

# NCCNHR

The national consumer voice for quality long-term care

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November 9, 2007

The Honorable Fortney H. "Pete" Stark  
Chair, Subcommittee on Health  
House Committee on Ways and Means  
1135 Longworth House Office Building  
Washington, DC 20515

The Honorable Dave Camp  
Ranking Member, Subcommittee on Health  
House Committee on Ways and Means  
1135 Longworth House Office Building  
Washington, DC 20515

Dear Chairman Stark and Ranking Member Camp:

Twenty years after Congress passed landmark nursing home reform legislation, progress ensuring resident quality of care is threatened by the takeover of nursing home chains by private equity investors who are maximizing profits while isolating themselves from accountability to residents, workers, or regulators. A *New York Times* investigation, "At Many Homes, More Profits and Less Nursing," September 23, 2007, found that the typical private investor-owned facility scores worse on most quality indicators than other types of facilities; has 19 percent more serious health deficiencies than the national average; and ranks 35 percent below the national average in registered nurses. Unfortunately, staffing levels and quality of care at many for-profit, chain-operated facilities are already below acceptable standards.

The nursing home industry receives approximately \$75 billion a year in federal Medicare and Medicaid funding. As organizations that represent nursing home residents, their families, and nursing home workers, we urge you to use the Medicare legislation currently under consideration to take initial steps to improve transparency, accountability and staffing throughout the entire nursing home industry. These include the following recommendations, which can be implemented at minimal cost:

#### Increasing the transparency and accountability of corporate ownership

- Require full disclosure to the Centers for Medicare & Medicaid Services (CMS) of all affiliated entities with a direct or indirect financial interest in the facility and their parent companies, and the owners (including owners of the real estate), operators, and management of each facility; and require that all these entities be parties to the Medicare provider agreement and listed on Nursing Home Compare. CMS should maintain an ownership database and monitor the quality of care provided by the companies. Severe penalties, including exclusion from Medicare, should be established for hiding ownership or affiliated relationships.
- Many nursing home chains have created complex corporate structures that make compensating residents who have been harmed and recovering penalties from entities that actually have assets very difficult. As early as 1979, a GAO report, *Problems in Auditing Medicaid Nursing Home Chains*, HRD-78-158 (Jan. 9, 1979), <http://archive.gao.gov/f0302/108331.pdf>, identified complex transactions and relationships in chains and recommended better auditing practices. CMS should address this lack of transparency and the related problem of "judgment proof" or bankrupt entities that commit wrongdoing, such as violations of regulations or fraud, by requiring a surety bond. The provider agreement should be amended to require that providers including purchasers of an existing facility or company, deposit assets in a surety bond with the amount (to be determined) proportional to the number of beds in the facility. The bond would cover

*NCCNHR (formerly the National Citizens' Coalition for Nursing Home Reform) is a nonprofit membership organization founded in 1975 by Elma L. Holder to protect the rights, safety, and dignity of America's long-term care residents.*

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fines, civil monetary penalties, expenses associated with receiverships and temporary management arrangements imposed by state agencies, operational costs where residents are abandoned or workers are not paid, and attorneys' fees, litigation costs and damages awarded to plaintiffs in civil damage actions.

- Require CMS to certify the provider agreements annually to ensure that they are consistent with the current ownership structure and affiliated entities.
- Require CMS to post enforcement actions against facilities and maintain actual CMS Form 2567 survey reports on Nursing Home Compare.

#### Promoting improved staffing

- Require CMS to collect electronically submitted data from facility payroll records and temporary agency contracts on a quarterly basis, including data on turnover and retention; and require CMS to report that information on Nursing Home Compare as quality measures that include a ratio of direct care nursing staff (RNs, LPNs, and CNAs) to residents and turnover and retention rates. CMS should monitor the reported staffing levels on a quarterly basis and direct that a survey be conducted at facilities where staffing appears to be low and/or declining. CMS has already developed a system to collect and report this staffing information. The National Quality Forum has also recommended that CMS establish a nurse staffing quality measure.
- Require that information on cost reports for Medicare be reported based on five cost centers: (1) direct care nursing services; (2) other direct care services (e.g., activities, therapies); (3) indirect care (e.g., housekeeping, dietary); (4) capital costs (e.g., building, equipment and land costs); and (5) administrative costs. The cost reports should be reported electronically to CMS and summary data should be made available on Nursing Home Compare. In 2004, MedPAC recommended requiring nursing facilities and skilled nursing facilities to publish nursing costs separately from other costs on cost reports. This recommendation was reiterated in a June 2007 MedPAC report ([www.medpac.gov/Chapters/Jun07\\_Ch08.pdf](http://www.medpac.gov/Chapters/Jun07_Ch08.pdf)).
- Require CMS to conduct audits of nurse staffing data reports and cost reports at least every three years to ensure the accuracy of the data reported and to prevent fraud. Severe penalties should be established for filing false reports or failing to file timely cost reports.

It is imperative that Congress take immediate action to prevent the further deterioration of care.

Please contact Janet Wells, NCCNHR Director of Public Policy, 202/332-2275, or Michelle Nawar, SEIU Assistant Director of Legislation, 202-730-7232, if you have questions.

Sincerely,

NCCNHR: The National Consumer Voice for Quality Long-Term Care  
Alliance for Retired Americans  
American Federation of State, County, and Municipal Employees  
B'nai B'rith International  
Center for Medicare Advocacy  
Consumers Union  
National Senior Citizens Law Center  
OWL – The Voice of Midlife and Older Women  
Service Employees International Union

cc: All Members, Subcommittee on Health, House Committee on Ways and Means

Equity and Inequity:  
How Private Equity Buyouts  
Hurt Nursing Home Residents



## Equity and Inequity: How Private Equity Buyouts Hurt Nursing Home Residents

**Equity and Inequity:  
How Private Equity Buyouts Hurt Nursing Home Residents**

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### **Executive Summary**

*As more private equity firms take over nursing homes, the effects these takeovers have on resident care are beginning to become clearer. From the buyouts of Mariner and Beverly nursing homes, we see increases in the number of resident care deficiencies along with a trend toward restructuring that in effect limits liability, minimizes tax responsibilities, and makes it difficult for the public to determine how effectively Medicare and Medicaid dollars are spent.*

*This pattern suggests that the Carlyle Group's buyout of Manor Care could harm its residents. Because Manor Care already has a poor record of resident care, the Carlyle Group must take action to improve care when they take over the company. Yet, the Carlyle buyout will saddle Manor Care with between \$412 million and \$440 million in annual interest expense in year one of the deal. If Manor Care cuts costs and requires cost reductions evenly across divisions and staffing levels, the company could cut 7,874 hours of CNA time per day (which equates to the time worked by more than 980 full-time CNAs). Furthermore, Carlyle has signaled that it will restructure Manor Care in a way that we believe shields it from liability, reduces its tax responsibilities, and makes it difficult for regulators to hold the company accountable for quality care.*

## Introduction

Stakes are high as the Carlyle Group, one of the world's largest private equity buyout firms, moves to complete the \$6.6 billion leveraged buyout of HCR Manor Care, the nation's largest nursing home care provider. New research shows this deal could come at the expense of nursing home residents and taxpayers.

The Manor Care takeover is one of the largest to date in an industry where private equity ownership has become a national trend. By acquiring one of the nation's largest nursing home chains, Carlyle expects to be able to keep its nursing home beds full as the U.S. population ages, and expects Medicare to be a profitable revenue source for these beds.

Already, though, we've seen the negative effect that private equity buyouts have on the quality of care at nursing homes. Private equity firms take on significant debt to buy nursing homes and they must service that debt and the interest that comes along with it. But are these firms cutting costs to pay off the debt in a way that jeopardizes patient safety and care? Private equity firms restructure nursing homes to maximize profit but in the end create a maze of control and ownership that makes it difficult to hold nursing homes and private equity companies accountable for providing quality care.

Our new research shows that the debt and potential staff cutbacks could have significant, quantifiable effects on nursing home residents' dignity and day-to-day well-being. The cost of Carlyle's debt could mean longer waits for care, less assistance, and fewer hours of care from nursing staff.

