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Hon. Kathy Angerer, Chair
Health Policy Committee
Michigan House of Representatives
S0989 House Office Building
P.O. Box 30014
Lansing, MI 48909-7514

Hon. Robert Jones, Chair
Senior Health, Security, and Retirement
Michigan House of Representatives
N0094 House Office Building
P.O. Box 30014
Lansing, MI 48909-7514

Dear Chairpersons Angerer and Jones:

My name is Rickman Jackson, and I am the President of SEIU Healthcare Michigan. SEIU Healthcare Michigan represents more than 55,000 healthcare workers across the State. Our agenda includes advocating for improvements in the health care system, including putting patients first, providing affordable care to every man, woman and child in America, ensuring long term care for Michigan's elderly population, and ensuring higher standards for pay, benefits, training and staffing for health care workers.

I submit this testimony on behalf of our 55,000 members and as a patient care advocate to share my grave concerns about what the buyout of HCR Manor Care by the Carlyle Group could mean for the future of nursing home care in Michigan. Manor Care is an important nursing home provider in Michigan, with 28 homes and 3,531 resident beds. This buyout could impact the health and welfare of the more than 17,000 residents – our parents, grandparents, and loved ones – who enter a Manor Care home in Michigan each year.

Carlyle is one of the world's largest private equity firms, and until recently has focused on the defense, aerospace, and energy sectors. Carlyle has very little experience in the long-term care industry and no known prior experience at all owning nursing homes. LifeCare Hospitals, the only other long-term care provider owned by Carlyle, was recently alleged to bear responsibility for at least 24 patient deaths in New Orleans following Hurricane Katrina after the administrator and medical director evacuated the facility, leaving others to care for highly vulnerable residents during this critical time.

The Manor Care takeover is the largest to date in an industry where private equity ownership has become a national trend. By acquiring the nation's largest nursing home chain, Carlyle is looking to cash in and bank big profits from the increasing demand for long term care by the aging baby boomer population.

Carlyle has issued public statements pledging "to continue to provide quality health care services."[1] But Manor Care already has a very troubled patient care track record. Manor Care homes in Michigan average just 3.52 nursing hours per patient per day[2] – about 14 percent below the 4.1 nursing hours per patient per

[1] Company Press Release, "The Carlyle Group Issues 'Patients First' Pledge as Purchase of Nursing Home Company Manor Care Nears Completion," October 22, 2007.
[2] Based on information from "About the Nursing Home–Staff," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 9/7/2007.

day standard found in a government-funded study to improve patient care outcomes.[3] In fact, every single Manor Care home in Michigan except one staffs below this standard, placing residents in these homes at substantially increased risk of quality of care problems.[4] We have appended a copy of this study to our written comments for the Committee's review and consideration.

A significant body of research suggests staffing levels are the best measure of quality of nursing home care.[5] Certified Nurse Assistants, or C.N.A.s, account for the largest component of the 4.1 nursing hours standard, at 2.8 hours. This is because C.N.A.s provide the majority of direct care to Nursing Home residents, including assistance with such critical daily activities as dressing, bathing, walking, brushing teeth, eating, and toileting. It is therefore particularly troubling that every Manor Care home in Michigan fails to provide this level of C.N.A. staffing, and one home provides nurse assistant staffing of just 1.78 hours per patient per day, 36 percent below the standard recommended in the government-funded study. According to a model developed for this study, staffing at this facility is so low that incontinent residents must wait, on average, 131 minutes to receive incontinent care. The same model suggests that because Manor Care facilities in Michigan are already so short-staffed, each day an estimated 3,300 exercise treatments are missed – that's at least one missed treatment for every resident. Exercise-related care is critical to preserving residents' mobility and physical and mental health. While top Manor Care executives will take a payday out of this deal that may total as much as $254 million – including $10,777,252 for Chief Operating Office Stephen Guillard from his various stock holdings and options as reported in Manor Care's SEC filings[6] – residents may be forced to sit for hours in soiled clothes and miss exercise treatments necessary to regain their strength because there aren't enough staff to care for them. Guillard's one day payout is more than Manor Care projects it spent last year to operate the average Michigan nursing homes for an entire year.[7] Our society will be judged by how we treat our elderly – not our executives.

