IN THE UNITED STATES BANKRUPTCY COURT
FOR THE DISTRICT OF DELAWARE

In re:	)	
	)	
GULF COAST HEALTH CARE, LLC, et al.[1]	)	Case No. 21-11336 (KBO)
	)	Chapter 11
Debtor.	)	(Jointly Administered)
	)	
	)	**Related Docket No. 166**

UNITED STATES' OBJECTION AND RESERVATION OF RIGHTS TO THE DEBTORS' MOTION FOR ORDER AUTHORIZING TRANSFER OF MANAGEMENT, OPERATIONS, AND RELATED ASSETS FREE AND CLEAR OF LIENS, CLAIMS, ENCUMBRANCES AND INTERESTS AND SEEKING RELATED RELIEF

The United States of America (the "United States"), on behalf of the United States Department of Health and Human Services ("HHS"), and its component agencies, the Centers for Medicare & Medicaid Services ("CMS") and the Health Resources and Services Administration ("HRSA"), objects to the above-referenced debtors' (the "Debtors") motion seeking authorization to transfer the management, operations, and related assets, of skilled nursing facilities (the "Motion").[2] In support of its objection, the United States respectfully states as follows:

[1] The last four digits of Gulf Coast Health Care, LLC's federal tax identification number are 9281. There are 62 Debtors in these jointly administered chapter 11 cases. A complete list of the Debtors and the last four digits of their federal tax identification numbers are not provided herein. A complete list of such information may be obtained on the website of the Debtors' proposed claims and noticing agent at https://dm.epiq11.com/GulfCoastHealthCare. The location of Gulf Coast Health Care, LLC's corporate headquarters and the Debtors' service address is 40 South Palafox Place, Suite 400, Pensacola, FL 32502.

[2] Motion for Order (I) Authorizing Transfer of Management, Operations, and Related Assets of Omega Facilities Free and Clear of Liens, Claims, Encumbrances, and Interests (II) Approving Procedures for Future Assumption and Assignment of Executory Contracts and Unexpired Leases; (III) Approving Rejection and Termination of Master Lease, and Allowance of Omega Rejection Damages Claim in Connection Therewith; (IV) Approving Form of Management and Operations Transfer Agreement; and (V) Granting Related Relief [Dkt. 166].

BACKGROUND

1. On October 14, 2021, the Debtors filed voluntary petitions for relief under chapter 11 of title 11 of the United States Code (the "Bankruptcy Code"). By Order of the Bankruptcy Court, the Debtors' chapter 11 cases are being jointly administered under the above caption. [Dkt. 43].

2. A committee of unsecured creditors was appointed by the United States Trustee on October 25, 2021. [Dkt. 111].

3. On November 2, 2021, the Court entered an Order approving a Stipulation entered into by the Debtors and CMS, providing for release of pre-bankruptcy Medicare payments to the Debtors in exchange for certain protections to CMS (the "CMS Stipulation"). [Dkt. 158-1].

4. On November 3, 2021, the Debtors filed the Motion seeking authority for Debtor Gulf Coast Health Care, LLC ("GC") and affiliated Debtors (the "Existing Operators") to transfer management and operation of twenty-four (24) skilled nursing facilities (the "SNFs") to new operators under proposed "Management and Operations Transfer Agreements." ("MOTAs"). [Dkt. 166-2, Exh. 2].[3] The Debtors also seek authority to transfer certain assets used at the SNFs free and clear of liens, claims, encumbrances and interests pursuant to Section 363(f) of the Bankruptcy Code, and seek approval of procedures for assuming and assigning executory contracts and unexpired leases associated with the facilities under Section 365 of the Bankruptcy Code.

5. The Existing Operators are parties to Medicare Part A Health Insurance Benefit Agreements (commonly known as a "Provider Agreements" or "Medicare Provider Agreements") with the Secretary of HHS (the "Secretary"), acting through CMS, under which they receive payment for services provided to Medicare beneficiaries pursuant Title XVIII of the Social Security

[3] Capitalized terms not otherwise defined herein shall have the same meaning ascribed to them in the Motion and the form MOTA attached thereto.

Act, 42 U.S.C. §§ 1395-1395lll (the "Medicare Act") and regulations promulgated thereunder. 42 C.F.R. § 400.202 *et seq*.