The Carlyle Manor Care buyout raises serious concerns for nursing home staff trying to provide quality care, the taxpayers who fund the bulk of this care, and, most importantly, for the residents who may suffer. Meanwhile, Carlyle Group and Manor Care executives pay themselves millions while saddling Manor Care—a company that already has a record of failing to provide quality care—with billions in debt.

Carlyle has indicated an interest in closing the deal by the end of the year and Manor Care shareholders have already approved the deal, adding urgency to the questions about the impact of this corporate takeover and its role on seniors and people with disabilities who live in Manor Care homes.

## Private Equity's Effects on Care

### Decrease in the Quality of Care Delivery

In a recent front-page expose (9/23/07), *The New York Times* investigated what happens to nursing home quality of care when one chain of nursing homes in Florida was bought out by private equity firms. The *Times* found that among other concerns there have been serious quality of care deficiencies and staffing cuts, sometimes below federally recommended levels:

**“Serious quality-of-care deficiencies—like moldy food and the restraining of residents for long periods or the administration of wrong medications —rose at every large nursing home chain after it was acquired by a private investment group from 2000 to 2006....”**

Our new research, based on CMS data, supports this finding. We looked at two major nursing home chains, Mariner Health Care and Beverly Enterprises, that have already been bought by private equity firms. In December 2004,<sup>2</sup> National Senior Care acquired Mariner’s 29,685<sup>3</sup> nursing home beds in 252 facilities across 19 states.<sup>4</sup> To analyze the impact of National Senior Care’s Mariner buyout on quality care, we compared the number of federal resident care violations from the inspection prior to the facility being bought by private equity with the number found during their most recent inspection for each of the homes. In Mariner’s case, we found a 29.4 percent increase in violations of federal resident care. This was more than double the 11.9 percent increase of the other homes in the states in which Mariner operates.<sup>5</sup>

***Mariner Health Care Inc. was taken private in December 2004 by National Senior Care Inc. of Atlanta, in a deal valued at about \$615 million plus the assumption of \$385 million in debt.<sup>6</sup>***

Moreover, deficiencies are both more frequent and more serious in the years after the buyout. Serious deficiencies at Mariner facilities increased significantly more than in the non-Mariner homes in the states in which Mariner operates. For example, violations that caused actual harm increased by almost 67 percent as compared to 1.5 percent in non-Mariner facilities.

Deficiency Type	Mariner % Increase Post Buyout	Non-Mariner % Increase
All Deficiencies	29.4%	11.9
Potential for Minimal Harm	8.0%	13.3%
Potential for Actual Harm	33.6%	18.0%
Actual Harm	66.7%	1.5%
Immediate Jeopardy	87.5%	13.3%

Over the same period, the percent of Mariner facilities cited for 10 or more deficiencies during an inspection increased from 25.1 percent prior to sale to 43.8 percent of facilities. Other facilities operating in the same states as Mariner saw a much smaller increase over that time, from 21.6 percent of all facilities cited for 10 or more deficiencies to 25.9 percent of all facilities.

## What do these deficiencies mean?

Deficiencies with "potential for minimal harm" are those that have the potential for causing no more than a minor negative impact on a resident.<sup>7</sup>

Deficiencies with "potential for actual harm" reflect noncompliance on the part of the nursing home in a way that causes, or has the potential to cause, no more than minimal physical, mental, or psycho-social harm to a resident.<sup>8</sup>

Deficiencies that "cause actual harm" cause real injury to fragile nursing home residents.<sup>9</sup> Examples of actual harm citations include:

- Failure to give residents enough fluids to keep them healthy and prevent dehydration.
- Failure to give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.
- Failure to make sure that residents who cannot care for themselves receive help with eating/drinking, grooming, and hygiene.<sup>10</sup>

Deficiencies that "cause immediate jeopardy" mean that something the nursing home did or failed to do put residents' health, safety, and lives directly in harm's way. These deficiencies require immediate correction.<sup>11</sup> Examples of immediate jeopardy citations include:

- 1) Failure to hire only people who have no legal history of abusing, neglecting, or mistreating residents, or 2) failure to report and investigate any acts or reports of abuse, neglect or mistreatment of residents.
- Failure to protect each resident from all abuse, physical punishment, and being separated from others.<sup>12</sup>

Examples of resident care violations at Mariner homes post-buyout include:

### *Belmont Lodge Health Care Center—3/29/2007*

After the facility failed to prevent and properly treat bed sores, one resident's wound worsened so much that the resident had to have his leg amputated above the knee.<sup>13</sup>

This resident developed a pressure sore on his left heel in November 2006. Over the following three months, this sore grew worse; it got bigger, became necrotic, and began to smell bad. Finally, in late February 2007, the resident was hospitalized for fever, pain in the wound, continued worsening of the sore, and a potential bone infection in the left heel. During the hospital stay, the resident's left heel had to be debrided to drain the infected wound, and then the resident's left leg was amputated above the knee as the result of the infected wound.

A family member of the resident told a state inspector that family members often found the resident either wet or soiled when they arrived for visits and that facility staff did not reposition the resident on a regular basis. Ensuring that a resident stays dry and is repositioned helps prevent the development of sores. In addition, the resident did not promptly receive a pressure-relieving wheelchair that his doctor had ordered.

About three weeks after the resident's leg was amputated, the resident had developed three more pressure sores on his right foot.

***Palisades Living Center—12/14/2006***

State inspectors cited the facility for failing to have enough nursing staff to meet residents' care needs. Residents told inspectors that there were no longer enough nurse's aides on the night shift to help residents with bowel and bladder management:

"I have defecated in my bed because I couldn't get help [on nights]."

"I've fallen asleep on my bedpan waiting for them to come back and take me off."

"The [nurse's aides] we have are good but there's just not enough of them."

"If there was just one more person [like there used to be] on nights, it would help."

Several residents reported that facility administration already knew of the understaffing problem, and believed that telling them "wouldn't do any good."

Nurse's aides told inspectors that sometimes they have had to work on an entire hall with 32 residents by themselves. One aide, while working alone on the hall during the night shift, told inspectors: "I'm overwhelmed. We used to be two here on nights but about three weeks ago they [facility administration] changed from eight-hour shifts to 10-hour shifts and [they decreased the nurse's aides] to just one on nights ... I definitely need more help ... there's just too many [residents] that need assistance."<sup>14</sup>

**Decrease in the Quality of Care at Beverly**

Mariner's performance post-buyout is not an anomaly. When we looked at the impact of the sale of Beverly Enterprise to Fillmore Capital Partners<sup>15</sup>, the largest single nursing home company to be bought by private equity to date, we see a similar increase in federal violations during their most recent inspections when compared to inspections immediately prior to the sale. Since Beverly's sale in March 2006<sup>16</sup>, their most recent annual inspections show a 19.4 percent increase in such violations, again more than double the 8.2 percent increase in violations cited in other homes located in the states where Beverly operates<sup>17</sup>.

Deficiency Type	Beverly % Increase	Non-Beverly % Increase
All Deficiencies	19.4%	8.2%
Potential for Minimal Harm	29.0%	-7.1%
Potential for Actual Harm	19.1%	11.2%
Actual Harm	8.1%	-3.6%
Immediate Jeopardy	12.5%	13.0%

Just as with Mariner, each of these increases point to real harm to fragile nursing home residents. Examples of Beverly's violations:

***Golden Living Center, Lima—12/4/2006***

A resident, whose history of eating problems meant that she was supposed to be monitored while eating, was left alone in her room while eating a meal, choked on her food, and died at the hospital after efforts to clear her airway and perform CPR failed. This resident, who was mildly mentally retarded and had chronic airway obstruction, gastroesophageal reflux disorder, and seizure disorder, had a history of eating too fast. Facility staff reported that she "wolfed down" her food and would take excessively large bites. As a result, she was supposed to be supervised at mealtime and eat only in the dining room.<sup>18</sup>

***Golden Living Center, Camp Hill—4/11/2007***

Over the course of just three months, a resident in the facility experienced a severe weight loss of 14 percent of her total body weight. As the resident began quickly losing weight, her doctor prescribed a nutritional supplement for her, but the facility failed to give her the supplement as it was ordered, and then discontinued the supplement even though the doctor had ordered that it continue to be administered. The resident's care record did not reflect any attempts other than the improperly administered nutritional supplement to ensure that the resident maintained a healthy weight.<sup>19</sup>

***Golden Living Center, Valley—12/1/2006***

Even though nursing homes are required by federal law to have a registered nurse on duty for eight hours a day, seven days a week, there was no RN working in the facility one day a week during the time that state surveyors performed their inspection.<sup>20</sup>

The quality of care at nursing homes is a serious concern throughout the industry, but the analysis of the CMS data, indicates an even greater cause for alarm at private equity-owned firms:

## Transparency and Accountability

Publicly traded companies are subject to federal securities laws and regulations as well as to daily scrutiny by financial analysts and the business media.

