County), which in turn operates both the Mendocino Coast Home Health Agency and the North Coast Family Health Center, a rural health care clinic. Construction of the hospital was completed in 1971, [99] and it provides a variety of services, including a pharmacy, laboratory, diagnostic imaging, physical therapy, inpatient and outpatient surgery and an emergency room. [100]

***210** The District's immediate need for chapter 9 relief surfaced in February 2012, when the hospital's chief financial officer determined that, unless there was a "dramatic" improvement in the financial projections, the hospital would run out of cash in the middle of November 2012 if the District had to fund its existing compensation obligations under a memorandum of understanding it had executed with the United Food and Commercial Workers Local 8 just eight months earlier. [101] In April 2012, the District initiated the mediation process required by the then newly-enacted sections 53760 through 53760.9 of the California Government Code (AB 506) before filing a chapter 9 case. It was unable to reach an agreement with its two "most interested" creditors, the California Mortgage Loan Insurance program and Local 8, despite extending the mediation period to 90 days, [102] and on October 17, 2012, filed its petition for relief under chapter 9 of the Bankruptcy Code. [103]

Once in bankruptcy, the District focused on streamlining operations, reducing costs, re-negotiating contracts and leases, and resolving various litigation disputes. [104] It successfully reached settlements with most of its major creditors, including Local 8. In December 2014, the bankruptcy court approved the District's proposed disclosure statement, and thereafter approved a settlement of the District's alleged Stark Law liabilities and confirmed the District's plan of adjustment in March 2015. [105] Assuming that final distributions are made as provided in the plan, holders of general unsecured claims will receive an estimated aggregate distribution of approximately 54.4% of their allowed claims. [106]

Since closing of the case on November 16, 2015, the hospital remains in operation but continues to face financial and operational challenges. The hospital went from showing a net operating income of more than $2 million in 2016, to a net operating loss of more than $1 million in 2017, and more than $2 million in ***211** 2018. [107] On June 5, 2018, District voters approved the imposition of a new annual special tax of $144 per parcel for 12 years, to raise approximately $1.7 million in annual tax revenues to help maintain and upgrade healthcare facilities and services (but not administrators' salaries, benefits or pensions). [108]

Yet the District's problems persist. In early 2019, the District removed its Chief Executive Officer from his position. [109] An interim CEO was appointed, and the District issued a request for proposal and invited five potential health care "partners" to submit proposals to lease or buy the hospital in April 2019. [110] Two (American Advanced Management Group and Adventist Health) submitted responses, expressing their interest in partnering with the District. [111] On October 24, 2019, the District published a "Mendocino Coast District Hospital-Adventist Health affiliation fact sheet," advising the public that it is only considering an affiliation with Adventist Health at this point, and that, if negotiations are successful, its terms would be presented to voters via ballot measure on March 3, 2020. [112]

D. Palm Drive Health Care District (N.D. Cal. 2007 and 2014)

Palm Drive Health Care District encompasses a majority of the western portion of Sonoma County and owns Palm Drive Hospital, which was formerly a 37-bed acute care hospital in the City of Sebastopol (Sonoma County) built in 1976. The District was formed in 2000 through the efforts of area residents to continue ***212** operation of the hospital after its former owner advised the community it was planning to close the hospital in 1998. [113]

According to a 2007 official statement for the issuance of bonds, the District had been experiencing significant financial difficulties for many years. It had a great deal of deferred maintenance and aging equipment, and it faced significant financial pressures as a result of the mandatory payment reductions by government and insurance programs and increased regulatory

requirements. Many of the surrounding residents were uninsured or under-insured, which also imposed a substantial bad debt load on the District. [114] By late winter 2006/early spring 2007, the District faced a serious cash shortfall, and on April 5, 2007, it filed for chapter 9 protection. [115]

The District received financing from four different community supporters to assist in its immediate working capital needs during bankruptcy. [116] By June 2009, the District had obtained an order confirming a plan of adjustment, but had to delay its effective date repeatedly due to problems in obtaining exit financing. [117] The financing was finally obtained, and the plan became effective on May 19, 2010. The chapter 9 case was closed on March 7, 2014.

Barely one month later, the District filed a second chapter 9 case, [118] apparently because of a cash crisis in the spring of 2014. "[T]o avoid further cash losses, and operate only consistent with its ... high standard of medical care and patient safety," the District also closed the hospital on April 28, 2014 and laid off all but a "skeleton administrative staff." [119]

***213** The District thereafter sought proposals from members of the medical community and civic-minded members of the community. In March 2015, it entered into a management and staffing services agreement with Sonoma West Medical Center (SWMC), a non-profit § 503(c)(3) organization formed to reopen the hospital. SWMC agreed to re-open and manage the hospital and meet the hospital's operating expenses, and the District agreed to contribute up to $1 million per year for maintenance and refurbishment of the hospital facilities. Two District residents also donated over $6 million, and the hospital re-opened in October 2015 under the name Sonoma West Medical Center. [120]

Unfortunately, the new fiscal arrangement and support was not sufficient, and the hospital again encountered financial difficulties. In 2016-17, SWMC sought to subcontract its management role to experienced outside hospital operators. Several operators were "brought in, some on a trial basis, to see if they could bring the hospital to break-even financial performance." [121] None were successful. There also were operational problems. According to one press report, hospital operations were reduced due to the discovery of black mold contamination that shut down the surgery rooms on May 31, 2017, and a fire in the boiler room in December 2017 took months to repair, which impacted revenues. [122]

SWMC then took an entirely different tack. In June 2017, it entered into an arrangement with Durall Capital Holdings, a toxicology testing company, to use features of a federal hospital laboratory program and have the hospital and its laboratory serve as reference labs and bill for lab tests at the higher hospital-based rates. The additional revenue allowed SWMC to "run in the black for the remainder of 2017." In late 2017, however, Anthem Blue Cross alleged that the SWMC-Durall lab testing arrangement was "illegitimate" and had caused Anthem Blue Cross and its affiliates to be overcharged by $13.5 million. Although SWMC and the District strongly disputed these allegations, Durall ceased sending specimens for testing at the hospital laboratory in early 2018, and SWMC again encountered monthly operating shortfalls. [123]

***214** Anthem Blue Cross and certain of its affiliates filed a lawsuit against SWMC, Durall and others (but not the District) for fraud, negligent misrepresentation and restitution, among other claims, on June 1, 2018, and demanded reimbursement in excess of $13 million. [124] SWMC did not answer the complaint, and default was entered against it. On September 7, 2018, SWMC filed its own petition for relief under chapter 7 of the Bankruptcy Code. [125]

In May 2018, the District issued a request for proposals to purchase the hospital and continue operating it as an acute care hospital. Although no formal bids were received, several parties engaged in discussions with the District as to how to modify the hospital's business model to make it sustainable as a medical facility. The most promising of these concepts was put forward by American Advanced Management Group (AAMG). The AAMG concept was to operate the hospital as a long term acute care hospital (LTCH), including an urgent care center, elective surgeries, radiology services, standard laboratory services, and other hospital-based medical services. [126]