Such low staffing levels may explain why, over the past three survey cycles, Manor Care nursing homes in Michigan have been cited for a total of **268 violations of federal health standards regulations, which have increased 26% in the most recent survey cycle.**[8] It may also explain why 4 Manor Care homes were cited in the past 15 months for a serious resident care violation that caused actual harm or even immediate jeopardy to resident health or safety, which is the most severe level of harm CMS assigns to health violations.[9]

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[3] Schnelle, et al. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II final report. Centers for Medicare and Medicaid Services, December 2001.

[4] Based on information from "About the Nursing Home – Staff," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 11/9/2007 – staffing data was not available for 3 facilities; Schnelle, et al. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Phase II final report. Centers for Medicare and Medicaid Services, December 2001.

[5] Institute of Medicine (IOM), Wunderlich, G.S. and Kohler, P., Eds. 2001. *Improving the Quality of Long-Term Care.* Washington, DC: National Academy of Sciences, IOM; Harrington, C., Zimmerman, D., Karon, S.L., Robinson, J., and Beutel, P. 2000. Nursing Home Staffing and Its Relationship to Deficiencies. The Journal of Gerontology: Social Sciences. 55B (5):S278-286; Burgio, L.D., Engel, B. T., Hawkins, A., McCormick, K., and Scheve, A. (1990). A descriptive analysis of nursing staff behaviors in a teaching nursing home: Differences among NAs, LPNs, and RNs. *The Gerontologist, 30*, 107-112.

[6] Manor Care, Inc. Schedule 14A, August 6, 2007.

[7] Michigan Medicaid cost report data for 2006, reported for 22 Manor Care facilities.

[8] Based on information from "About the Nursing Home – Inspections," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 8/23/2007.

[9] Based on information from "About the Nursing Home–Inspection Results," Centers for Medicare and Medicaid Services Nursing Home Compare data, downloaded 11/8/2007.

The real tragedy here lies in the human stories behind each of these statistics: the resident who sat in feces for five hours and the called the police[10]; or the resident who was totally dependent on facility staff for her care and unable to speak who was found with ants crawling on her mouth.[11]

Manor Care's low staffing levels and poor performance on numerous indicators of quality care are particularly alarming in light of the real possibility of even further staffing cuts and deterioration in the quality of care once Carlyle takes over. As the New York Times reported in its September 23 expose, clinical registered nurse staffing was cut at 60% of homes purchased by large private equity firms between 2000 and 2006, sometimes far below levels required by law. The New York Times also reported an increase in serious quality of care deficiencies at these homes.

Manor Care may itself come under pressure to further cut staffing in order to service the massive $5.5 billion debt it will have once the deal is complete. SEIU estimates the increase in the interest expense alone in just the first year after the Carlyle takeover to be $400 million. This figure, which does not even include the increase in principal payments, is already more than double Manor Care's entire profit of $167 million in 2006.[12] How will this massive new expense be paid for? Are we really to believe Carlyle's investment plan for Manor Care is to drive a profitable company deeply into the red, and not cut costs to keep its investment profitable?

Once Carlyle's applications for nursing home licenses are approved, it may be very difficult to hold these homes accountable to ensure such a scenario does not take place. As the New York Times reported, "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." Carlyle intends to adopt a corporate structure similar to those other private equity firms have used to render their homes impervious to oversight, which involves spreading assets among an elaborate web of special purpose LLCs and holding companies. Although Manor Care has claimed in its communications that "The Carlyle Group has no intention of separating real estate from the management of those assets," Manor Care's own filings with the SEC, Carlyle's own applications to regulators in Michigan and in numerous other states, and a November 8 Washington Post article all make clear Carlyle does intend to do precisely that. Carlyle has told reporters it does not intend to use these Byzantine structures to evade liability, but what is to stop exactly this from happening?

Michigan's license application process exists precisely to ask these questions now so reasonable steps may be taken to avoid problems before they occur. Licenses are not transferable, and applicants who request a license because of a transfer of ownership or essential ownership interest must first receive a certificate of need before their license application may be considered. *Id.* §333.20164(2). The Michigan Public Health Code vests authority over the certificate of need ("CON") and licensure processes in the Department of Community Health and the Bureau of Health Systems. The principal mission of both the Department and the Bureau is to exercise their authority to protect the citizens of Michigan and to ensure safe, effective, and accessible health care. Michigan's licensing requirements are intended to protect Michigan's citizens and to improve access to quality care. *See id.*; MCL §333.20131; MCL §333.1111.