However, private equity buyout firms operate virtually free of oversight and public accountability, their profits and practices largely hidden from view. Far from a coincidence, this lack of transparency is built into their business model, providing buyout firms with certain advantages that publicly traded companies do not enjoy. For example, private equity-owned companies do not have to:

- disclose to the public their debt levels, or other aspects of their capital structure;
- report executive compensation;
- report events that have a material impact on their business, whether positive or negative; or
- report acquisitions or divestitures.

In sum, buyout firms operate behind a veil of secrecy that allows them to conceal virtually all aspects of their business from regulators, affected stakeholders, the general public, and their competitors.

One of the defining characteristics of private equity buyouts of nursing homes is the lack of disclosure about how firms intend to reorganize the company after it has been purchased. The nursing home industry is trending toward separating the real estate and the operations components of nursing homes, which can impact the quality of care. A December 2006 study prepared by Harvard Medical School experts for the U.S. Department of Health and Human Services, detailed these impacts:

"Integrated Health Services, Mariner Health Care, and, most recently, Beverly, are examples where equity groups purchased chains with the intention of separating the real estate and operations with the goals of limiting liability and enhancing profitability"<sup>21</sup>

As the *Journal of Health Law* describes,

"Dividing the nursing home business into real estate investment and real estate operations will reduce the nursing home company's exposure to risks associated with owning and operating one or more nursing homes. The degree to which this reduction of risk can be maximized will be a function of how elaborate a corporate structure the particular company is willing to create. The ultimate structure would consist of forming a real property SPE [single-purpose entity] to hold each piece of real estate, as well as a separate operating SPE for each nursing home business."<sup>22</sup>

### What is a private equity buyout?

Called "leveraged buyouts" in the 1980s, private equity takeovers use money invested by limited partners—typically wealthy individuals or public pension funds—to purchase an established company. These deals often entail significant levels of debt; the private equity firm contributes some equity and uses the assets of the target company as collateral for the majority of the purchase price. In order to ensure a profitable exit later, the buyout firm may pursue a number of operational strategies to raise revenues and limit costs. The buyout firm itself makes money in two ways: through fees, including transaction and management fees during the life of the investment, and through their cut of the profits realized at sale, typically 20 percent.

As the new owners of Mariner, National Senior Care hired roughly 80 attorneys from a half-dozen law firms to help design and execute a complicated web of corporate structures that took nearly seven months to complete. To help pay for the deal, National Senior Care immediately sold approximately two-thirds of the homes it had purchased to another company called SMV Property Holdings.<sup>23</sup> SMV set up separate real estate holding companies for each of the properties purchased<sup>24</sup> and then leased the facilities back to Mariner or SavaSenior Care,<sup>25</sup> an affiliate of National Senior Care.<sup>26</sup> Adding to the structural complexity, documents submitted to California regulators indicate that at least some former Mariner homes are actually run by subsidiary operating companies that are unique to each location.<sup>27</sup> Not surprisingly, the lawyers who helped set up the National Senior Care deal called it one of the most complicated transactions they had ever been involved in.<sup>28</sup>

While we don't know the exact amount of rent that the Mariner homes paid to these related parties, the building and fixture-related capital costs that Mariner reported on its Medicare cost reports rose by 60 percent the year after National Senior Care took over. (In the previous three years it had increased by a total of only 11 percent.) In addition, interest expense payments, an indicator of how much debt has been incurred, increased by 145 percent from 2004 to 2005, the year after the buyout. At the same time, the number of Mariner facilities that reported any interest expenses in 2005 was more than four times the number that had reported interest expenses in any of the previous three years.<sup>29</sup>

The restructuring undertaken after a nursing home moves from being a public company to private ownership also makes it difficult to hold nursing home companies accountable for poor care, because more entities are involved in the transaction of business in the home.

*The New York Times* found:

"Private investment companies have made it very difficult for plaintiffs to succeed in court and for regulators to levy chainwide fines by creating complex corporate structures that obscure who controls their nursing homes ... The Byzantine structures established at homes owned by private investment firms also make it harder for regulators to know if one company is responsible for multiple centers. And the structures help managers bypass rules that require them to report when they, in effect, pay themselves from programs like Medicare and Medicaid."<sup>30</sup>

While the restructuring may help increase profitability, it makes it far more difficult for taxpayers, residents, and their survivors to hold the company accountable for the care it provides.

### **Profiting from Public Funds**

At the same time that *The New York Times* and our research shows care suffers under private equity's ownership, Medicare and Medicaid resources that are intended to support vulnerable Americans are being diverted to the private benefit of wealthy investors.

Taxpayers trust these Medicare and Medicaid dollars will go toward providing seniors with quality care. Medicare's conditions of participation and other rules permit for-profit nursing homes and other providers to participate in the Medicare program. Standards of care are the same for all ownership types. The industry is overwhelmingly financed by public funding, with many companies relying on Medicare and Medicaid for as much as two-thirds of their income. Yet nursing home companies owned by private equity firms appear to fall short of these standards more often than other nursing home types.

While the heavy debt load may force cuts to operating expenses, the takeover will result in a windfall of as much as \$254 million for top Manor Care executives and directors, including as much as \$186 million for Manor Care CEO Paul Ormond<sup>31</sup>. Simultaneously, Carlyle stands to reap fees on the deal that could total hundreds of millions of dollars. These fees and payouts would be better spent on resident care. Smaller fees and payouts to insiders, and a larger equity contribution by Carlyle, would mean less overall debt would be necessary, and less cost pressure would be placed on nursing services and other important components of quality care.

### **Net Tax Impact of the Carlyle Buyout of Manor Care**

Based on available data and conservative assumptions, we believe that Carlyle's buyout of Manor Care will reduce net taxes paid to federal and state governments by approximately \$612 million during the time Carlyle holds it at

as private company.

## THE CARLYLE MANOR CARE BUYOUT

Behind the Buyout: Facts about the Carlyle Group  
Takeover of HCR Manor Care

**Private equity buyout firm:** The Carlyle Group, Washington, D.C.  
**Company being bought out:** HCR Manor Care, Toledo, Ohio

**Deal value:** \$6.6 billion

**Equity financing:** \$1.3 billion (13 percent)

**Debt financing:** \$5.5 billion (87 percent)

**Sale price:** \$67 per share, representing a 20 percent premium over Manor Care's stock price on April 10<sup>2007</sup>

**Deal announced:** July 2, 2007

**Deal closed:** Expected to close by the end of 2007

### Fees reported to date :

- \$35 million to P. Morgan for fairness opinion and transaction fee
- \$5 million to Citigroup for fairness opinion

The Carlyle Group will receive significant additional fees for arranging the deal. For example, buyout firms typically charge as high as 1 percent of the value of the transaction for overseeing the transaction; in this case an estimated \$60 million. Buyout firms also typically are paid an annual management fee. Information regarding the management fees for this deal, if any, has not yet been made public.

### Executive Compensation

- Manor Care CEO Paul Ormond—Up to \$186 million stock payout
- Other Manor Care executives—Up to \$68 million combined in stock payouts

### About HCR Manor Care

HCR Manor Care, based in Toledo, Ohio, is one of the largest nursing home providers in the country, with more than 37,000 resident beds nationwide and \$3.6 billion in annual revenue.