On August 26, 2018, the District entered into a long-term management contract with AAMG, and AAMG commenced operation of the hospital under the name Sonoma Specialty Hospital. Although the emergency room was closed, the urgent care center opened on February 6, 2019. Under the terms of the management agreement, the District owed AAMG a management fee

of $100,000 per month and was responsible for any operating losses that AAMG might incur. The management fee could be deferred for up to five years. [127]

On March 5, 2019, District voters approved a lease of the hospital to AAMG with a vote of 75% in favor and 25% opposed. The lease is for a term of two years, renewable for two additional two-year terms. The lease also contains an option for AAMG to purchase the hospital for an agreed price of $5.2 million, of which $4 million is a cash payment and $1.2 million is a ten-year promissory note. If the purchase option is not exercised within the first two-year term of the lease, a fresh appraisal of the fair market value of the hospital will be required. The purchase ***215** option is structured to incentivize AAMG to continue operating the premises as a medical facility for the community. For this purpose, if AAMG continues to operate the premises as a medical facility for the ten-year term of the promissory note, the note will be forgiven. Sale of the hospital to AAMG may require the District to pay off some or all of its secured tax exempt bonds, which it plans to do with a combination of sale proceeds and refinancing with taxable bonds. [128]

The lease to AAMG, together with a settlement of claims asserted by the chapter 7 trustee of SWMC relating to equipment at the hospital and collection of accounts receivable, enabled the District to confirm its amended plan of adjustment as modified on June 24, 2019. [129] AAMG is in the process of qualifying the hospital as an LTCH, and the extended hour urgent care center is expected to meet about 90% of the needs of the previous emergency room at lower patient cost. [130] The District has requested proposals for ways in which it can use the revenues from its $155 parcel tax to provide other healthcare services. [131]

One of the consequences of the District's financial and operational problems has been a reduction of the areas included in the District. In April 2016, the areas in the "river corridor" along the Russian River petitioned the Sonoma County Local Area Formation Commission (LAFCO) for detachment. The LAFCO approved detachment of these areas from the District, with the result that the detached areas are liable only for the portion of the parcel tax that supports indebtedness existing at the time of detachment, and not for taxation supporting repayment of post-detachment bonds or other indebtedness incurred by the District. [132] On May 1, 2019, the LAFCO approved a second detachment, this time ***216** of an area of the District in Bodega Bay. [133]

E. Southern Inyo Healthcare District (E.D. Cal. 1999 and 2016)

Southern Inyo Healthcare District was formed in 1949, and located its hospital in Lone Pine (Inyo County), which sits at the foot of Mt. Whitney. The hospital currently owns and operates three facilities: an emergency and acute care facility with four beds, a skilled nursing facility with 33 beds, and an outpatient medical clinic. [134] It is a critical access hospital and the only hospital within a 137 miles stretch of Highway 395 between the cities of Ridgecrest and Bishop. [135]

The District's first chapter 9 case was filed on July 20, 1999. [136] After submitting several versions of its plan of adjustment, the District confirmed its fourth amended chapter 9 plan on March 19, 2003. The case was finally closed on April 30, 2007.

Beginning in or about 2008, the District again encountered substantial financial difficulties. It experienced declines in collections from governmental agencies and insurers, while maintaining high operational costs for new equipment purchased in 2012 to improve the facility and higher salaries to recruit qualified medical staff. Hospital occupancy rates went from 84% in 2012, to 67% in 2015, and gross operational revenue fell by 20% over only four years. [137] Former management failed to respond to the reduced patient demand with reduced staffing and overhead expenses. Instead, management actually increased staffing by over 17%, resulting in net losses of approximately $2.7 million. [138] By October 2015, the District was unable to pay for employee health insurance; by the end of November 2015, it was unable to pay payroll for existing hospital staff and amounts due under its contracts with the emergency room doctors; and by December 2015, ***217** the hospital and emergency room had been closed, and the District began transferring the skilled nursing facility patients to other facilities. [139] The District's entire board resigned, and on December 29, 2015, the California Department of Public Health (CDPH) threatened to suspend or revoke the District's license if it was unable to provide the basic medical services required under its license by January 5, 2016. [140]

With essentially no cash on hand, the District sought chapter 9 protection. On January 2, 2016, it entered into a management agreement with Healthcare Conglomerate Associates (HCCA), a restructuring advisory firm focused on reorganizing hospitals,

to manage the operations of the District. On January 3, 2016, the District declared a "fiscal emergency" (as permitted under AB 506), and on January 4, 2016, filed its petition for relief under chapter 9 of the Bankruptcy Code. [141]

The District immediately began taking steps to obtain financing and reopen the facility. The District filed suit against CDPH, claiming that its efforts to suspend or revoke the District's license violated the automatic stay, but on March 1, 2016, the District and CDPH were able to reach an agreement to reinstate the District's license. [142]

Over the next year and a half, the District sought to stabilize its operations and revenue deficits and negotiate a plan of adjustment with its creditors. It reevaluated its billing practices to reduce the number of insurer discounts (and thus increase net revenues). It began using governmental programs that provide revenues to hospital and nursing facilities that maintain high level of services, and also looked for additional governmental subsidies to increase non-operational revenues. [143]

***218** In October 2017, however, the District's restructuring plans changed sharply. On October 17, 2017, it filed an emergency motion for authority to terminate the HCCA management agreement, alleging mismanagement and general misconduct on the part of HCCA. Among other things, the District alleged that HCCA had engaged in unauthorized transactions of District funds with Tulare Local Healthcare District, which also had been managed by HCCA and had just filed its own chapter 9 case. [144] HCCA was immediately removed as a signatory on the District's bank accounts, and the management agreement was rejected. The District filed suit against HCCA for unauthorized post-petition transfers, breach of contract, breach of fiduciary duty and equitable subordination. It also objected to a $2.5 million administrative claim asserted by Tulare Local Healthcare District to recover unauthorized transfers of funds by HCCA from Tulare to Southern Inyo. [145]

Subsequently, the District restarted its efforts to reorganize by hiring a new management team and financial advisory firm. The District also began to explore alternative methods of generating new revenue and funding a plan of adjustment, including seeking a second voter-approved parcel tax increase (the first one failed in 2018), and obtaining funding from the Los Angeles Department of Water and Power (the largest employer in Southern Inyo), grants from the Great Basin Pollution Control District, and investments in the Local Agency Investment Fund, as well as partnerships with other providers and hospitals and provision of services to the Toiyabe tribe. [146]

F. Surprise Valley Health Care District (E.D. Cal. 2018)

Surprise Valley Health Care District filed its chapter 9 petition on January 4, 2018. [147] The District has owned and operated Surprise Valley Community Hospital, a 26-bed critical access hospital with four acute care beds, 22 skilled nursing beds and an emergency room, in Cedarville (Modoc County), since 1953. The District also owns and operates a rural health clinic.