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[10] Heartland Health Care Center– Georgian Bloomfield, certification survey dated 3/2/2007.
[11] Heartland Health Care Center– Kalamazoo, certification survey dated 12/26/2006.
[12] Manor Care's reported net income in 2006 was $167,084,000. Manor Care, Inc., Schedule 10-K for Fiscal Year ended 12/31/06, p. 45.

The Department has broad authority and is required to conduct a thorough investigation into Manor Care's new ownership structure and operations before issuing a license. Specifically, the Department is required to "investigate and consider" each application, and, before issuing any license, must conduct all "surveys, inspections, and investigations necessary to determine compliance with applicable licensing standards." MAC §325.20205. The Department's investigatory process may include, but is not limited to: (1) inspections of the facility and its operation and maintenance; (2) inspection and copying of books, records, patient clinical records, and other documents maintained by the facility; and (3) the acquisition of any other information, including otherwise privileged or confidential information, from any person who may have relevant information. *Id.* §325.20206. License applicants must provide the Department with all data and statistics necessary to conduct their review, and the Department may request any additional information needed to conduct a complete review. *See* MCL §333.20141(5); MAC §325.20206. The Department is also expressly directed to use "public disclosure" to improve the effectiveness of the licensing process. MCL §333.20131(4).

Manor Care has put heavy pressure on elected officials and regulators to approve the deal on a rapid timeline. As recently as October 23, Manor Care filed a form 8-K with the SEC reaffirming its goal of closing the deal by November 7. Yet Manor Care's own merger agreement with Carlyle does not require the companies to complete the merger until **March 31, 2008** – a deadline which may even be further extended to **May 30, 2008.**[13] There is therefore no reason to short-circuit the Department of Community Health's review process and limit stakeholder input by rushing ahead with a rapid and reckless timeline. The MDCH should use the coming months to carefully review Carlyle's track record and its plans for operating Manor Care's 8 homes in Michigan, and take every reasonable step to ensure this deal protects the interests of Manor Care's present and future residents. We urge the Committee to work closely with the Department of Community Health to ensure a thorough examination of The Carlyle Group's takeover of Manor Care homes before granting Carlyle licenses to operate these homes.

SEIU is not alone in expressing concern about private equity's influence in the nursing home industry. In Congress, the House Ways & Means Subcommittee on Health and the Senate Special Committee on Aging both held related hearings earlier this month. The House Energy and Commerce Committee and the House Financial Services Committee have also announced investigations into the impact of private equity ownership on nursing homes. These announcements come on the heels of requests by Senators Grassley and Clinton for the Government Accountability Office to investigate private investor ownership of nursing homes, and letters sent by Senators Grassley and Baucus to five private investment firms seeking information on their ownership and management of nursing home chains, and to the Centers for Medicare and Medicaid Services about its oversight of such homes.

In addition to Michigan, state legislators in Washington, Wisconsin, Illinois, Maryland, Florida, and Pennsylvania have all called upon regulators to investigate the Carlyle buyout of Manor Care, and legislative hearings have also been held in Pennsylvania, Illinois, and Wisconsin and announced in Maryland. These states are the locations of nearly half of Manor Care's nursing homes. In fact, Florida's Agency for Health Care Administration (ACHA) signaled on November 19 that it intends to deem incomplete, and therefore deny, 7 of the Carlyle Group's 29 applications for the transfer of operating licenses for Manor Care nursing homes after Manor Care failed to provide in a timely manner additional information requested by AHCA to rectify deficiencies in Manor Care's applications.

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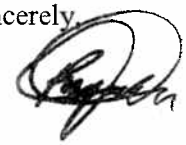
[13] Manor Care, Inc. Schedule 14A, August 6, 2007, p.8.

On December 4, 2007, Manor Care submitted written testimony to Chairwoman Angerer. SEIU Healthcare MI has obtained a copy of this testimony and found it to contain many inaccuracies and misleading statements. In an effort to set the record straight, we have attached clarifications and responses to just some of the most glaring misleading statements by Manor Care.

We urge this Committee to work closely with the Department of Community Health to conduct a thorough examination of The Carlyle Group's takeover of Manor Care homes, and ensure the interests of Michigan residents will be protected before granting Carlyle licenses to operate these homes.