### About the Carlyle Group

With more than \$75 billion in assets under management, the Carlyle Group is one of the five largest corporate buyout firms in the nation. Washington, D.C.-based Carlyle owns companies that together employ more than 280,000 workers. The firm's three co-founders, David Rubenstein, William Conway, and Daniel D'Antello, each have a net worth estimated by *Forbes* at more than \$2.5 billion. A recent study estimated Rubenstein's 2006 compensation at \$260 million. For more information on the Carlyle Group, visit [www.BehindtheBuyouts.org/carlyle](http://www.BehindtheBuyouts.org/carlyle)

When the primary source of revenue for a target acquisition is taxpayer funding, there should be a greater level of accountability and assurances that those funds will be used for their stated purpose. Roughly two-thirds of HCR Manor Care's skilled nursing, assisted living, and rehabilitation revenues came from Medicaid and Medicare reimbursements in 2006.<sup>34</sup> Therefore, elected officials with oversight of those programs have the right—indeed, the responsibility—to understand the financial implications of the buyout transaction and their potential impact on patient safety and quality of care.

Based on the very limited information disclosed to the SEC by Manor Care, serious concerns have been raised about the ability of the Carlyle Group to service the new debt burdens they intend to place on the company without significant cost cutting measures that could undermine quality patient care in the company's more than 280 nursing facilities.<sup>35</sup>

SEIU has examined both the past care record of HCR Manor Care and forecasts for how the nursing homes will operate under Carlyle, and the facts raise serious questions about the company's ability to provide high quality care to seniors at a good value to taxpayers.

### **Manor Care's Resident Care Record**

Even prior to the buyout, Manor Care has a record of failing to provide all its residents with quality care. Under federal law, nursing homes are required to be inspected every nine to 15 months. Over the past three survey cycles, violations of basic patient care standards at Manor Care nursing homes have increased by 23 percent.<sup>36</sup> By comparison, violations of care standards increased by 14.5 percent between 2004 and 2007 for non Manor Care nursing homes in the states in which Manor Care operates.<sup>37</sup>

Eighty-one percent of Manor Care facilities reported nursing staff levels below 4.1 hours per resident per day<sup>38</sup>—a figure recommended in a government-commissioned study.<sup>39</sup>

Some problems have happened again and again—despite the fact that Manor Care administrators assured state inspectors that the problems would be corrected and prevented in the future.

For instance, 30 Manor Care homes in Pennsylvania have been cited more than once over the past three survey cycles for failing to give residents care and services to maintain the highest possible quality of life, 10 have been cited more than once for failing to have a proper program to prevent infections from spreading around the home, and eight have been cited for failing to store, cook, and give out food in a safe way.<sup>40</sup>

Of Manor Care nursing homes nationwide, only 4 percent were in full or substantial compliance with federal care standards on their most recent inspection. Ninety-six percent were cited for resident care violations that caused or had the potential to cause more than minimal harm to residents.<sup>41</sup>

**Examples of Manor Care's patient care violations:**

- **Manor Care at Arlington Heights, Ill.:** Facility staff gave a resident an overdose of her antidepressant medication, which resulted in respiratory failure and her hospitalization. The resident was given a dose of an antidepressant drug that was four times the prescribed amount, and was later found unresponsive by facility staff. Facility staff called 911 and ran a full code; the resident was transported to the hospital, where she was intubated, put on a ventilator, and given charcoal to treat overdose-induced respiratory failure.<sup>42</sup>
- **Heartland of Perrysburg, Ohio:** A resident who was known to wander was left unattended, fell down a set of concrete stairs, and died. This resident, who had senile dementia and serious vision impairment, used a wheelchair. In addition to her wandering, she was also known to open doors on her own and have poor judgment of safety issues. According to a state inspection report, the resident, while unattended, opened the door to a secured stairwell, wheeled herself to the top of the stairs, and fell. A facility nurse later found her at the bottom of a flight of stairs, "face down on her right side with [her] wheelchair partially on top of her. She had no vital signs, no respirations; [her] pupils were fixed and dilated, and there was blood from a laceration on her head." The county coroner found that the reason for the resident's death was a subdural hematoma resulting from her fall down the stairs.<sup>43</sup>
- **Heartland of Bellefontaine, Ohio:** A resident's blister was left untreated and developed into an infected, necrotic pressure sore. Nurses at the facility had identified a blister on the resident's right heel, but did not put together a plan to prevent this blister from becoming a serious pressure sore. Over the following weeks, the sore got worse, developed a bacterial infection, became necrotic, began to smell bad, and was debrided. Meanwhile, the facility repeatedly failed to relieve pressure on the resident's heel; more than three months after the resident's blister became a sore, the resident was observed sitting in a chair with no interventions in place to relieve pressure on her right heel.<sup>44</sup>
- **Manor Care Health Services, Camp Hill, Pa.:** The facility's failure to ensure routine dental examinations resulted in one resident having surgery to remove all of her teeth. She had developed tooth

decay, fractured teeth, and abscesses over the course of seven months. The resident had not been given any dental care in nearly three years, even though facility staff knew she had broken, missing, and decaying teeth, and despite an existing order from her doctor to have a dental examination. When the resident was admitted to the facility in 1998, she had all of her own teeth and had no broken teeth or mouth pain.<sup>45</sup>

### **Carlyle Debt and Pressures on Care**

According to Manor Care's SEC filings, the company had approximately \$994 million in debt and paid \$31.5 million in interest in 2006.<sup>46</sup> The Carlyle Group's proposed buyout includes \$5.5 billion in debt,<sup>47</sup> a more than five-fold increase of Manor Care's debt burden. If we assume an average blended interest rate in the range of 7.5 percent to 8 percent on \$5.5 billion, Manor Care's annual interest expense in year one would be between \$412 million and \$440 million.<sup>48</sup> As a result of the Carlyle Group buyout, Manor Care's annual interest expenses could increase by approximately \$400 million over prebuyout 2006 levels.

Manor Care's massive new debt obligations could affect staffing and resident care if Manor Care decides to cut costs in order to make its interest payments. Among other costs, Manor Care could cut its long term care operating expenses, more than half of which were attributable to staffing and other labor-related expenses in 2006.<sup>49</sup> These types of labor-related cuts could reduce the quality of care provided to Manor Care residents nationwide.

If Manor Care cuts costs and requires cost reductions evenly across divisions and staffing levels, the company could cut 7,874 hours of CNA time per day (which equates to the time worked by more than 980 full-time CNAs). This would likely reduce CNA-provided care in the average Manor Care nursing facility from 2.1 hours per resident per day to 1.9 hours per resident day per day.

To gauge the impact this staffing reduction could have on resident care, we can turn to a model developed in a study commissioned by the federal government's Centers for Medicare and Medicaid Services (CMS). This model determined the nurse's aide staffing necessary to carry out five daily care needs in nursing homes:

1. Consistently repositioning and changing wet linens for incontinent residents who could not successfully toilet if given assistance.<sup>50</sup>
2. Providing timely toileting assistance for incontinent residents who could successfully use the toilet. Residents should be toileted every two hours.<sup>51</sup>
3. Providing feeding assistance to either physically dependent residents or those with low food intake.<sup>52</sup>
4. Providing exercise to all residents. Some residents need exercise assistance at least three times a day while other, more mobile residents may only need exercise assistance once every two days.<sup>53</sup>

5. Providing assistance that enhances the ability of residents to dress and groom themselves.<sup>54</sup>

When staffing levels decrease, residents must either wait longer for assistance with these activities or, in extreme cases, may see their needs go unmet. Over the long run, an inability to meet patient care needs could lead to health problems for Manor Care residents.