***219** Shortly after the commencement of the chapter 9 case, the District filed a motion for approval of an unusual financing transaction. Under the terms of the credit agreement, which was approved by the bankruptcy court, Cadira Group Holdings, LLC agreed to loan the District up to $4 million secured by a first priority lien on the District's assets. Of this amount, $1.5 million was for the purpose of funding the District's operations and chapter 9 administrative expenses, and $2.5 million was used to finance the purchase of Serodynamics, LLC, a medical testing laboratory in Denver, Colorado and an affiliate of Cadira.

The loan by Cadira was effectively an advance on the purchase of the hospital. Pursuant to an asset purchase agreement approved by the bankruptcy court in May 2018, Cadira agreed to buy substantially all of the District's assets in exchange for forgiveness of the loan (including the $2.5 million used to purchase Serodynamics), plus a $700,000 cash payment. [148] District voters approved a ballot measure in June 2018 authorizing the sale to Cadira. [149]

The business plan behind the purchase of Serodynamics was to bring revenue to the hospital by billing insurers through the hospital for laboratory tests performed by Serodynamics, regardless of where the patients receiving the tests were located. The practice of laboratory billing for remote patients has been embraced by other struggling rural hospitals because Medicare and commercial insurers often pay rural hospitals more for laboratory tests than they pay to urban hospitals or independent laboratories. Although the legality of the practice is questionable, and the subject of fraud allegations and lawsuits elsewhere (*see* discussion of Palm Drive Health Care District above), Cadira contended that the structure of its operations was different.

According to Cadira, the hospital could legally bill laboratory tests, performed by its laboratory subsidiary, for patients treated remotely through telehealth services. [150]

***220** Following bankruptcy court and voter approval of the Cadira transactions, there were press reports that Cadira's principal had disappeared and that the websites for his healthcare businesses had been shut down. [151] Finally, on October 23, 2019, 17 months after bankruptcy court and voter approvals, the District filed a motion for approval of a settlement with Cadira. [152] According to the motion papers, Cadira was unable to complete the sale "due to changed circumstances." [153] As a result, the District proposed to unwind the transactions through, among other things: (a) rescission of the District's purchase of the Serodynamics laboratory (which is no longer operating), with the District retaining the right to collect $440,000 of charges generated as a result of work performed by the laboratory and invoiced under the hospital's billing system; (b) return of the $2.5 million laboratory purchase price as a credit against the secured loan to the District; (c) termination of the asset purchase agreement; (d) a $300,000 cash payment by the District to Cadira in full settlement and satisfaction of the $743,000 advanced by Cadira for the District's operating expenses; and (e) release by Cadira of all liens on the District's assets. [154]

In October 2019, the District stated that it "ha[d] used the breathing space provided by its Chapter 9 filing and the cash infusion provided by Cadira to overhaul its operations." It believed that it could confirm a plan of adjustment and continue operations without the necessity of a sale. [155]

G. Coalinga Regional Medical Center (E.D. Cal. 2003 and 2018)

Coalinga Hospital District opened Coalinga Regional Medical Center in Coalinga (Fresno County) in 1946. The hospital, which had 24 acute care beds, 99 skilled nursing beds, an emergency department, and a rural health clinic, has been the debtor in two chapter 9 cases.

***221** A major factor in the financial difficulties leading to the first chapter 9 case was a medical office building constructed in the 1990s that was never able to attract sufficient tenants to cover expenses. [156] The hospital filed a chapter 9 petition on May 1, 2003, and its chapter 9 plan was confirmed on May 13, 2004. [157]

The hospital remained open during and after its first chapter 9 case but encountered financial difficulties 14 years later, with $4.5 million in losses during the 18 months ending May 2018. Prior to completion of the announced closure of the hospital, the District entered into a management agreement with American Advanced Management Group to reopen terminated services and operate the hospital for five years. However, the California Department of Public Health determined that the hospital had ceased providing essential services, was no longer operating lawfully, and no longer qualified for reimbursement under Medicare and Medi-Cal. The costs and delays of reapplying for a hospital license were prohibitive, and the hospital closed completely in June 2018, leaving the residents of Coalinga without an emergency room for 40 miles. [158]

The hospital filed its second chapter 9 petition on September 7, 2018. [159] In March 2019, District voters approved (by a margin of 93.75% to 6.25%) a ballot measure for a 20-year lease of the hospital facility to Coalinga Medical Center (CMC), an affiliate of American Advanced Management Group, with an option to purchase the facility for the greater of $1 million or fair market value as of the date of the commencement of the lease. [160] The lease transaction requires CMC to open an acute care hospital with an emergency room not later than March 30, 2020, and failure to continue operation of a hospital and emergency room is a default under ***222** the lease. If CMC exercises the purchase option and thereafter fails to operate a hospital and emergency room at the facility, the District has a right of first refusal to purchase the facility at fair market value for a period of ten years after the date of exercise of the option. Interestingly, CMC has a right to terminate the lease if a new federally qualified health clinic or rural health clinic is opened in the District, or if Adventist Health significantly expands its nearby rural health clinic, and CMC determines that there would be a significant negative effect on the financial viability of the hospital. The bankruptcy court approved the transaction by order entered April 20, 2019. [161]

As of the commencement of the chapter 9 case, the District owed approximately $11 million to holders of certificates of participation (COPs) issued by the District in 2008. Because the lease to CMS would result in a loss of the tax exempt status of a portion of the COPs, the District refinanced the COPs by issuing special revenue bonds secured by the District's *ad valorem*

tax revenues. The entire issuance of special revenue bonds, which have a lower interest rate than the COPs, was purchased by Western Alliance Bank. [162]

The District's proposed amended plan of adjustment, filed on October 4, 2019, contemplates that unsecured creditors will receive distributions aggregating 45% to 56.25% of their allowed claims over a period of 10 years. After confirmation, the District plans to provide non-hospital healthcare services. [163]

The *Coalinga* case has attracted significant attention as a result of the bankruptcy court's reported decision determining that the United States Trustee does not have authority to appoint an unsecured creditors' committee in a chapter 9 case. [164] As it typically does in chapter 9 cases, the U.S. Trustee had appointed a committee of unsecured creditors shortly after commencement of the case. When ***223** the committee filed applications to employ counsel several months later, the District objected on the ground that the U.S. Trustee lacked authority under the Bankruptcy Code to appoint a committee in a chapter 9 case. Following the reported decision in the City of Detroit chapter 9 case, the *Coalinga* court agreed. [165]

The *Coalinga* court's analysis was purely statutory. Section 901(a) of the Bankruptcy Code lists the sections of the Bankruptcy Code that apply in a chapter 9 case. Among the listed sections is section 1102, which authorizes the U.S. Trustee to appoint committees. Section 1102(a)(1) provides that:

> as soon as practicable *after the order for relief under chapter 11 of this title*, the United States trustee shall appoint a committee of creditors holding unsecured claims ....