Sincerely,



Rickman Jackson, President
SEIU Healthcare Michigan

Below is SEIU Healthcare Michigan's response to Manor Care's written testimony, dated 12/4/2007.

1. **Manor Care falsely claims that it will not be restructured in a similar method to that outlined in the September 23 *NYT* article.** The *NYT* article describes how ownership of the real estate and operation of the facilities are separated and spread across dozens of corporations. The article also mentions that the operating and management corporations are held separately from the real estate assets. Based on their filings with the Department of Community Health and interviews with DCH staff, this is what Manor Care plans to do: separate the operating and real estate assets using single-purpose LLCs and multiple holding companies. While it is unclear from their filings whether they plan to trifurcate or merely bifurcate the ownership structure of each individual nursing home, this structure nevertheless raises serious questions about the ability of regulators and injured residents to hold the reorganized Manor Care accountable.

2. **Manor Care falsely claims that the new structure "is not a shield against ultimate liability of Manor Care – all of the assets will still be owned 100% by the parent company."** Manor Care's applications to MDCH make clear the ultimate parent company will be "Carlyle and other Stockholder", not Manor Care. In addition, the restructuring will create hundreds of LLCs and several additional holding companies, creating additional layers of ownership that potentially shield the parent company from liability. If the holding companies do not exist to limit liability, then what purpose do they serve in the corporate structure?

3. **The reorganized corporate chart Manor Care provides in its testimony is oversimplified and doesn't demonstrate the additional layers of ownership that will shield the company from liability.** Based on the "simplified" corporate structure provided to the Department of Community Health with its certificate of need filings, Carlyle will create a corporation as a holding company to own the entire Manor Care chain, create separate LLCs for both the real estate holdings and operations of each Manor Care home, and create four additional holding companies to further shield Manor Care from liability for substandard patient care. Government programs require nursing homes to disclose payments to affiliates to ensure that such payments are not artificially inflated. Referring to a corporate structure similar to that proposed by Manor Care, the *New York Times* describes how regulators are often not aware when payments are made to affiliates, leading to decreased regulatory oversight in programs funded with public money.

4. **The testimony states that Carlyle will invest $1.3bn in equity in the company, but neglects to mention the $5.5bn in debt that will also be acquired in the deal.** The $5.5 billion that Manor Care will take on as a result of the deal is more than 5 times the current debt of the company, and more than 32 times the company's total profits in 2006.

5. **Manor Care claims the money to finance the debt will be covered by the share buybacks and quarterly dividends to public shareholders.** However, we are unaware of any documentation submitted by Manor Care that supports this claim, nor are we aware of any *binding commitments* by Manor Care or Carlyle not to further reduce staffing once the deal is completed.

6. **Manor Care takes pride in the fact that "nearly two-thirds of [residents] stay in our centers for less than 40 days and half less than 30 days." This is due in large part to**

Manor Care's moving away from Medicaid patients. Currently, six Michigan facilities do not accept Medicaid and the LTC Ombudsman has stated in a letter to regulators that "HCR Manor Care has decertified some Medicaid beds in some of its facilities in order to move their business model away from serving long term Medicaid residents and toward serving more Medicare and privately funded short term rehabilitation stays." She continues that "while this is a legitimate business model for some long term care facilities, it causes access problems for people who must use Medicaid benefits." The Ombudsman is correct: the pursuit of profitability should not come at the cost of access to vital health services for those without the resources to pay privately for care.

7. **Manor Care states that "regardless of the validity of the *NYT* article, Manor Care's performance should be judged on its own merits." In Michigan, Manor Care homes staff below and have more health deficiencies than the state average.** 57% of Manor Care's Michigan homes received more health deficiencies in their most recent survey than the state average, and 76% of Manor Care's Michigan homes provide fewer nursing hours per patient per day than the state average. The increase in debt to $5.5 billion in debt could put even further pressure on Manor Care to reduce staff.

8. **"Manor Care will appoint an independent and well-regarded committee of experts to advise the Quality Committee and Board on quality of care."** Like the "Patients First Pledge" released by Carlyle and Manor Care, this is another nonbinding statement: once Manor Care becomes a private company, it will be under no obligation to appoint such a committee, nor will its Board be under any obligation to follow the committee's recommendations even if the committee is appointed.