6. Under the Provider Agreements, SNFs receive Medicare Periodic Interim Payments ("PIPs"). 42 U.S.C. § 1395g(e)(2); 42 C.F.R. § 418.307, 42 C.F.R. § 413.64(h)(2)(v). PIPs are biweekly payments approximating the cost of services that will be furnished during the current fiscal year. PIP payments are periodically adjusted to reflect current claim levels and to determine if overpayments have been made during a fiscal year. As of the date of this Objection, CMS records showed $50,723.63 in outstanding prepetition overpayment obligations, although the amount of such overpayments could potentially grow significantly as a result of additional cost reporting. Exhibit "A" hereto itemizes the overpayments and other liabilities of each of the Existing Operators.

7. Additionally, twenty (20) Existing Operators owe CMS for funds advanced to those operators prior to the bankruptcy cases under the Medicare Advanced and Accelerated Payment program ("MAAP").[4] The Existing Operators' total MAAP obligations are $8,031,101.54 as of the date of this Objection. Exhibit "A" itemizes the MAAP liabilities for each Existing Operator.

8. Prior to the bankruptcy cases, HRSA distributed $20,261,375.40 to the Existing Operators from HRSA's COVID-19 Provider Relief Fund ("PRF"). HRSA distributes PRF funds to eligible healthcare providers to prevent, prepare, and respond to the spread of COVID-19. Recipients must repay PRF distributions if they fail to agree to certain associated Terms and Conditions or fail to use the funds for permitted COVID-19 related purposes. HRSA has yet to audit the Existing Operators' use of the PRF distributions to determine whether the Existing Operators used the PRF funds for permitted purposes and otherwise complied with the PRF funds' Terms and Conditions. Exhibit "A" itemizes PRF distributions to each Existing Operator.

[4] CMS records indicate that four (4) Existing Operators, NF Panama, LLC, NF Nine Mile, LLC, SF Brevard, LLC, and SF Lake Placid ALF, LLC, have no outstanding MAAP liabilities.

9. HRSA is also preparing to release certain "Phase IV" PRF distributions to eligible healthcare providers who submitted timely applications. The application period closed on November 3, 2021, and HRSA is reviewing such applications to determine which providers are eligible. HRSA has confirmed that at least twenty-three (23) of the Existing Operators have applied to receive further PRF distributions.[5] HRSA anticipates that distributions to eligible providers will begin in December, 2021. PRF distributions (as well as any obligation to repay them) are not transferable.[6]

10. In the MOTAs, the Debtors propose to transfer management of SNFs to a "new manager" on December 1, 2021 (the "Management Transfer Date"). [Dkt. 166-2, Exh. 2, ¶ 13(a)]. The new manager will manage each SNF on behalf of the Existing Operator during a "Management Period." [*Id.,* Recital ¶ D]. The Management Period will terminate when a new operator has completed licensure and other requirements necessary to begin operating the SNF (the "License Transfer Date"). [*Id.,* Recital ¶ E].

11. Besides their assets, the Debtors propose to transfer the Provider Agreements to new SNF operators on the License Transfer Date.[7] If CMS has not approved the new SNF operators' Medicare enrollment applications (the "CHOW Applications") in time to transfer the Provider Agreements by the License Transfer Date, however, the MOTAs permit the new operators to use the

[5] As of the date of this Objection, HRSA is unable to confirm whether NF Panama, LLC applied to receive Phase IV PRF distributions.

[6] HRSA*, Provider Relief Programs: Provider Relief Fund and ARP Rural Payments Frequently Asked Questions* (Oct. 26, 2021), https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/provider-relief-fund-faq-complete.pdf (Where PRF recipient transfers facility and assets to new operator, "the original recipient must use the funds for its eligible expenses and lost revenues and return any unused funds to HHS.").

[7] The Motion and MOTAs define the License Transfer Date as the date on which the new operator "has obtained all requisite approval and licenses to operate the Facility." [Dkt. 166, ¶4; Dkt. 166-2, Exh. 2, Recital ¶ E].