(emphasis supplied). Considering the language of the statute, the bankruptcy court stated that there is "nothing ambiguous or mysterious" about section 1102(a)(1). "The subsection plainly states the condition to the UST's exercise of its authority [to appoint a committee] is 'after the order for relief under chapter 11,"' but "[t]here is no 'order for relief under chapter 11' in a chapter 9 case." [166]

In reaching this conclusion, the *Coalinga* court noted that there is "nothing illogical or legally inconsistent about a literal application of section 1102(a)(1) excluding its application in chapter 9 cases." Other subsections of section 1102 are also inapplicable in chapter 9 even though section 1102 is fully incorporated in chapter 9 by section 901(a). For example, section 1102(a)(3) provides that the court may order that no committee be appointed in a case involving a small business debtor, but a chapter 9 debtor cannot be a small business debtor. Similarly, section 1102(b)(2) governs committees of equity security holders, but a chapter 9 debtor does not have equity security holders. [167]

The *Coalinga* court did not decide whether the U.S. Trustee's appointment of the unsecured creditors' committee was void or merely voidable. If voidable, the court determined that it had authority to disband the committee under section ***224** 105(a) and elected to do so. [168] Interestingly, the court noted that the U.S. Trustee's official policy was to appoint creditors' committees in chapter 9 cases in all districts except the Eastern District of Michigan, where the City of Detroit case was decided. [169] As a result of the *Coalinga* decision, it is possible that the U.S. Trustee will similarly no longer appoint creditors' committees in chapter 9 cases in the Eastern District of California.

It should also be noted that notwithstanding the *Coalinga* court's decision that the U.S. Trustee lacks authority to appoint a creditors' committee in a chapter 9 case, a bankruptcy court may have discretion to appoint a creditors' committee under section 1102(a)(2) (authorizing the appointment of additional committees). The *Coalinga* court considered this issue in the context of a motion by one of the former committee members to appoint a committee. The court did not decide the issue, however, because it determined that regardless of whether it had authority to appoint a committee under section 1102(a)(2), it would not appoint one in the District's case because a committee was "not necessary in order to assure adequate representation of creditors." The court reasoned that, among other factors, (a) the District only had about 100 creditors, (b) the only two creditors who had expressed interest in serving on the committee were trade creditors (who were not representative of the creditor body), (c) the case had already reached an advanced stage (the court having previously approved a lease of the District's hospital and the District having already filed a proposed plan of adjustment), and (d) the financial resources of the District were limited. Accordingly, the *Coalinga* court denied the motion to appoint a creditors' committee. [170]

IV. Early Health Care District Bankruptcies [171]

A. Avenal Hospital District (E.D. Cal. 1993)

Avenal Hospital District operated Avenal District Hospital, a 28-bed hospital in Avenal (Kings County), as well as a rural health clinic and ambulance ***225** services. The District filed a chapter 9 petition on November 12, 1993, but the case was dismissed on October 5, 1999, for lack of prosecution. [172] The hospital closed in 1992 prior to the commencement of its chapter 9 case, and the District currently provides only ambulance services. [173]

B. Los Medanos Health Care Corp. (N.D. Cal. 1994)

Los Medanos Community Health Care District was one of the three original county health care districts formed in California after passage of the Local Hospital District Law in 1945. It operated Los Medanos Community Hospital in Pittsburg (Contra Costa County) for 46 years, from 1948 until 1994. The hospital closed at or about the time of the filing of the chapter 9 petition by Los Medanos Health Care Corp. on April 22, 1994, and never reopened. A plan of adjustment was confirmed by the bankruptcy court on August 18, 1998. [174]

In January 2002, the District reopened a portion of the former hospital building as the Pittsburg Health Clinic, a medical clinic that hosted more than 100,000 visits during fiscal year 2016-17. In November 2017, the Contra Costa County Supervisors determined that the County could administer the clinic more efficiently than the District and voted to apply to the Contra Costa Local Agency Formation Commission to begin dissolution of the District and to transfer all of the District's assets and debts to the County. Shortly thereafter, in April 2018, a Contra Costa grand jury issued a report recommending that the District be dissolved because the District was spending more money administering grants than on the grants themselves and was not tracking the effectiveness of its programs. Depending on the outcome of pending litigation by the District, it is possible that the District may be dissolved. [175]

*226 C. Heffernan Memorial Hospital District, dba Calexico Hospital (S.D. Cal. 1995)

Heffernan Memorial Hospital District was created in 1951. The District operated Calexico Hospital, a 34-bed hospital in Calexico (Imperial County) that was the only hospital in Calexico. The hospital closed at or about the time of the filing of the chapter 9 petition on September 21, 1995. [176] A plan of adjustment was confirmed on September 26, 1996. [177]

The bankruptcy court issued two reported decisions during the chapter 9 case. In the first decision, the court held that the United States Department of Health and Human Services (HHS) could recoup a pre-petition Medicare overpayment to the debtor arising in one fiscal year against pre-petition Medicare reimbursements owing to the debtor for services rendered in another fiscal year. [178] The decision was significant because it disagreed with a decision by the Third Circuit that treated each fiscal year as a separate contract under Medicare and barred recoupment with respect to debts arising in different years. [179]

In the second reported decision, the bankruptcy court held that certain sales tax revenues levied by the City of Calexico, but statutorily required to be used exclusively for the District, were "special revenues" under Bankruptcy Code section 902(2). [180] Under the plan of adjustment, the District assigned and pledged ***227** the sales tax revenues to a newly-created entity, the Calexico Special Financing Authority. The Authority acquired certain debt of the District and issued sales tax revenue bonds in order to obtain funds to pay creditors of the District. In return, the District assigned and pledged the sales tax revenues to the Authority so that the Authority could make payments on the bonds. The bankruptcy court determined that the sales tax revenues were "special revenues" because they were not available for general municipal purposes.

Shortly after confirmation, in November 1996, the District contracted with a for-profit operator to manage the hospital, and the hospital was reopened in June 1997. However, the hospital failed to pass its initial survey by the California Department of Health Services (DHS). Without certification, the hospital was ineligible to participate in the Medicare and Medi-Cal programs, was unable to survive financially, and closed in January 1998. The management company sued DHS in Imperial County Superior

Court for violation of the federal civil rights statute [181] by reason of its wrongful failure to schedule a new survey. The jury awarded the management company $12 million against DHS.

