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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

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In re:	:	Chapter 11
	:	
SOUND SHORE MEDICAL CENTER OF WESTCHESTER, et al.,	:	Case No. 13-22840 (RDD)
Debtors.	:	(Jointly Administered)
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STIPULATION AND AGREEMENT REGARDING DEBTORS' ASSUMPTION AND ASSIGNMENT OF MEDICARE PROVIDER AGREEMENTS AND PROVIDER NUMBERS FOR SOUND SHORE MEDICAL CENTER OF WESTCHESTER, THE MOUNT VERNON HOSPITAL AND HOWE AVENUE NURSING HOME D/B/A/ HELEN AND MICHAEL SCHAFFER EXTENDED CARE CENTER

TO THE HONORABLE ROBERT D. DRAIN,
UNITED STATES BANKRUPTCY JUDGE:

IT IS HEREBY STIPULATED AND AGREED, by and among Sound Shore Medical Center of Westchester ("SSMC"), The Mount Vernon Hospital ("MVH") and the Howe Avenue Nursing Home d/b/a Helen and Michael Schaffer Extended Care Center, as debtors and debtors-in-possession in the above-captioned case ("SECC," together with SSMC and MVH, the "Medical Centers"), together with their affiliated

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debtor entities (collectively, the "Debtors") and Montefiore New Rochelle Hospital, Inc., Schaffer Extended Care Center, Inc., Montefiore Mount Vernon Hospital, Inc. (collectively, the "Buyers") and the United States, acting on behalf of the United States Department of Health and Human Services ("HHS") Centers for Medicare & Medicaid Services ("CMS"), acting by and through their respective counsel, as follows:

RECITALS

WHEREAS:

A. SSMC is a not-for-profit 242-bed, community-based teaching hospital offering primary, acute, emergency and long-term health care to the residents of southern Westchester. SSMC is a teaching affiliate of New York Medical College, is home to a comprehensive orthopedic program and stroke and bariatric centers of recognized excellence, and houses the only trauma center in southern Westchester as well as a reputable level 3 perinatal hospital.

B. MVH is a voluntary, not-for-profit, 176-bed hospital located in Mount Vernon, New York. MVH houses a full range of diagnostic and therapeutic medical and surgical services, specialty programs and ambulatory clinics. MVH also offers comprehensive inpatient and outpatient behavioral health programs consisting of psychiatric services designed specifically for individuals whose needs have not been met through traditional approaches.

C. SECC is a 150-bed, comprehensive facility offering short-term rehabilitation/sub-acute care, as well as skilled long-term care. SECC dedicates 100-

beds for long-term skilled medical management for individuals with chronic conditions or disabilities who are no longer capable to live independently. The remaining 50-beds are utilized for short-term stays and rehabilitation to accommodate patients recovering from heart surgery, heart attacks, strokes, and orthopedic surgery.

D. On May 29, 2013, the Medical Centers and each of their affiliated debtor entities (collectively, the "Debtors") filed voluntary petitions for relief under title 11 of Chapter 11 of the United States Code (the "Bankruptcy Code"). Since the commencement of these jointly administered cases, the Debtors have been operating their businesses and managing their properties as debtors-in-possession pursuant to sections 1107 and 1108 of the Bankruptcy Code.

E. On June 10, 2013, the United States Trustee for the Southern District of New York appointed the official committee of unsecured creditors (the "Creditors Committee") [Docket No. 67]

The Medicare Reimbursement System

F. Under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq. (the "Medicare Act"), CMS is responsible for the administration of the Medicare program. Part A of the Medicare Act provides insurance coverage for hospital and skilled nursing care. Part B of the Medicare Act provides a voluntary program of supplemental medical insurance covering expenses including, without limitation, physician services, x-rays, hospital outpatient services and medical supplies.

G. The Secretary of HHS (the "Secretary") contracts with Medicare Administrative Contractors (MACs) to administer payment to providers for services

covered by Medicare. Pursuant to Medicare regulations codified at 42 C.F.R. Part 413 and the terms of the provider agreements, MACs reimburse Medicare providers under various applicable methods in accordance with the Medicare Act and the Secretary's regulations and policies. MACs make some payments on an interim basis based on the claims or other data submitted by the provider to the MAC.