Provider Agreements and CMS provider numbers of the Existing Operators for an indefinite period. [Dkt. 166-2, Exh. 2, Recital ¶ G].[8]

ARGUMENT

12. The United States objects for seven reasons. First, the Existing Operators seemingly seek to transfer their Provider Agreements free of pre-transfer liabilities owed to CMS, in contravention of the CMS Stipulation, the Medicare Act, and CMS Regulations. Second, the MOTAs propose that the new operators may use the Prior Operators' provider numbers and Provider Agreements while the new operators seek CHOW approval, also directly contravening Medicare regulations. Third, the MOTAs allow the new manager to receive Medicare Payments instead of the Existing Operators, violating Medicare Act anti-assignment restrictions. Fourth, the MOTAs make the License Transfer Date contingent upon the approval of a Change of Ownership ("CHOW"), which is inherently infeasible because it is impossible to process a CHOW Application prior to the transfer of SNF operations. Fifth, to the extent that the MOTAs seek to transfer the PRF distributions, they cannot, as such a transfer would violate the PRF Terms and Conditions and related HRSA guidance. Sixth, the proposed order impermissibly attempts to confer jurisdiction upon the Bankruptcy Court to resolve disputes arising from the Provider Agreements. Finally, any order approving the transfers must preserve the United States' rights and defenses, including any rights of set off, recoupment or counterclaims under applicable non-bankruptcy law.

I. New Operators Must Assume Provider Agreements Subject to All Associated Liabilities.

13. CMS objects to any assignment of the Provider Agreements without explicit assumption of all associated liabilities. Not only do the Medicare Act and CMS regulations require

[8] Pursuant to Paragraph 17(r) of the MOTAs, recitals are incorporated into the terms of each agreement. [Dkt. 166-2, Exh. 2, ¶ 17(r)].

assumption of liabilities, the Debtors have previously agreed in a court-approved stipulation that the transfers of the Existing Operators' provider agreement will be subject to such liabilities.

14. Among other protections provided by the CMS Stipulation, the Debtors agreed that any transfer of Provider Agreements "will be accomplished in a manner such that the transferee will assume all liabilities associated with such agreement. . ." [Dkt. 158-1, ¶ 3]. Indeed, the Stipulation allows CMS to impose a new freeze on Medicare payments if a Debtor attempts to transfer a Provider Agreement without associated liabilities. [Dkt. 158-1, ¶ 3]

15. These provisions simply reflect the requirements of the Medicare Act and Medicare regulations. The Medicare Act and regulations explicitly require new operators to accept all associated liabilities when assuming provider agreements. 42 C.F.R. § 489.18(d). Medicare Part A Provider Agreements may be assigned only if the provider undergoes a "change of ownership" (a "CHOW"). 42 C.F.R. § 489.18. When CMS determines that a valid CHOW has occurred, the existing Provider Agreement is automatically assigned to the new owner. 42 C.F.R. § 489.18(c); *See United States v. Vernon Home Health, Inc.*, 21 F.3d 693, 696 (5th Cir. 1994); *UPMC St. Margaret Hosp. v. Leavitt,* No. 06-1237, 2007 WL 4389842, at *3 (W.D. Pa. Dec. 12, 2007), *aff'd sub nom*. *UPMC St. Margaret Hosp. v. Sebelius*, 349 F. App'x 786 (3d Cir. 2009). An assigned agreement, however, is subject to all statutory and regulatory terms under which it originally was issued, including the adjustment of payments to account for previously made overpayments. *In re Charter Behav. Health Sys., LLC*, 45 F. App'x 150, 151, n. 1 (3d Cir. 2002); *Vernon*, 21 F.3d at 696 (*citing* 42 C.F.R. § 489.18(a), (d)).

16. To obtain formal approval for the transfer of a provider agreement, the transferee must submit a CHOW Application. The application may be submitted up to 90 days prior to the anticipated CHOW. *See* MPIM, CMS Publ. 100-08, Chap. 15, § 15.7.7.1.3(F). However, CMS finally determines whether a valid CHOW has occurred only after the proposed CHOW actually

occurs. SOM, § 3210.1E.[9] Upon a valid CHOW, the existing Provider Agreement is automatically assigned to the new owner, unless that new owner rejects such assignment. See 42 C.F.R. § 489.18(c).