A potential cost-cutting decrease in staffing in Manor Care nursing homes' from the current average of 2.1 hours of CNA care per resident per day to 1.9 hours of CNA care per resident per day would have real, tangible effects on the fragile nursing home residents that rely on Manor Care to meet their daily needs. Using a model articulated in a study produced for CMS, we estimate:

- Approximately 21,700 Manor Care residents will need incontinence-related care such as changing, repositioning, or help using the toilet. If CNA staffing is cut from 2.1 hours per resident per day to 1.9 hours per resident per day, treatment could be missed for *more than 21,700 incontinence-related incidents*—enough missed incidents to affect every resident who needs this basic care.
- Incontinent residents could also have to wait more than 30 minutes more for each episode of incontinence care—meaning that residents could be left longer with soiled linens and clothes.
- Approximately 32,200 Manor Care residents will need assistance with exercise. If CNA staffing is cut from 2.1 hours per resident per day to 1.9 hours per resident per day, many more incidents of exercise-related care will be missed—enough missed incidents to affect most of the 32,200 residents who need exercise-related care. Exercise is critical to preserving residents' mobility and physical and mental health.
- Approximately 16,900 Manor Care residents will need help with eating and 32,000 Manor Care residents will need assistance with dressing or grooming. If Manor Care cuts staffing to make its interest payments, waits for feeding and grooming care will likely grow longer and more care episodes will probably be missed. Eating, dressing, and grooming are basic activities fundamental to each resident's health and quality of life.

## **Restructuring**

Public documents indicate the Carlyle Group is planning changes to the corporate structure of nursing home chain HCR Manor Care, as part of its pending \$6.6 billion takeover deal.

The changes could limit Carlyle's legal liability in the case of poor patient care and make it difficult for regulators and plaintiffs' attorneys to hold the buyout firm responsible for what happens to residents inside the homes. *The New York Times* uncovered similarly "Byzantine" corporate structures in a Sept. 23, 2007, investigation of other nursing homes owned by private equity firms.

### **Hiding the Assets**<sup>55</sup>

Applications for nursing home licenses in Maryland, Michigan, Washington, and West Virginia lay out a four-tiered structure for Carlyle, shield Manor Care's assets and distance itself from any liability for poor care in Manor Care homes.

- (1) Create a corporation as a holding company to own the entire Manor Care chain.
- (2) Create limited liability corporations for the operations of individual Manor Care homes.
- (3) Create limited liability corporations for the real estate holdings of individual Manor Care homes.
- (4) Create another affiliated corporation to lease all the properties from the ownership corporations, and then sublease to the operating corporations.

The documents were obtained by SEIU in public records requests. In the other states where Manor Care operates, similar documents have been unable to be obtained, or requests for the documents are pending.

### **What The New York Times Investigation Found**

*"Private investment companies have made it very difficult for plaintiffs to succeed in court and for regulators to levy chainwide fines by creating complex corporate structures that obscure who controls their nursing homes.*

*"By contrast, publicly owned nursing home chains are essentially required to disclose who controls their facilities in securities filings and other regulatory documents.*

*"The Byzantine structures established at homes owned by private investment firms also make it harder for regulators to know if one company is responsible for multiple centers. And the structures help managers bypass rules that require them to report when they, in effect, pay themselves from programs like Medicare and Medicaid."*

Excerpted from *The New York Times*, "At Many Homes, More Profit and Less Nursing," by Charles Duhigg, Sept. 23, 2007.

### **Misrepresentations**

In response to *The New York Times* investigation, Manor Care has claimed in communications to employees that it has no intention of changing its "operating structure" or of separating its nursing homes' real estate from management. At least one local Manor Care administrator told reporters, "There will be no changes at the corporate or local level."<sup>56</sup>

But Manor Care's own SEC filings reveal that it plans a significant "restructuring" as part of the deal.<sup>57</sup> The company's "restructuring" will send each nursing home's operations to an entirely new corporate entity and will separate real estate and operations into two completely separate companies. It is clear from the filings that the restructuring comes at Carlyle's request, as the merger agreement provides for "unwinding" the structure if the deal does not go through.

### **Limited Liability**

Part of Carlyle's restructuring plan involves creating a limited liability corporation, or LLC. The advantage of doing this was explained in a 2003 article in the *Journal of Health Law*:

*"In the context of nursing home ownership and operation, legal entities such as corporations, limited liability companies and limited liability partnerships can be formed to benefit nursing home companies by limiting the financial liability and Medicare and Medicaid exclusion exposure of the real estate investors and business owners... The business entities can also prevent litigants from obtaining judgments against related companies, and the owners personally, in proceedings alleging Medicare or Medicaid overpayments, false claims, or negligence."*<sup>58</sup>

Furthermore, the assets that are held by other entities are so heavily mortgaged that there are few available funds.

### **Restructuring to Help Finance a Leveraged Buyout**

Companies with extensive real property holdings have often been attractive to private equity firms seeking to pay themselves dividends and recoup investments even before selling the company, though not always with positive results for the longevity of the business. According to the *Wall Street Journal*, "Manor Care owns, rather than leases, nearly all its own facilities and boasts arguably the best real estate portfolio in the business."<sup>59</sup> The Carlyle takeover of Manor Care is valued at \$6.6 billion, but Carlyle has only committed to putting up to \$1.3 billion in equity into the deal.<sup>60</sup> As one analyst noted "Unlocking the real estate value is key" to making this highly leveraged buyout work.<sup>61</sup> Sure enough, according to published reports, Carlyle plans to use Manor Care's real estate holdings as collateral for \$4.6 billion of the overall debt.<sup>62</sup>

## **Conclusion**

Because of serious questions that Carlyle's leveraged buyout of Manor Care raises for nursing home residents, taxpayers, and the public, legislators and regulators should closely examine the deal before allowing Carlyle to move forward. Past private equity nursing home buyouts coupled with Manor Care's resident care record and Carlyle's acquired debt suggest residents at nursing homes could be put at risk if the deal closes. Now is the time to take action to protect nursing home residents and be good stewards of taxpayer funding.

## **Methodology**

### **Deficiency Data Sources**

Data on nursing home inspections comes from the Centers for Medicare and Medicaid Services (CMS) Online Survey, Certification, and Reporting (OSCAR) data. Descriptions of specific resident care problems in individual states are from state inspection reports generated by state inspectors as part of regular facility inspections, documented in Statements of Deficiencies and Plans of Correction (see below).

### **Defining a Violation**

Federal regulations governing patient care conditions are contained in the 1987 Omnibus Budget Reconciliation Act (OBRA) and are found in 42 CFR 483.10 ff. These guidelines are used to assess a nursing home's compliance with basic patient care standards.

State inspectors inspect facilities under contract with the Centers for Medicare and Medicaid Services (CMS). When state inspectors enter a facility, either for an annual inspection or to investigate complaints, they have a responsibility to cite all violations of state and federal regulations. This report examined only violations of federal regulations identified on annual certification surveys. Inspectors complete the CMS Form 2567, also known as the Statement of Deficiencies and Plan of Correction.

### **The Inspection Process**

State inspectors visit each nursing home every nine to 15 months to ensure that facilities are complying with federal and state standards for resident care. A team of inspectors evaluates the facility for approximately one week during each inspection visit. Since a review of the care given to each resident in a facility is time consuming, the team observes the care given to a selected number of residents, called "sample residents," who represent the overall facility.

Inspectors note violations of federal regulations on the Statement of Deficiencies and Plan of Correction, including a reference to the specific regulation violated and a description of what the inspectors found in each case. The violations are discussed with the managers of the facility being inspected, who must submit a proposed "plan of correction" to remedy each violation and prevent its recurrence. The plan of correction is then added to the statement of deficiencies.

### **Establishing the number of nursing homes operated by Mariner Health Care**

Mariner Health Care, a national nursing home operator, was acquired by the private equity company National Senior Care in December 2004. According to SEC filings, the deal closed on December 10, 2004.<sup>63</sup>

Three documents helped establish the number of homes operated by Mariner as of Dec. 10, 2004, the date Mariner closed its sale to National Senior Care. As part of Massachusetts regular cost reporting requirements on two Mariner-owned facilities in that state, Mariner was required to list all of the skilled nursing facilities it either owned or operated, along with their addresses. In its 2003 cost report, filed with the Massachusetts Division of Health Care Finance and Policy on April 30, 2004, Mariner listed 252 related skilled nursing facilities. This list was cross-checked against two facility listings, Annex Two and Annex Three, that were prepared as part of Mariner's bankruptcy filings.

Because this analysis looks at what happens when nursing home companies fall into private hands, we only wanted to look at facilities that National Senior Care continues to own or operate as of October 2007. Establishing operators for nursing homes is difficult and made more complicated by the variety of legal entities nursing home companies establish to shield themselves from liability.