Calexico Hospital never reopened, although the District (now called Heffernan Memorial Healthcare District) still exists and supports various healthcare programs, including a partnership with the Imperial Valley Cancer Support Center. Pioneers Memorial Healthcare District currently operates a medical clinic and urgent care center in the City of Calexico. [182]

D. Corcoran Hospital District, aka Corcoran District Hospital (E.D. Cal. 1996)

Corcoran Hospital District operated a 32-bed hospital in Corcoran (Kings County). The District filed a chapter 9 petition on July 25, 1996, and a plan of adjustment was confirmed on May 13, 1999. [183]

***228** The bankruptcy court in the chapter 9 case ruled on two objections to plan confirmation by the creditors' committee. [184] In the first objection, the committee asserted that the plan was not proposed in good faith because the District should be obligated to raise taxes, or at least attempt to raise taxes, to pay unsecured creditors in full. The bankruptcy court rejected this argument because any attempt to raise taxes would be futile given that Corcoran was the fifth poorest community in California, and there had been no successful efforts to raise property taxes in the City in the past eight years. Moreover, notwithstanding a California state court appellate decision requiring a city to raise taxes to pay judgment creditors, [185] the rules in bankruptcy are different because proofs of claim are not judgments. In addition, although Bankruptcy Code section 903 expressly reserves to the states the power to control municipalities, [186] if state law authorizes a municipality to file for chapter 9 protection, the bankruptcy laws necessarily permit adjustment of the municipality's debts and do not require payment in full to creditors. [187]

In its second objection, the committee asserted that the plan unfairly discriminated among unsecured creditors because it separately classified and provided different treatment for the unsecured claims of DHS, the unsecured claims of a medical group, and general unsecured claims. The court ruled that both the separate classification, and the more favorable treatment for DHS and the medical group, were justified because both DHS and the medical group had significantly reduced their claims, and DHS had waived its right of recoupment, in exchange for the more favorable treatment. [188]

The District initially thrived after confirmation of its plan of adjustment, in part because it was providing health care for prison inmates. By 2013, however, the District was once again in financial difficulties because Corcoran State Prison drastically reduced the number of prisoners sent to the hospital for surgeries. The hospital closed its emergency room and inpatient unit in March 2013, and ceased all operations on October 1, 2013. Adventist Health took over operation of the rural health clinic that the District had previously operated at the hospital. In November ***229** 2016, District voters approved a ballot measure to sell all of the District's assets to Adventist Health. Adventist Health continues to operate a rural health clinic at the former hospital location. [189]

E. Kingsburg Hospital District (E.D. Cal. 1997)

Kingsburg Hospital District, which includes parts of Fresno, Kings and Tulare Counties, operated Kingsburg Medical Center, a 35-bed hospital in Kingsburg (Fresno County). The District filed a chapter 9 petition on June 23, 1997, and a plan of adjustment was confirmed on April 5, 2000. The chapter 9 case remained open until October 24, 2006. [190]

The hospital closed in 2010, and its license expired in 2013. On November 10, 2010, District voters passed a ballot measure that authorized the District to sell the hospital facilities to a qualified hospital operator. Despite efforts to sell the hospital to a hospital operator, the hospital buildings remained empty until 2015, when the District leased the facilities to Crestwood Behavioral Health for use as a mental health rehabilitation center. The name of the District was changed to Kingsburg Tri-County Health Care District in 2016. In November 2016, District voters defeated a ballot measure that would have authorized a sale of the hospital facilities to Crestwood, although Crestwood continues to operate a mental health rehabilitation center in the former hospital buildings pursuant to a lease with the District. The District continues to administer healthcare grants.

In 2016-2017, the Fresno County Grand Jury conducted an investigation of the District's financial records to determine whether the District had been fiscally responsible in the use of public funds. In its July 2017 report, the Grand Jury found that the District "demonstrated a lack of sound financial management" and that the District's Board of Directors "may have abdicated its fiduciary responsibilities to outside contracted professionals." [191]

***230 F. Southern Humboldt Community Health Care District (N.D. Cal. 1999)**

Southern Humboldt Community Health Care District, which includes parts of Humboldt and Mendocino Counties, filed a chapter 9 petition on January 20, 1999. The chapter 9 plan was confirmed on October 26, 2000. [192]

At the time of confirmation of its chapter 9 plan, the District did not have an impaired consenting class because its largest unsecured creditor, Six Rivers National Bank, voted against the plan. The Bank held an unsecured claim of approximately $665,000 that the District had initially sought to classify separately from the claims of other general unsecured creditors. The bankruptcy court disallowed the separate classification as an impermissible attempt to gerrymander an accepting class. The bankruptcy court then estimated the claim for voting purposes at zero because of the "inescapable conclusion that the Bank's claims against the District were completely unenforceable." [193] The Bank's claim was for a debt incurred in a prior fiscal year, in violation of the limitations of California Health and Safety Code section 32130. Section 32130 provides as follows:

> A district may borrow money and incur indebtedness in an amount not to exceed 85 percent of all estimated income and revenue for the current fiscal year, including, but not limited to, tax revenues, operating income, and any other miscellaneous income received by the district, from whatever source derived. *The money borrowed and indebtedness incurred under this section shall be repaid within the same fiscal year.*

(emphasis supplied). Once the Bank's claim was included in the same class as other general unsecured creditors but disallowed for voting purposes, the bankruptcy court found that the class of general unsecured creditors had accepted the plan of ***231** adjustment and confirmed the plan.

The District has operated Jerold Phelps Community Hospital in Garberville (Humboldt County) since 1963. The hospital, which has 9 acute care beds, 8 skilled nursing beds and an emergency room, remained open during the chapter 9 case and continues operating today. It is a critical access hospital. In May 2017, District voters defeated a ballot measure for a $170 annual parcel tax for 45 years to provide funding for the hospital, including construction of a new hospital that would meet seismic requirements. Barely one year later, however, District voters approved a June 2018 ballot measure that continued the existing $125 annual parcel tax for 10 years. The District is planning a fundraising campaign to raise funds to build a new hospital on a site in Garberville, to be purchased from College of the Redwoods. [194]

G. Chowchilla Memorial Hospital District (E.D. Cal. 2000)

Chowchilla Memorial Hospital District was formed in 1956 and operated a hospital with five acute care beds, 19 skilled nursing beds, and an outpatient clinic in Chowchilla (Madera County). [195] It filed a chapter 9 petition on May 2, 2000, [196] apparently to obtain relief from several pending lawsuits and a $20,000 per month operating deficit. [197] It successfully confirmed a plan of adjustment on September 14, 2001, and closed its chapter 9 case on May 5, 2004.