17. If the new owner accepts assignment, a Medicare provider agreement is assigned in full on the terms and conditions under which it was issued, 42 C.F.R. § 489.18(d), including the new owner being subject to the provider's compliance history, civil money penalties and other enforcement remedies, recoupment of pre-CHOW debts, and other obligations and liabilities. *In re Charter Behav. Health Sys.,* 45 F. App'x at, n. 1 ("If the new owner elects to take an assignment of the existing Medicare Provider Agreement, it . . . assumes successor liability for overpayments and civil monetary penalties asserted by the Government against the previous owner") (*citing* 42 C.F.R. § 489.18(d); *See also Vernon supra.* 21 F.3d at 696; *Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100, 1103-04 (8th Cir. 2000) (holding that "an [assigned] provider agreement is taken subject to all the terms and conditions under which it was issued"); *BP Care v. Thompson*, 337 F. Supp. 1021, 1029 (S.D. Ohio 2003) (upholding successor liability for new owner), *aff'd on other grounds*, 398 F.3d 503 (6th Cir. 2005).

18. Purchasers and related entities cannot contract their way out of federal obligations and requirements. *See Vernon,* 21 F.3d at 696 (any state law "right to purchase only assets is preempted by the federal law mandating that all assignments of provider agreements be subject to federal terms and conditions."); *United States v. East Ridge Assocs.*, 295 F. Supp. 2d.101, 105 (D. Me. 2003) (Purchasers may not purport to receive property which is subject to federal law and regulations "as if the law or regulation does not exist."). Accordingly, because "federal law fixes the

[9] The Medicare Program Integrity Manual ("MPIM") and the State Operations Manual ("SOM") are available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (last visited 5/28/2018).

relationships and responsibilities of Medicare with beneficiaries and providers[,] these relationships and responsibilities are beyond the reach of private parties … to alter." *Mission Hosp. Reg'l Med. Ctr. v. Burwell*, 819 F.3d 1112, 1116 (9th Cir. 2016).

19. Here, the MOTAs include unclear and seemingly contradictory provisions on assuming the liabilities associated with the Provider Agreements. Paragraph 1(d) provides that the "New Operator shall expressly assume all of Prior Operator's obligations under Contracts *with respect to events or periods on and after the License Transfer Date*..." [Dkt. 166-2, Exh. 2, ¶ 1(d) (*emphasis added*)]. This provision is qualified with respect to Provider Agreements by a statement that *all* overpayment and MAAP liabilities (not just liabilities arising on or after the License Transfer Date) pass to the new operator:

> …the Assumed Liabilities shall include any and all overpayment liabilities associated with the Prior Operator's provider agreements, including any funds that Prior Operator previously received from CMS pursuant to the Medicare Accelerated and Advance Payment Program (collectively, the "MAAP Liabilities"). . .

Id. Elsewhere, however, the MOTAs list among "excluded liabilities" claims under Provider Agreements if they "relate to or arise from the acts, obligations, or omissions of Prior Operator *for dates of service prior to the Transition Time.*" [Dkt. 166-2, Exh. 2, ¶ 1(e)(2)] (*emphasis added*). Thus, while the new operators purport to assume all liabilities for Medicare overpayments and MAAP payments in paragraph 1(d), in paragraph 1(e), they appear to exclude at least some pre-transfer liabilities.

20. Even if the MOTAs can be read to require assumption of overpayment and MAAP liabilities, other liabilities exist and must be assumed with the Provider Agreements. Provider agreement terms and conditions subject a new provider to the previous provider's compliance history, potential civil money penalties and other enforcement remedies, as well as recoupment or setoff of all pre-CHOW debts, and other obligations and liabilities.

21. The Debtors and new operators cannot exclude any pre-transfer liabilities when assuming provider agreements. They must clearly provide that overpayment and MAAP liability, as well as any other liabilities under the Provider Agreements, pass to the transferee. Accordingly, CMS objects to any proposed order which does not specify that the Provider Agreements are being assigned subject to all associated pre- and post- transfer liabilities, regardless of any MOTA provision suggesting otherwise.

II. The New Operators Cannot Use the Existing Operators' Provider Agreements and Provider Numbers After the License Transfer Date While Seeking Approval for a CHOW.

22. The MOTAs allow the new operators "to continue to use Prior Operators' provider numbers and agreements. . ." after transfer of the SNFs while the new operators seek CHOW approval, [Dkt. 166-2, Exh. 2, Recital ¶ G], and authorize the Existing Operators "to enter into any management or other agreement" to accomplish this. [Dkt. 166-2, Exh. A, ¶ 17]. These provisions directly contravene Medicare regulations. A provider cannot allow any other party to use its existing Provider Agreement or provider number. *See* 42 C.F.R. § 424.550(a) ("provider or supplier is prohibited from selling its Medicare billing number or privileges . . . or allowing another individual or entity to use its Medicare billing number.").