Of the 219 homes included in the analysis, 181 are listed in the directory of facilities on the Sava/National Senior Care Web site<sup>64</sup> To establish the current operator for the remaining facilities we used information from state licensing agencies and state corporate records, occasionally relying on a facility's Web site information to determine ownership. Where we were unable to definitively establish continued National Senior Care operation of a nursing facility, we did not include that facility in the analysis.

#### **Establishing the number of nursing homes operated by Beverly Enterprises**

Beverly Enterprises Inc., a national nursing home operator, was acquired by a private equity firm, Fillmore Capital Partners, LLC on March 14, 2006.<sup>65</sup> The Beverly name was retained for its leased facilities (Beverly Living Center). As of August 2006, the other facilities, roughly 260 facilities, operate under the name Golden Living Center.<sup>66</sup> The parent company is Golden Horizons and is based in Fort Smith, Ark.<sup>67</sup>

Beverly's latest Web sites refer to 344 nursing facilities but the full facility list for each state only amounts to 332<sup>68</sup>. Of those 332 nursing facilities, three were eliminated from the analysis: Lake Ridge Adult Daycare, Minnesota; Golden Living Center-Watertown, South Dakota; and Golden Living Center-Arab, Alabama. The Lake Ridge facility was not comparable in operation to other nursing facilities, no inspection data was recorded for the Watertown facility, and there was no post-sale inspection data for the Arab facility. Therefore, the analysis is based on 329 facilities for which there is valid data.

### Facilities Included in Peer Group Analysis

Though CMS establishes the guidelines for survey inspections nationally, enforcement (and interpretation) of those standards is left up to individual state Medicaid programs. To establish a peer group of facilities with which to compare the Mariner and Beverly facilities, we looked at all other facilities in the states where Mariner and Beverly operate. For Mariner this meant 19 states<sup>69</sup> and for Beverly this meant 23 states<sup>70</sup>.

### Mariner and Beverly Health Violation Analysis

CMS makes health violation data available in quarterly reports beginning in the third quarter of 2003. For the violation analysis before the buyout, we used the inspection survey results closest to and before the date the sale closed. For Mariner, this was Dec. 10, 2004, and for Beverly it was March 14, 2006. For the analysis of the current number of violations, we used the most recent survey data available based on a download of CMS quarterly inspection data, which included inspections through Sept/ 26, 2007.

### Peer Group Violation Analysis

For the peer group comparison to Mariner, this analysis looks at homes which had a survey completed in 2004 prior to Dec. 10, the Mariner sale date.<sup>71</sup> For the analysis of the current number of violations at those homes, we used the most recent survey data available based on a download of CMS quarterly inspection data, which included inspections through Sept, 26, 2007. If a facility has not been surveyed since 2005, it is not included in this analysis. The total number of peer group homes included in the Mariner analysis was 7,867 prior to the buyout and 7,814 homes that have had inspections since the buyout.

Since the Beverly sale was relatively recent, a number of facilities in Beverly's states have not had an inspection since the sale<sup>72</sup>. However, in order to present a more complete analysis of the conditions of non-Beverly homes in these states, they are included in the presale analysis. The total number of peer group homes included in the Beverly analysis was 8,593 prior to the buyout and 8,197 homes that have had inspections since the buyout. The percent increase in deficiencies was calculated on a number per facility basis.

### Calculating Percentage Changes in Violations by Level of Violation

CMS quarterly data includes descriptions of each violation for which a facility has been cited. Each deficiency is also categorized based on the scope and severity of the problem, using a 12-point grid. Violations labeled A, B or C are Level 1 violations, violations with potential for minimal harm. Violations labeled D, E or F are Level 2 violations, violations with potential for actual harm. Those labeled G, H, or I are Level 3 violations, violations where actual harm occurred, and those labeled G, H or I are Level 4 violations, violations that place residents in immediate jeopardy.

To determine the percentage change in each level of violation, this analysis first counts the number of deficiencies per facility by level that Mariner or Beverly facilities were cited during the surveys immediately before their respective sales and in the survey most recently taken at the facility, and then the percent change in the number of deficiencies per facility at each level is calculated. The same analysis is performed on the peer group universe.

### **Calculating the Amount That Costs Will Be Cut Due to Increased Debt**

Manor Care has provided the public with very little information about how it intends to cover its increased interest expenses resulting from Carlyle's highly leveraged buyout model. As discussed above, we have assumed for purposes of this report that Manor Care will cut costs to make its higher interest payments and that it will cut costs proportionally across all its lines of business (e.g., if nursing homes are 80 percent of revenues then 80 percent of cuts will come from nursing homes) and proportionally within each line of business (e.g. if CNA staffing costs are 13 percent of nursing home costs then 13 percent of cuts will come from CNA staffing).

### **Interest Expenses Attributed to CNA Staffing**

The amount of debt interest payments that would have to come from CNA staffing was calculated as follows: Amount of debt x percentage of revenue attributable to nursing homes x percentage of nursing home costs attributable to nurse's aides.

This number was then divided by the number of Manor Care nursing home beds and then divided by 365 to come up with a debt per bed per day figure.

The debt per bed day was then multiplied by the number of Manor Care beds in the state to come up with an amount of money lost per day.

### **Nursing Home Revenues**

Nursing Home revenues were determined by totaling the amount of revenue from Manor Care nursing homes as reported in its 2005 Medicare cost reports. To arrive at the percentage of revenues attributable to nursing homes we compared the Medicare cost report total to the 2005 total revenue amount listed in the company's 10k filing from Feb. 21, 2007. Since we did not have Medicare cost report data for all of Manor Care's nursing homes we estimated the total revenue by comparing the number of resident days reported to the Centers for Medicare and Medicaid Services (CMS) with those in the cost reports and increased the costs by the same proportion.

To confirm this result, we also subtracted the annualized fourth quarter 2005 revenues from Manor Care assisted living facilities reported in an earnings conference call on Jan. 27, 2006, from total skilled nursing and assisted

living revenues in 2005 reported in Manor Care's 10k filing from Feb. 21, 2007. To arrive at the percentage of revenues attributable to nursing homes we compared the estimated nursing home revenue to the 2005 total revenue amount listed in their 10k filing from Feb. 21, 2007.

In both cases the nursing home revenues were determined to be 80 percent of total revenue.

### **Staffing Data**

Staffing data for each facility was obtained from the CMS Online Survey Certification and Reporting (OSCAR) database. As part of the annual inspection process, each facility reports its staffing for the two-week period prior to the inspection. These figures are then recalculated to reflect hours per resident day. Staffing data was used from the most recent annual inspection.

### **Percentage of Nursing Home Costs Attributable to Nurse's Aides**

The percentage of nursing home costs attributable to nurse's aides was calculated as follows:

First, we calculated the annual cost of the nurse's aides using the following formula: weighted average of nurse aide hours per resident per day x number of resident days x national average CNA wage<sup>73</sup> x amount paid for benefits<sup>74</sup> x 365.

Second, we divided this number by the estimated total nursing home revenues to come up with a percentage of nursing home costs attributed to nurse's aides. This number is a conservative one since we assumed that nursing home revenues and costs were equal. If Manor Care made a profit on its nursing home business then this number will be understated.

### **Calculating Amount of CNA Reductions**

To calculate the amount of CNA hours that would be lost as a result of the increased debt, we took the amount of money lost per day and divided it by the cost of each CNA hour.

The number of CNAs lost was derived by dividing the total hours lost by eight.

The cost of each CNA hour was calculated as the average 2005 CNA wage divided by a benefit factor of .716. (From the June 2007 Bureau of Labor Statistics Employer Costs for Employee Compensation for service workers in nursing care facilities.)

The CNA hours per resident per day are weighted averages calculated by adding each facility's total CNA hours together (*i.e.*, CNA hours per resident per day x total residents) and dividing by the total Manor Care residents).