H. The interim payments subsequently are reconciled to the amounts properly payable under the applicable Medicare payment methods by the MAC after the submission of provider cost reports (the "cost reports") pursuant to 42 U.S.C. § 1395g, and the MAC determines the provider's actual, rather than estimated, reimbursement amount for the year. The MAC then issues a "Notice of Amount of Medicare Program Reimbursement" (NPR), which determines whether the provider was overpaid or underpaid for that fiscal year. 42 C.F.R. §§ 412.110 et seq., 413.60, 405.1803.

I. The NPR determination is final unless it is revised by the MAC or appealed to the Provider Reimbursement Review Board. 42 C.F.R. § 405.1807. The Medicare regulations also permit reopening in order to make limited corrections on otherwise final cost report determinations. 42 C.F.R. § 405.1885.

Assumption and Transfer of the Medical Centers' Medicare Provider Agreements and Provider Numbers

J. The Medical Centers participate in the Medicare program and render services to Medicare beneficiaries. The Medical Centers' participation in the Medicare program is governed by provider agreements (the "Medical Centers' Provider

Agreements") with the Secretary, pursuant to 42 U.S.C. § 1395cc(a)(1) and 42 C.F.R. § 489.10. The Medical Centers were assigned several provider numbers for billing purposes (the "Medical Centers' Provider Numbers"), including the main provider numbers of 330184 for SSMC and 330086 for MVH, and the related sub-provider numbers of 335337 for SECC, 337103 for SSMC and 33s086 for MVH

K. The Medical Centers collectively receive on average, approximately $1.45 million weekly from its participation in the Medicare program.

L. In connection with the Medical Centers' participation in the Medicare program, National Government Services ("NGS") serves as the MAC between HHS and the Medical Centers, and determines Medicare payments to the Medical Centers based on various applicable payment methods.

M. In addition, the Medical Centers receive Medicare reimbursement for graduate medical education ("GME"). The Buyers seek as their Medicare GME reimbursement cap the amount of the Medical Centers' reimbursement caps. However, under applicable Medicare regulations, policies and procedures, as interpreted by the Secretary, the Buyers cannot attain and/or retain such reimbursement caps after the Sale (as defined below) without being assigned the Medical Centers' Provider Agreements.

N. By Order dated August 8, 2013 [Docket No. 259], and as supplemented by Order dated October 15, 2013 [Docket No. 381] (together, the "Sale Order"), this Court approved the sale (the "Sale") of substantially all of the Debtors' assets to certain of the Buyers' affiliates (the "Montefiore Buyers") pursuant to the terms

and subject to the conditions contained in that certain Amended and Restated Asset Purchase Agreement filed with the Court on June 27, 2013 [Docket No. 123-2] (the "APA").

O. Prior to the hearing approving the Sale Order, the Debtors and the Montefiore Buyers accepted language proposed by CMS and their counsel, the United States Attorney's Office for the Southern District of New York (the "United States Attorney"), for inclusion in the proposed Sale Order specifically providing that "[n]othing in this Order shall be construed as authorizing the sale or transfer of the [Provider Agreements and Provider Numbers], free and clear of any liability or continuing obligations to the United States. The Debtors, [the Montefiore Buyers], [CMS], and the [United States Attorney] will separately address the issue of the liability of the [Montefiore Buyers] to the United States with respect to the Debtors' [Provider Agreements and Provider Numbers] in the event the [Provider Agreements] are among the Assigned Contracts identified in Schedule 2.1(d) of the Purchase Agreement." *See* Sale Order, ¶ K.

P. To receive an uninterrupted stream of Medicare reimbursements for services provided to Medicare beneficiaries at the Medical Centers after the Sale and for the Buyers to receive the Medical Centers' GME reimbursement caps, the Buyers and the Medical Centers seek to have the Provider Agreements and Provider Numbers assigned to the Buyers in conjunction with the APA.

Q. CMS desires to facilitate the Sale so as to ensure the continuing availability of medical services for the communities that traditionally have relied on the

Medical Centers.

The Covered Liabilities Arising Under the Provider Agreements

R. NGS has finalized the auditing process for some but not all of the Medical Centers' cost reports and other known claims for fiscal years 2008 through 2012.