The District has continued to face challenges following implementation of its plan of adjustment. [198] In 2006, the District surrendered its license as an acute care hospital because it was unable to retain required around-the-clock medical providers and obtain sufficient revenues to support hospital services. In 2007, the District obtained a new license as a freestanding skilled nursing facility. [199] It ***232** currently offers a rural health clinic, a skilled nursing and rehabilitation facility licensed for 30 beds, wound care, diabetic care, restorative therapy programs and in-house lab and diagnostic x-ray services. [200] Unfortunately, the change from an acute care hospital to skilled nursing facility reportedly resulted in a "decline in federal and state reimbursement levels," and it is claimed that the change continues to challenge the District's cash flow and contributes to its "inability to consistently make timely payments due" on its bonds. [201]

H. Eastern Plumas Hospital District and Sierra Valley District Hospital (E.D. Cal. 1995 and 2000)

Eastern Plumas Hospital District operated a critical access hospital, with 10 acute care beds and 14 skilled nursing beds, in Portola (Plumas County), that opened in 1971. The District filed a chapter 9 petition on October 19, 1995, and its chapter 9 plan was confirmed on December 30, 1997. [202]

Sierra Valley District Hospital was a critical access hospital, with six acute care beds and 34 skilled nursing beds, in Loyalton (Sierra County), that opened in 1951. The District filed a chapter 9 petition on September 13, 2000, and its chapter 9 plan was confirmed on July 3, 2002. [203]

Both hospitals remained open during their chapter 9 cases. In 2003, the licenses of the two hospitals were consolidated into a two-campus hospital operated by Eastern Plumas Health Care District under an agreement with Sierra Valley Hospital District. The Loyalton campus has been solely licensed as a skilled nursing facility, with no acute care beds, since 2009. In 2018, the two Districts proposed annexation of a portion of Sierra Valley Hospital District by Eastern Plumas Health Care District and the concurrent dissolution of Sierra Valley ***233** Hospital District. [204] The reorganization of the two districts was completed in early 2019. [205]

I. Alta Healthcare District (E.D. Cal. 2001)

Alta Healthcare District was formed in 1946 as the Alta Local Hospital District to provide hospital services to an underserved and primarily rural area. At different times, the hospital, located in Dinuba (Tulare County), housed 54 beds and had a medical-surgical unit, an emergency department and trauma room, a short-stay skilled nursing facility, and a rural health clinic. [206] With the enactment of the Balanced Budget Act of 1997 and its cuts to healthcare, plus the cuts to Medicare and Medi-Cal reimbursement rates and its own high payroll costs, [207] however, the District experienced significant cash shortages and filed a chapter 9 petition on August 21, 2001. [208]

The District's chapter 9 case took 14 years to complete. Disputes arose almost immediately and the hospital closed within the first 60 days of the case, [209] leaving the District with substantial unpaid post-petition debts, including over a month's worth of payroll. [210] One major creditor claimed to have discovered numerous (and serious) violations of the hospital's safety and confidentiality requirements, plus a failure to comply with the California Department of Health Services' closure plan. [211] The disruption was such that the bankruptcy court issued ***234** an order to show cause re dismissal, [212] but elected not to dismiss the case, most likely due to the creditors' committee's position that bankruptcy better served the interests of unsecured creditors.

Once the hospital closed, the District sought to liquidate its assets. In March 2002, it negotiated a lease and potential sale of its facility to a private surgery center. [213] In June 2002, the creditors' committee filed a motion to appoint a special trustee to exercise the District's avoidance powers and assert preference claims against the City of Dinuba, one of the District's primary secured creditors. Pursuant to a settlement among the District and its major stakeholders, however, an administrator was instead appointed for "evaluation of the proposed sale of the hospital building," "assessment of the various disputed interests," and "development and formulation" of a plan of adjustment. [214] A consensual plan of adjustment was negotiated based on the sale of the hospital facility to the surgery center, but the sale fell through in 2003 due to compliance problems with new state seismic requirements. [215] The major stakeholders then negotiated a second compromise, this time requiring, among other things, that the District deed the hospital facilities to the City of Dinuba in return for a cash payment and cancellation of the City's security interest. [216]

On August 31, 2004, the bankruptcy court confirmed the District's plan of adjustment. The confirmed plan (a) permitted the District to continue to collect property tax revenues from assessments on property in the District, and (b) authorized the administrator to liquidate the District's remaining personal property assets and make payments to creditors. The District successfully made all payments required under the plan of adjustment over 10 years, which resulted in over $3.2 million being distributed to creditors and all unsecured creditors being paid in full. [217]

***235** The District remains in existence today. Instead of operating a hospital, however, it uses the property tax revenues it collects to provide "grants to various public and private organizations that provide health related services to the community." [218]

V. Conclusion

The large number of health care district bankruptcies in California reflects the increasing financial pressures on hospitals in general, and rural hospitals in particular. It is likely that increasing numbers of California health care districts will seek chapter 9 protection in the future. [219]

236** ***Appendix I

CALIFORNIA HEALTH CARE DISTRICT CHAPTER 9 BANKRUPTCIES

YEAR	HEALTH CARE DISTRICT	COURT	CASE NO.
1991	Indian Valley Hospital District	Eastern	91-21089
1993	Avenal Hospital District	Eastern	93-15960
1994	Los Medanos Health Care Corp.	Northern	94-42864
1995	Heffernan Memorial Hospital District, dba Calexico Hospital	Southern	95-10251
1995	Eastern Plumas Hospital District	Eastern	95-29930
1996	Los Medanos Community Hospital District	Northern	96-41356
1996	Corcoran Hospital District	Eastern	96-15051
1997	Kingsburg Hospital District	Eastern	97-15254
1999	Southern Humboldt Community Health Care District	Northern	99-10200
1999	Southern Inyo County Local Healthcare District	Eastern	99-16515
2000	Chowchilla Memorial Hospital District	Eastern	00-13597
2000	Sierra Valley District Hospital	Eastern	00-30288
2001	Alta Healthcare District	Eastern	01-17857
2003	Coalinga Regional Medical Center	Eastern	03-14147
2003	Indian Valley Health Care District	Eastern	03-32839
2004	Tri-City Mental Health Center, aka Tri-City Mental Health Authority [220]	Central	04-13167
2006	West Contra Costa Healthcare District, dba Doctors Medical Center	Northern	06-41774
2007	Palm Drive Health Care District	Northern	07-10388
2007	Valley Health System	Central	07-18293

2009	Sierra Kings Health Care District	Eastern	09-19728
2012	Mendocino Coast Health Care District	Northern	12-12753
2014	Palm Drive Health Care District	Northern	14-10510
2016	Southern Inyo Healthcare District	Eastern	16-10015
2016	West Contra Costa Healthcare District, dba Doctors Medical Center	Northern	16-42917
2017	Tulare Local Healthcare District, dba Tulare Regional Medical Center	Eastern	17-13797
2018	Surprise Valley Health Care District	Eastern	18-20070
2018	Coalinga Regional Medical Center	Eastern	18-13677