23. While the new operators' desire to avoid billing disruptions during the CHOW process is understandable, that desire does not justify violating regulations prohibiting their use of the Provider Agreements. MPIM, CMS Publ. 100-08, Chap. 15, §§ 15.7.7.1.4, 15.7.7.1.5, 15.7.7.1.6 ("It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period."). Medicare regulations limit billing disruptions and reimbursement by permitting a new operator to file its new enrollment application before the CHOW. The MOTAs, in fact, contemplate the Existing Operators, new manager and new providers submitting CHOW Applications before the

transfer of the SNFs to the new operators through the "Management Period" mechanism. [Dkt. 166-2, Exh. 2, Recitals D, G].

24. In any case, the Debtors cannot accomplish in this Motion what Medicare regulations prohibit, allowing new operators to use the Existing Operators' Provider Agreements and numbers. Any proposed order should indicate explicitly that new operators are not entitled to use Existing Operators' Provider Agreements after transfer of the SNFs.

III. The New Manager Cannot Receive Payments Under an Existing Operator's Provider Agreement Prior to a CHOW.

25. The MOTAs also provide detailed mechanisms for management of the facilities during the Management Period. Those mechanisms allow the new manager to request that CMS make Medicare payments during the Management Period directly to it, instead of to Existing Operators. [Dkt. 166-2, Exh. 2, Recital D, G, ¶ 4(a)]. The anti-assignment provisions of the Medicare Act preclude redirecting Medicare reimbursement to third parties. 42 U.S.C. §§ 1395g(c) and 1395u(b)(6); see 42 C.F.R. § 424.73(a). "Medicare funds cannot be paid directly by the government to someone other than the provider . . . ." *DFS Healthcare Receivables Trust v. Caregivers Great Lakes, Inc.*, 384 F.3d 338, 350 (7th Cir. 2004). Accordingly, CMS objects to any provision which might require it to make payment to any manager or other party other than the Existing Operator.

IV. Making the License Transfer Date Contingent Upon Prior Approval of a CHOW is Inherently Infeasible.

26. In addition, the MOTAs create in inherent "timing" problem by conditioning the License Transfer Date on CHOW approval. The MOTAs set no date certain for the transfers of SNF operations. Instead, the License Transfer Date expressly depends upon the new operator obtaining "all requisite approval and licenses to operate the Facility." [Dkt. 166-2, Exh. 2, Recital ¶ E].

27. Assuming that CHOW approval is one of the "requisite approvals" referenced in this provision, the MOTAs fail to account for CMS not finally determining a CHOW unless and until that CHOW has actually occurred. SOM, CMS Publ. 100-07 §§ 2005E1 & 3210.2 (CMS RO decides if CHOW has actually occurred); *see also* MPIM, Chap. 15 § 15.7.7.1.6 (prohibiting certain changes of information prior to issuance of tie-in notice for CHOW). "It is not possible to know beforehand whether a CHOW will take place on a planned CHOW date. In every case, one must wait until after a proposed CHOW date to determine whether the planned CHOW event actually occurred." SOM, CMS Publ. 100-07, Chap. 3 § 3210.1E. For this reason, processing a CHOW prior to the effective date is impossible.

28. If the CHOW cannot be approved until the facilities actually have a new operator (i.e., after passage of the License Transfer Date), but the facilities will not have a new operator unless and until a CHOW is approved, then—logically speaking—the transfer of operations will never be consummated. Thus, to make the transactions feasible, the proposed order should make clear that CMS's approval of the CHOWs shall not be a condition precedent for the License Transfer Date.

V. All HRSA PRF "Phase IV" Distributions Must Be Retained by the Existing Operator.

29. The MOTAs are also unclear regarding the use of any HRSA PRF distributions to Existing Operators. The Debtors have likely applied to participate in Phase IV PRF distributions and, if eligible, would likely receive PRF distributions within the coming weeks.