### Calculating the Effect of Inadequate Numbers of Certified Nurse's Aides on Resident Care

The model used in this report was developed by John F. Schnelle, Ph.D., Sandra F. Simmons, Ph.D., and Shan Cretin, Rand Corp., for a study produced for the Centers for Medicare and Medicaid Services. The study addressed the "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." For a full description of this model, see Chapter 3 of the Phase II Final Report—available on the CMS Web site. As described in our report above, this model was developed to determine the minimum CNA time needed to provide care in five basic care processes. It did this by looking at the amount of time needed to carry out each care process and the number of times each process needed to be carried out for the different types of residents in a facility (*i.e.*, the number of care episodes that need to be provided).

By looking at how much staff time is required to provide all the necessary care, we can start to look at how much care won't be provided with lower staffing levels. Implicit in this are certain assumptions about prioritizing time.

For purposes of this report we have made the following assumptions:

- All homes are low workload homes (see the "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes" study above).
- If care processes need to be dropped, then they will be dropped equally as to all residents who need the care. For example, if 15 episodes of incontinence care cannot be provided, then we assumed that 15 residents who need incontinence assistance would each miss one episode of care (*e.g.*, instead of being turned every two hours there would be once in the day where they didn't get turned for four hours).
- We assumed—based on the Schnelle *et al.* study—that the care processes most likely to be dropped first are incontinence care and assistance with exercise. This is based on interviews done with caregivers as part of the simulation study. Building on this assumption, we assume for purposes of this report that all care processes that will not be provided (*i.e.*, all missed incidents of care) will be incontinence care or assistance with exercise. In the real world, the type of care not provided would vary (*e.g.*, residents might not get assistance with eating instead of not getting assistance with exercise), but the underlying fact that certain, necessary care would not be provided does not change.
- The CMS study only looked at the effects that reduced staffing would have on care in increments of 0.2 hours per resident day (*e.g.*, effects at 2.2 hours per resident per day, at 2.0 hours per resident per day,

etc.). When necessary, we filled in the additional .1 increments (e.g., effects at 2.1 hours per resident per day) by averaging the care episodes missed in the two adjoining increments. For example, the number of care episodes missed at 2.1 hours per resident day was assumed to be the average of the care missed at 2.2 hours per resident per day and 2.0 hours per resident per day.

- The model is conservative in the assumptions it makes about the numbers of CNAs it would take to provide the necessary care. It assumes that all CNAs will work at extremely high productivity and efficiency levels.

The calculations in the simulation study are based on a low workload 40-bed unit with 100 percent occupancy. In this unit:

- 27 residents (67.5 percent) need assistance with incontinence care -repositioning, changing and/or toileting.
- 21 residents (52.5 percent) need assistance with eating.
- 40 residents (100 percent) need some form of assistance with exercise/mobility. For some residents it's only once every other day, for others it's as much as three times a day.
- 40 residents (100 percent) need some assistance to help dress and groom themselves. For some residents it's only a couple of minutes for others it can be as much as 15 minutes.

To calculate the number of incidents for which care would not be provided if Manor Care cut CNA staffing from 2.1 hours per resident per day to 1.9 hours per resident per day, we first took the number of care episodes (incontinent and exercise assistance) provided at the 2.1 hours per resident per day and subtracted the number of care episodes provided at the 1.9 hours per resident per day staffing levels.

This number of missed care episodes was then compared to the number of residents needing the particular care to come up with a percentage of residents that missed care that day. For example, if 10 exercise-related care incidents in a particular nursing home would be missed, and if there were 10 residents in that home who are likely at some point to need exercise-related care, then we assumed that the 10 missed incidents were spread evenly among the 10 residents and that all 10 residents (100 percent) would be affected by the reduced staffing.

The calculations on the number of Manor Care residents affected are based on extrapolating the percentage of residents affected in a 40-bed unit to the total number of Manor Care residents. For example, if 30 percent of the residents in the 40 bed unit missed at least one episode of incontinence care, then the report assumes that 30 percent of all Manor Care residents would miss at least one episode of incontinence care.

To calculate the total percentage of residents not receiving care we compared the number of care episodes missed to the total amount of care that should have been provided. In the case of incontinence care, this was 240 episodes per day in a low-workload 40-bed unit, and for exercise assistance (all other care) it was 323 episodes for a similar 40-bed unit.

#### **Net Tax Effects of the Carlyle Buyout of Manor Care**

Based on available data and conservative assumptions, we believe that Carlyle's buyout of Manor Care will reduce net taxes paid to federal and state governments by approximately \$612 million during the time Carlyle holds it as private company. What follows is an explanation of our assumptions and calculations.

Carlyle is buying Manor Care for \$6.3 billion, with an equity contribution of \$1.3 billion, and debt financing totaling \$5.5 billion, consisting of \$900 million in senior secured credit facilities and \$4.6 billion under a secured real estate (CMBS) credit facility.<sup>75</sup> Based on current LIBOR rates and spreads, we assume an average blended interest rate of 7.5 percent to 8 percent for the debt.<sup>76</sup> We also assume that Manor Care will maintain a constant debt load, neither paying it down nor increasing its leverage during the Carlyle holding period.

Over the last four years, Manor Care has grown earnings before taxes (EBT) at a compound annual growth rate of approximately 6 percent<sup>77</sup>, and we assume that growth rate will continue during the Carlyle holding period. We assume the length of that period to be five years, using the assumption JP Morgan used in its fairness opinion.<sup>78</sup> We also assumed an exit multiple of EBITDA equivalent to the purchase multiple, and that Carlyle would achieve an IRR of 21 percent, all consistent with the JP Morgan fairness opinion.<sup>79</sup>

For tax rates, we assumed that tax rates effective in 2006 would remain constant throughout the duration of Carlyle's ownership of Manor Care, including the effective corporate tax rate, the tax rates for dividends and for capital gains, as well as the tax rate for Carlyle's partners' carried interest. Finally, we assume that Manor Care's public shareholders are all taxable investors, since it is difficult to calculate the percentage of shares owned by tax-exempt investors, even though assuming some percentage of tax-exempt investors would exacerbate the effect of the transaction on tax revenues, since the taxes collected on capital gains created by the LBO exceed the taxes foregone by the lack of dividend payouts.

With those assumptions, here is a summary of our calculations:

With the assumed 6 percent growth rate, we assume Manor Care's EBT during the Carlyle holding period will total approximately \$1.7 billion. However, the incremental interest payments on the debt will also total approximately \$1.7 billion, completely wiping out the company's corporate tax liability.<sup>80</sup> Without those interest payments, Manor Care's corporate tax liability on the \$1.7 billion in EBT would have totaled \$615 million. In addition, if Manor Care had remained a public company and continued to pay out dividends at the current annual rate of 68 cents/share to shareholders, again assuming a 6 percent annual growth rate, shareholders would have received \$320 million in dividends during the Carlyle holding period, which at the current 15 percent dividend tax rate would have generated \$48 million in taxes, assuming all shareholders were taxable.

However, it could also be argued that the buyout itself created capital gains that generated taxes above what would have been collected absent the buyout. The \$67/share buyout price represents a 20 percent premium over the closing stock price of \$55.75 on April 10, 2007, prior to the company's April 11 announcement it would evaluate strategic alternatives.<sup>81</sup> If one assumes that all holders as of April 10 earned incremental long-term capital gains of \$11.25 per share as a result of the buyout, and that all holders were taxable, then the buyout generated incremental capital gains taxes of \$124 million.

Finally, if we plug all of our assumptions into a simple leveraged buyout model, then Carlyle would earn a total profit of \$1.84 billion upon selling Manor Care after five years. Carlyle keeps 20 percent of that profit as its carried interest, and under current law Carlyle's individual partners' portions of that carried interest is taxed at the 15 percent rate for capital gains. If the tax treatment of carried interest were to be changed from capital gains to ordinary income, then the increased taxes Carlyle partners would owe the IRS would be \$73.5 million.<sup>82</sup>

Summing these numbers up, if one adds up all the tax implications of the Carlyle LBO of Manor Care, federal and state governments stand to lose more than \$600 million in tax revenues from Manor Care during the expected period of Carlyle ownership as a result of the LBO.

Parenthetically, we should note that Manor Care currently derives two-thirds of its revenue from government sources, i.e. Medicare and Medicaid. Using the same assumptions, those revenues add up to more than \$15 billion in tax-funded dollars for healthcare services paid to Manor Care during the period of Carlyle ownership.