S. All of the SSMC pre-2009 cost reports are closed and satisfied. CMS has closed the MVH Cost Report audits for years 2009 and 2010. CMS is prepared to close out the remaining open cost report years (2009-2012 for SSMC and 2011-2012 for MVH). The agreed upon amount to be paid to CMS for the closure and final settlement of all cost reports through December 31, 2012 is $3,488,276 In addition the Debtors owe $751,580 relating to outstanding non-RAC claim receivables; and $657,707 relating to outstanding amounts on overpayments determined by Recovery Audit Contractors ("RAC"). The parties agree the Debtors owe CMS a total of $4,897,563 in outstanding debt due the Medicare program as of November 4, 2013 ("CMS Claims"). A more detailed schedule of the CMS Claims is annexed hereto as Exhibit A, which reflects amounts through November 4, 2013.

T. CMS, in finally settling the MVH cost report liability for 2009 and 2010, determined there was a significant overpayment owing to CMS. MVH requested, and CMS agreed, that it would partially recoup the overpayment by withholding 10% from interim payments that the MAC thereafter was making to MVH in the ordinary course (the "MVH Withhold").

U. The parties wish to resolve certain issues relating to the assumption

and assignment of the Provider Agreements and related Provider Numbers, including the resolution and payment of the CMS Claim, and avoid the uncertainty and expense of future litigation relating to the CMS Claim. Absent the assignment of the Provider Agreements to the Buyers the Sale cannot close. Accordingly, the parties agree to the Debtors' assumption and assignment of the Provider Agreements and related Provider Numbers to the Buyers subject to the terms and conditions set forth herein.

NOW, THEREFORE, IT IS HEREBY AGREED that:

1. Pursuant to section 365(a) of the Bankruptcy Code, under the conditions set forth in the APA, the Sale Order, and this Stipulation and Order, the Medical Centers hereby assume their respective Provider Agreements and related Provider Numbers and Buyers shall accept assignment of the Provider Agreements and related Provider Numbers effective upon the date the Sale closes (the "Closing Date"). The Debtors' Medicare Provider Numbers 33-0184, 33-5337, 33-7103, 33-0086, and 33-s086 will be automatically assigned as provided by 42 CFR 489.18.

2. The parties agree the Debtors will pay CMS $4,897,563 from the sale proceeds in satisfaction of the known debt identified in Exhibit A (the "Settlement Payment"). Such amount will be paid to NGS within 10 days of the Closing Date.

3. The Settlement Payment accounts for the reduction in the 2009 and 2010 MVH final cost report settlements through MVH Withholds occurring through the date hereof. From and after the date hereof, any and all further MVH Withholds will be terminated by CMS.

4. For purposes of this Stipulation and Order, the parties agree that all

cost reports for the Medical Centers prior to and including the Medical Centers' December 31, 2012 cost reports are closed and final settled. The Medical Centers waive any appeals or right to contest or reopen any such cost reports for purposes of seeking additional reimbursements from CMS or any HHS MAC or otherwise. HHS, CMS, or any HHS MAC shall not review, audit or reopen for audit (as applicable) any cost reports herein deemed administratively closed and no NPRs shall be issued for any cost reports deemed closed as stated hereinfor purposes of recouping, offsetting or otherwise recovering from the Medical Centers, Buyers, or any affiliate of Buyers any additional amounts in connection therewith.

5. The Terminating Cost Report settlements (as defined below) for the 2013 period and all claim submissions shall be processed in the ordinary course, and to the extent any such claims, including claim reviews or settlements result in a finding of overpayment, such amounts shall be paid by, or otherwise recouped from any amounts owing or that become owing to Buyers. In the event such processing results in a determination of additional amounts due, such amounts shall be paid by the MAC to the Buyers.

6. The Buyers shall be allowed to prepare 14-month cost reports covering the period beginning on the Closing Date through December 31, 2014, which cost reports shall be due on or before May 31, 2015.

7. CMS will expedite approval of the Buyers' CMS-855A Provider Enrollment Application.

8. The Medical Centers shall timely submit their terminating cost

reports for 2013 covering the period from January 1, 2013 through the Closing Date (the "Terminating Cost Reports"). In the event the Medical Centers fail to submit their Terminating Cost Reports, the Medical Centers and Buyers agree as follows: the Buyers shall be responsible for filing the Terminating Cost Reports within the required time frame; and the Medical Centers shall be obligated to reimburse Buyers for the cost of preparing and filing such reports, including the imputed salary of Buyers' employees working on the matter and the fees and costs of Buyers' agents, advisors and professionals. Buyers' claims for reimbursement against the Medical Centers shall be an allowed administrative expense claim under section 503(b)(1)(A) of the Bankruptcy Code and shall be payable 10 days after invoicing by Buyers unless the Medical Centers or the Creditors Committee contest the amount thereof (including, but not limited to, the reasonableness of the fees and the costs), in which case the amount shall be paid to Buyers promptly after the parties agree on the amount or the Court enters an Order fixing the amount. CMS is not a party to this subagreement on the filing of the Terminating Cost Reports.