30. PRF Terms and Conditions permit only the PRF recipient to use the funds it receives,[10] and HRSA Guidance prohibits any assignment or transfer of PRF distributions made to

[10] Department of Health and Human Services, *Acceptance of Terms and Conditions*, https://www.hrsa.gov/provider-relief/past-payments/terms-conditions (stating that HRSA "shall

the Existing Operators, instead mandating that any funds not used by the recipient be returned to HHS. Specifically, the HRSA Guidance expressly prohibits a PRF recipient selling its assets from transferring PRF funds to a buyer. "[T]he original recipient must use the funds for its eligible expenses and lost revenues and return any unused funds to HHS."[11] If "a bankrupt recipient is liquidated, it must similarly use the funds for its eligible expenses and lost revenues and return any unused funds to HHS." An Existing Operator therefore must use PRF distributions itself or, if it has no COVID-related purposes for which to use the distributions, return them to HHS.

31. Paragraph 4(e) of the MOTAs addresses distributions of COVID Payments (including PRF funds) but it does not clearly prevent transfer of such payments to new operators. The paragraph states that COVID Payments "relating to periods prior to the Management Transfer Date" are considered Pre-Closing Accounts Receivable, which are excluded from transfer and retained by the Existing Operator. Any COVID Payments "relating to periods" during or after the Management Transfer Date, however, are seemingly transferred to the new manager or new operators for use as permitted under applicable law. [Dkt 166-2, Exh. 2, ¶ 4(e)].

32. The order authorizing the MOTAs must prohibit the transfer of PRF distributions to the new operator, and state explicitly that all such distributions are to be retained by the Existing Providers and used as permitted by applicable non-bankruptcy law and HRSA regulations.

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reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.").

[11] HRSA, *Provider Relief Programs: Provider Relief Fund and ARP Rural Payments Frequently Asked Questions* (Oct. 26, 2021), https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/provider-relief-fund-faq-complete.pdf (Where PRF recipient transfers facility and assets to new operator, "the original recipient must use the funds for its eligible expenses and lost revenues and return any unused funds to HHS.") (hereinafter, "HRSA Guidance").

VI. The Proposed Order Fails to Acknowledge the Medicare Act's Limitations on the Court's Jurisdiction.

33. The Debtors cannot confer jurisdiction upon the Bankruptcy Court to resolve disputes involving or related to the Provider Agreements. Section 1395ii of the Medicare Act incorporates the jurisdictional bar contained in Section 405(h) of the Social Security Act (42 U.S.C. § 405(h)), thereby "channel[ing] most, if not all, Medicare claims through [the] special review system." *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 8 (2000); *See Heckler* v. *Ringer*, 466 U.S. 602, 614, 621 (1984) ("all aspects" of claims arising under the Act must be "channeled" through the administrative process).

34. Here, the proposed order grants the Bankruptcy Court jurisdiction over "the rights and duties of the parties hereunder or thereunder or any issues relating to the MOTA and *any related agreements.*" [Dkt. 166-2, Exh. A, ¶ 22) (*emphasis added*)]. The Debtors, however, cannot confer jurisdiction upon the Bankruptcy Court over disputes arising under the Provider Agreements, if such disputes have not met the Medicare Act's requirements for presentment and appropriate exhaustion of administrative remedies, 42 U.S.C. §§ 405(h), 1395ii. Accordingly, any order should exclude disputes concerning the Provider Agreements from the exclusive Bankruptcy Court jurisdiction.

VII. Other Objections and Reservations of Rights.

35. The United States also objects to the transfers, and reserves all rights concerning the Motion, absent provisions in the proposed order preserving the United States' rights and defenses, including any rights of setoff, recoupment or counterclaims under applicable non-bankruptcy law. That such rights create secured claims in favor of the United States entitled to priority over the liens of secured creditors of the Debtors is well-settled. *See In re Metropolitan Hosp.*, 131 B.R. 283, 291 (E.D. Pa. 1991). The United States submits that any order approving the transfers should include language preserving these rights of the United States.

CONCLUSION

Based on the foregoing, the United States objects to the Motion and reserves all rights with respect to the Motion, and reserves its right to amend or supplement this Objection to the extent that additional grounds for objection become known. By filing this Objection, the United States waives no other rights, claims, actions, defenses, setoffs, or recoupments to which it entitled, including its right to raise additional objections to the Motion, and all rights, claims, actions, defenses, setoffs, and recoupments are expressly preserved.

Dated: November 17, 2021

Respectfully Submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that I caused a copy of this Objection to be served November 17, 2021, through the Court's electronic noticing system (CM/ECF) upon the Movant and all other parties requesting electronic service of notices.

/s/*Augustus T. Curtis*
Augustus T. Curtis