Footnotes

220 Tri-City Mental Health Center is a municipal joint powers authority, not a health care district.

238** ***Appendix II

OUTCOMES OF CHAPTER 9 BANKRUPTCIES OF CALIFORNIA HEALTH CARE DISTRICTS

HOSPITAL CLOSED AND NEVER REOPENED	HOSPITAL CLOSED; FACILITY CONVERTED TO OTHER HEALTH CARE USE	HOSPITAL REMAINS OPEN BUT OPERATED BY THIRD PARTY	HOSPITAL REMAINS OPEN AND OPERATED BY DISTRICT
Avenal Hospital District (district now provides ambulance services)	Los Medanos Health Care Corp. (medical clinic operated by third party)	Valley Health System (sold all assets of hospitals and skilled nursing facilities to third parties; district now funds grants for community healthcare projects)	Eastern Plumas Hospital District
• 1993	• 1994	• 2007	• 1995
Heffernan Memorial Hospital District (district now funds healthcare programs)	Corcoran Hospital District (converted to rural health clinic and sold to third party)	Sierra Kings Health Care District (sold personal property and leased real property to third party hospital operator)	Southern Humboldt Community Health Care District (Jerold Phelps Community Hospital)
• 1995	• 1996	• 2009	• 1999
Alta Healthcare District (district now funds grants for health related services to community)	Kingsburg Hospital District (mental health rehabilitation center leased to third party)	Palm Drive Health Care District (hospital converted to long term acute care and leased to third party with option to purchase)	Mendocino Coast Health Care District
• 2001	• 1997	• 2007 and 2014	• 2012

Indian Valley Health Care District (property still listed for sale)	Chowchilla Memorial Hospital District (skilled nursing facility)	Tulare Local Healthcare District (sold personal property and leased real property to third party hospital operator)	Southern Inyo Healthcare District
• 1991 and 2003	• 2000	• 2017	• 1999 and 2016
West Contra Costa Healthcare District (1 hospital closed and property vacant; 2nd hospital closed and sold to third party for use as casino parking lot)	Sierra Valley District Hospital (consolidated with Eastern Plumas Hospital District and converted to skilled nursing facility)	Coalinga Regional Medical Center (hospital closed prior to second chapter 9 case but then leased during case to third party operator who will reopen it)	Surprise Valley Health Care District (failed sale to third party hospital operator; chapter 9 case still pending)
• 2006 and 2016	• 2000	• 2003 and 2018	• 2018

Footnotes

1 Mary H. Rose is a shareholder of Buchalter, A Professional Corporation, in Los Angeles. Rebecca J. Winthrop is of counsel at Norton Rose Fulbright US LLP in Los Angeles. Both Ms. Rose and Ms. Winthrop specialize in financial restructuring and bankruptcies, mergers and acquisitions, and general business matters in the healthcare industry.

2 The information in this article has been updated through October 31, 2019.

3 CAL. HEALTH & SAFETY CODE §§ 32000-32499.4.

4 California Assembly, Committee on Local Government, *"Oversight Hearing: The Evolution of Healthcare Districts,"* Mar. 8, 2017 [hereinafter *Assembly Oversight Hearing*], at 1; Margaret Taylor, *California's Health Care Districts,"* prepared for California HealthCare Foundation (Apr. 2006) [hereinafter *Foundation Report*], at 5.

5 *Assembly Oversight Hearing*, *supra* note 4, at 1; *Foundation Report*, *supra* note 4, at 6.

6 CAL. HEALTH & SAFETY CODE § 32121.

7 Marc Joffe, *California Healthcare Districts in Crisis*, Research Studies, Jan. 22, 2015.

8 California Bill Analysis, Senate Floor, 1993-1994 Reg. Sess., S.B. 1169, CA B. An., S.B. 1169 Sen. (Aug. 12, 1994).

9 *See* CAL. HEALTH & SAFETY CODE § 32000.1 ("Any reference to 'hospital district' or 'district' shall mean 'health care district'"); *see also Assembly Oversight Hearing*, *supra* note 4, at 1. The 1994 legislation also included provisions governing transfers of property, conflict of interest, healthcare trade secrets and the public meeting act, lease agreements, and sales of property and assets. *See Foundation Report*, *supra* note 4, at 8.

10 *Assembly Oversight Hearing*, *supra* note 4, at 2; Foundation Report, *supra* note 4, at 8-9; *Special Districts: Improving Oversight & Transparency,* prepared by the Little Hoover Commission, Aug. 30, 2017 [hereinafter *Little Hoover Commission Report*], at 41-42; Association of California Healthcare Services website, http://www.achd.org/achd-message. Medi-Cal is California's Medicaid program. *See* California Department of Health Care Services (DHCS) website, https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx.

11 Jenna Magan & Donald Field, *California Health Care District Financing Techniques*, July 27, 2016, *available at* https://www.orrick.com/Insights/2016/07/California-Health-Care-District-Financing-Techniques; Henry C. Kevane, *Bond Insurers Become Active Participants in Chapter 9s,* J. OF CORP. RENEWAL (May 2012).

12 CAL. HEALTH & SAFETY CODE §§ 32300-32314; CAL. GOV'T CODE § § 53506-53509.5.

13 CAL. HEALTH & SAFETY CODE §§ 32315-32322.

14 CAL. HEALTH & SAFETY CODE § 32121.

15 CAL. HEALTH & SAFETY CODE §§ 32127.2, 129000-129355.

16 11 U.S.C. §§ 101-1532 (the "Bankruptcy Code"). Bankruptcy Code section 101(40) defines a "municipality" as a "political subdivision or public agency or instrumentality of a State." *See In re* Valley Health Sys., 383 B.R. 156, 161 (Bankr. C.D. Cal. 2008) (observing that there was no issue that a California health care district is a municipality under Bankruptcy Code section 109(c)(1)).

17 Bankruptcy Code section 109(c)(2) provides, "An entity may be a debtor under chapter 9 of this title if and only if such entity ... is specifically authorized, in its capacity as a municipality or by name, to be a debtor under such chapter by State law, or by a governmental officer or organization empowered by State law to authorize such entity to be a debtor under such chapter; ..."

18 CAL. GOV'T CODE §§ 53760-53760.7. *See* Henry C. Kevane, *Legislative Update*, Am. Bar Ass'n, Bus. L. Sec., Bus. Bankr. Comm. (Jan. 23, 2012). Interestingly, school districts in California are now excluded from the local public entities that may commence a chapter 9 case. *See* CAL. GOV'T CODE § 53760.1(f).

19 Bankruptcy Code section 901(a) does not incorporate Bankruptcy Code sections 327, 363, or 364(a) or (b) into chapter 9, although Bankruptcy Code section 364(c)-(d), requiring court approval for secured or superpriority administrative expense financing, is incorporated.

20 Timothy R. Casey & Daniel Northrop, *Chapter 9: An Rx for Health Care Districts and Public Hospital Authorities?*, Oct. 14, 2013, *available at* https://www.drinkerbiddle.com/insights/publications/2013/10/chapter-9-an-rx-for-health-care-districts-and-pu; Henry C. Kevane, *Chapter 9 Municipal Bankruptcy: The New "New Thing"?, Parts I and II,* BUS. L. TODAY (May and June 2011); Jason J. DeJonker & Miles W. Hughes, *Overview of the Chapter 9 Bankruptcy Process and Specific Issues with Public Hospital Filings*, Am. Health Law. Ass'n (Feb. 2011).