## Endnotes

- 1 *New York Times*, "At Many Homes, More Profit and Less Nursing," by Charles Duhigg, Sept. 23, 2007.
- 2 The deal closed on Dec. 10, 2004, according to the company's filing with the SEC: <http://www.sec.gov/Archives/edgar/data/882287/000095014405001475/g93259bsv8pos.htm>.
- 3 This number, obtained from publicly available CMS data, represents the number of beds at 248 of the 252 facilities that were part of the deal. Four facilities that were part of the deal have since closed, and we are unable to find bed counts for those facilities.
- 4 Of the 252 facilities that were part of this deal, only 219 appear to still be operated by the company. For the purposes of this before and after analysis, only the 219 that continue to be operated by National Senior Care are looked at. A more detailed look at how the Mariner footprint was established and other issues can be found in the methodology section of this document.
- 5 CMS Quarterly data downloads beginning in the third quarter of 2003. Most recent survey data available based on a download of CMS quality inspection data which includes inspections through September 26, 2007.
- 6 Francis, Theo. "Real Estate Is Driver of Manor Care Buyout Deal—Nursing Home Firms, Attractive at Moment, Are Acquisition Targets." *Wall Street Journal*, July 3, 2007, A2.
- 7 Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.
- 8 Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.
- 9 Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.
- 10 Based on information from "About the Nursing Home—Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 10/29/2007.
- 11 Centers for Medicare and Medicaid Services, State Operations Manual, "Appendix P—Survey Protocol for Long Term Care Facilities—Part I—(Rev. 22, 12-15-06)," Section IV: Deficiency Categorization.
- 12 Based on information from "About the Nursing Home—Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 10/29/2007.
- 13 Belmont Lodge Health Care Center, inspection dated 3/29/2007. Available online at <http://www.hfemsd1.dphe.state.co.us/hfd2003/dtl3.aspx?tg=0314&eid=9GVR11&ft=ncf&id=020619&bdg=00&reg=FF04>
- 14 Palisades Living Center, inspection dated 12/14/2006. Available online at: <http://www.hfemsd1.dphe.state.co.us/hfd2003/dtl3.aspx?tg=0353&eid=FRUQ11&ft=ncf&id=021137&bdg=00&reg=FF03>
- 15 Beverly Finishes Sale to Fillmore, *Arkansas Democrat-Gazette* (Little Rock), March 15, 2006.
- 16 <http://www.sec.gov/Archives/edgar/data/1040441/000114336207000017/0001143362-07-000017.txt>
- 17 Center for Medicare and Medicaid Services, September 2004-September 2007.
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- 31 *Toledo Blade*, Manor Care sale would enrich execs; Firm's officials may receive more than \$200M for stock, July 6<sup>th</sup> 2007.
- 32 For an explanation of our assumptions and calculations see Methodology
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- 47 Manor Care Inc., Form DEFM14A filed with SEC on 9/14/07, p. 5.
- 48 A blended interest rate range of 7.5% to 8% is estimated using a one-month London Interbank Offered Rate (LIBOR) of approximately 5% plus a spread of 275 basis points (bps) on the \$700 million term loan to be used to finance the deal, and an assumed spread of 200 bps above LIBOR on the \$4.6 billion commercial mortgage-backed securities (CMBS) facility also used to finance the deal. A lower spread above LIBOR (*i.e.*, a lower interest rate) is assumed for the CMBS facility due to the security of the underlying property. See Donnelly, Chris, "Manor Care seeks TL Commitments at 98 OID," S&P LCD News, Oct. 19, 2007, and Donnelly, Chris, "Manor Care Details Financing for \$6.6B LBO," S&P LCD News, Sept. 14, 2007. One month LIBOR was accessed on October 23, 2007 at <http://www.bankrate.com/brm/ratewatch/1mo-libor.asp>.
- 49 Manor Care Inc., Form 10-K filed with SEC on 2/21/2007, p. 24.
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- 60 Manor Care 14A filing, dated 9/14/2007, p. 5.
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- 62 "Ill Wind hits Carlyle Healthcare Deal," *Financial Times*, October 25, 2007.
- 63 <http://www.sec.gov/Archives/edgar/data/882287/000095014405001475/g93259bsv8pos.htm>.
- 64 "<http://www.savaseniorcare.com/www/Locations/Default.aspx>"
- 65 Beverly Finishes Sale to Fillmore, *Arkansas Democrat-Gazette* (Little Rock), March 15, 2006.
- 66 Golden Chain of Corporate Names, *Arkansas Business*, Febr. 26, 2007.
- 67 *Ibid.*
- 68 <http://www.beverlycares.com/BI/Find+a+Nursing+Home/C.LocationSearch.Landing.htm>  
<http://www.goldenlivingcenters.com/GGNSC/Find+a+Nursing+Home/C.LocationSearch.Landing.htm>
- 69 Those 19 states are Alabama, California, Colorado, Connecticut, Georgia, Illinois, Massachusetts, Maryland, Michigan, Mississippi, North Carolina, Nebraska, Pennsylvania, South Carolina, Tennessee, Texas, West Virginia, Wisconsin, and Wyoming.
- 70 Those 23 states are Alabama, Arkansas, California, District of Columbia, Georgia, Indiana, Kansas, Kentucky, Massachusetts, Maryland, Minnesota, Missouri, Mississippi, North Carolina, Nebraska, New Jersey, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, West Virginia, and Wisconsin.
- 71 There were problems with CMS 2003 violation data and this prevented us including those homes whose survey date closest to the sale was in 2003.

- 72 n=396
- 73 2005-2006 AAHSA Nursing Home Salary and Benefits Report; Hospital and Healthcare Compensation Service, effective date of data May 2005.
- 74 Bureau of Labor Statistics Employer Costs for Employee Compensation—June 2007, Service Workers in Nursing Care Facilities p. 23.
- 75 Manor Care, Inc Preliminary Proxy Statement, Schedule 14A, filed Aug. 6, 2007, with the SEC. Total capital exceeds the purchase price because of fees and expenses, and to fund a revolving line of credit.
- 76 A blended interest rate range of 7.5% to 8% is estimated using current one month LIBOR of approximately 5% plus a reported spread of 275 bps on the \$700 mil term loan of Manor Care's operating company, and an assumed lower spread of 200 bps above LIBOR on the \$4.6 billion CMBS loan, due to the security of the underlying property. See Donnelly, Chris, "Manor Care seeks TL Commitments at 98 OID," S&P LCD News, Oct. 19, 2007, and Donnelly, Chris, "Manor Care Details Financing for \$6.6B LBO," S&P LCD News, Sept. 14, 2007. One month LIBOR was accessed on Oct. 23, 2007 at <http://www.bankrate.com/brm/ratewatch/1mo-libor.asp>.
- 77 Capital IQ
- 78 Manor Care, Inc. Schedule 14A, Aug. 6, 2007, p. 28.
- 79 Ibid.
- 80 Manor Care's FY 2006 interest payments were a low \$31.5 million, with most of its debt being in the form of long-term, low-interest convertible notes. We assume those payments would have remained constant had Manor Care remained a public company, and we subtract the five-year total of those payments from the payments on the new debt Manor Care will take on to fund the buyout. While these interest payments would be taxable to taxable holders of the debt, most taxable debt is held by tax-exempt investors. Raghavan, Anita, "Debt and the Corporate Tax Base," *Wall Street Journal*, June 16, 2007, p.A5.
- 81 Manor Care Press Release, July 2, 2007, at <http://www.hcr-manorcare.com/investor/strategicalternative.asp>
- 82 It should be noted that Carlyle's limited partners will also pay taxes on their share of the capital gains to the extent that they are taxable. This analysis does not seek to compare what Manor Care's public shareholders would have paid in capital gains had the company remained public, since it would be difficult to calculate what Manor Care's public share price would be even with the same growth assumptions, and it is difficult to model capital gains tax collections from the sale of public shares absent a corporate transaction.. However, since public companies tend to have a higher percentage of taxable shareholders than private equity limited partnerships, it is safe to assume that the same amount of capital gains would produce a higher amount of taxes in a public company than in one owned by private equity.

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