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23 Jamie Mason, *Hospitals Facing Sickness of Their Own*, 2018 WLNR 31079583 (Oct. 1, 2018).

24 Adam C. Rogoff, Anupama Yerramalli & Priya K. Baranpuria, "*Code Red: Healthcare Restructurings on the Rise*," 29 BNA'S BANKR. L. REP. 615 (May 25, 2017) [hereinafter *Code Red*].

25 *Issues and Options*, *supra* note 22, at 18.

26 Keeley Webster, *Multiple factors drive upswing of bankruptcies, closures among rural hospitals*, THE BOND BUYER, Feb. 8, 2018 [hereinafter *Multiple Factors*].

27 *Id.*

28 Lola Butcher, *Intermountain piloting app to manage the ebb and flow of nurse staffing*, MODERN HEALTHCARE, June 9, 2018 (citing Moody's Investors Service).

29 *Id.*

30 *Little Hoover Commission Report*, *supra* note 10, at 42.

31 *Code Red*, *supra* note 24, at 3; Rachel Z. Arndt, *No end in sight: EHRs hit hospitals' bottom lines with uncertain benefits*, MODERN HEALTHCARE, Oct. 13, 2018.

32 Lauren McSherry, *High Desert Hospitals Fighting for Financial Solvency*, CAL. HEALTHLINE, Dec. 3, 2012.

33 Jeff Lagasse, *Most California hospitals take a hit on Medicare reimbursement due to readmissions*, HEALTHCARE FINANCE NEWS, Oct. 1, 2018.

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35 *U.S. Not-For-Profit Health Care Small Stand-Alone Hospital Median Financial Ratios--2017*, S&P Global, July 17, 2018.

36 *Multiple Factors*, *supra* note 26.

37 Brystana G. Kaufman et al., *The Rising Rate of Rural Hospital Closures*, THE J. OF RURAL HEALTH (July 14, 2015) [hereinafter *Rising Rate*], at 35.

38 Glenn Melnick & Katya Fonkych, *Is Bigger Better? Exploring How System Membership Impacts Rural Hospitals*, California Health Care Foundation (May 3, 2018) [hereinafter *Is Bigger Better?*] at 6, *available at* https://www.chcf.org/publication/system-membership-rural-hospitals/.

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41 *Is Bigger Better?*, *supra* note 38, at 6. *See generally* Emily Rappleye, *GAO: 10 things to know about the spike in rural hospital closures*, BECKER'S HOSP. REV., Oct. 1, 2018; James Cosgrove et al., *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors*, U.S. GAO Report to Congressional Requesters, Aug. 2018; Alex Kacik, Steven Ross Johnson, Harris Meyer & Shelby Livingston, *Rethinking rural healthcare*, MODERN HEALTHCARE (Special Issue), June 9, 2018.

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45 Nina Flanagan, *Surviving the rural hospital closing challenge*, HEALTHCARE DIVE, Sept. 23, 2015.

46 *In re* Valley Health Sys., Case No. 07-18293 (Bankr. C.D. Cal.).

47 Prime Healthcare Mgmt. v. Valley Health Sys. (*In re* Valley Health Sys.), 429 B.R. 692, 700-705 and n.130 (Bankr. C.D. Cal. 2010).

48 *In re* Valley Health Sys., 383 B.R. 156 (Bankr. C.D. Cal. 2008).

49 *In re* Valley Health Sys., 331 B.R. 756 (Bankr. C.D. Cal. 2008).

50 Prime Healthcare Mgmt. v. Valley Health Sys. (*In re* Valley Health Sys.), 429 B.R. 692. This 57-page opinion provides detailed information regarding VHS and fully discusses each of the objections.

51 CAL. HEALTH & SAFETY CODE § 32121(p)(1).

52 CAL. HEALTH & SAFETY CODE §§ 32000-32314.

53 CAL. HEALTH & SAFETY CODE § 32121(p)(1).

54 Prime Healthcare Mgmt. v. Valley Health Sys. (*In re* Valley Health Sys.), 429 B.R. at 711-16. Another objection to confirmation was that the sale was not for fair value. An interesting portion of the opinion discusses the valuation methodology used by VHS's consultants, Valuation & Information Group, in preparing the fair value opinion. *Id.* at 725-38.

55 *In re* W. Contra Costa Healthcare Dist., Case No. 06-41774 (Bankr. N.D. Cal.).

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61 *In re* Tulare Local Healthcare Dist., Case No. 17-13797 (Bankr. E.D. Cal.).

62 *Id.*, Motion for Authorization To Reject Executory Contract (Healthcare Conglomerate Associates, LLC) (Oct. 10, 2017), ECF No. 32 at 2.

63 *Id.*, Healthcare Conglomerate Associates, LLC's Opposition to Motion for Authorization to Reject Executory Contract (Oct. 19, 2017), ECF No. 81 at 5-7.

64 *Id.*, Statement of Qualifications and Memorandum of Points and Authorities in Support by Tulare Local Healthcare District, dba Tulare Regional Medical Center (Oct. 26, 2017), ECF No. 145 [hereinafter *Tulare Chapter 9 Statement*] at 4).

65 Keeley Webster, *Hospital district in California files for Chapter 9 bankruptcy*, THE BOND BUYER, Oct. 2, 2017.

66 *Tulare Chapter 9 Statement*, *supra* note 64, at 6.

67 Civil Minutes, *In re* Tulare Local Healthcare Dist., Case No. 17-13797 (Bankr. E.D. Cal. Nov. 16, 2017), ECF No. 221.

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69 Tulare Local Healthcare Dist., dba Tulare Regional Med. Ctr. v. Healthcare Conglomerate Assocs., LLC, Adv. Proc. No. 18-01005 (Bankr. E.D. Cal.).

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78 *Id.*, Notice of Effective Date of Plan for the Adjustment of Debts Dated as of Apr. 30, 2019 (Oct. 18, 2019), ECF No. 1684 at 1-2).

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80 *Id.* at 19, 41.

81 Disclosure Statement Dated: Sept. 17, 2004, *In re* Indian Valley Health Care Dist. [hereinafter *Indian Valley II*], Case No. 03-32839 (Bankr. E.D. Cal. Sept. 22, 2004), ECF No. 66 [hereinafter *Indian Valley II Disclosure Statement*] at 1).

82 *In re* Indian Valley Hosp. Dist., Case No. 91-21089 (Bankr. E.D. Cal.) [hereinafter *Indian Valley I*].

83 *Indian Valley II*, *supra* note 81.

84 *Indian Valley II Disclosure Statement*, *supra* note 81, at 2-5.

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219 The authors and their respective law firms have represented or provided advice to parties in interest in certain of the cases discussed in this article. The opinions expressed in this article are those of the authors and do not necessarily reflect the views of their respective law firms or any of their clients.

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