9. CMS reserves the right to review and adjust data and statistics contained in any of the Medical Centers' cost reports for cost reporting periods through December 31, 2012 for the purpose of computing future reimbursement amounts dependent on the settlement of these cost reports. No additional amounts will be paid by, or any further payments sought from, the Medical Centers or Buyers for these cost reports based on these reviews and adjustments.

10. CMS reserves the right to reopen and review the Medical Centers'

cost reports for cost reporting periods through December 31, 2012 in order to comply with any act of Congress requiring CMS to rely on settled cost reports as a basis for adjusting Federal payment rates to Medicare providers. No additional amounts will be paid by, or any further payments sought from, the Medical Centers or Buyers for these cost reports based on these reviews and adjustments.

11. Other than to enforce this Stipulation and Order, the Medical Centers, the Debtors and the Buyers shall not institute any administrative appeals or federal district court action seeking further reimbursement in respect of any of the Medical Centers' cost reports, under any theory, known or unknown, related to any cost reporting periods through December 31, 2012.

12. The Medical Centers shall withdraw all existing appeals (the "Appeals") relating to any of the Medical Centers' cost reporting periods through December 31, 2012 that are pending on the Closing Date and shall not file any new Appeals relating to any of the Medical Centers' cost reporting periods through December 31, 2012. However, nothing in this Stipulation shall prohibit the Buyers from appealing existing or future claim overpayments including claim denials for services through the Closing Date or from appealing any issues resulting from the future settlement of the Medical Centers' Terminating Cost Reports by CMS and/or its MAC.

13. Buyers shall assume the Medical Centers' Provider Agreements and associated Provider Numbers and in so doing, in conjunction with continuing to operate the teaching programs in accordance with applicable regulations, CMS agrees that Buyers shall assume on a permanent basis the GME resident caps associated with

the Medical Centers' Provider Agreements. Nothing in this Stipulation and Agreement, however, shall be construed as limiting CMS' right to alter the amount of GME reimbursement to Buyers in accordance with applicable law and regulations.

14. The terms of this Stipulation and Agreement shall not be altered or amended in any plan of liquidation submitted for approval by the Bankruptcy Court.

15. This Stipulation and Agreement may not be modified except by a writing executed by the parties that is approved by the Bankruptcy Court.

16. The parties understand and agree that this Stipulation and Agreement contains the entire agreement among them with respect to the subject matter hereof and thereof, and that no statements, representations, promises, agreements, or negotiations, oral or otherwise, among the parties or their respective counsel that are not included herein shall be of any force or effect. Any disputes regarding the rights arising under this Stipulation and Agreement shall be governed by federal law.

17. Except as expressly stated herein, nothing in this Stipulation and Order shall constitute a waiver of any party's rights or defenses, and each party hereto expressly reserves all rights and defenses.

18. This Stipulation and Agreement is binding upon the parties and any of their respective successors or assigns.

19. The undersigned signatories represent and warrant that they are authorized to execute this Stipulation and Agreement in their official capacity on behalf of the parties.

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20. This Stipulation and Agreement shall be effective upon execution by the parties and the Closing Date. The terms reflected in this Stipulation and Agreement shall be subject to approval by the Bankruptcy Court. Debtors shall move promptly for Bankruptcy Court approval of this Stipulation and Agreement and shall exercise all reasonable efforts to obtain such approval. If for any reason the Bankruptcy Court declines to approve the Stipulation and Agreement upon Debtors' motion, then the Stipulation and Agreement shall be deemed to be nullified and void ab initio and nothing contained herein shall constitute an admission by any party.

21. The parties hereto agree that the Bankruptcy Court shall retain exclusive jurisdiction to interpret and enforce this Stipulation and Agreement, and to resolve any disputes arising out of or relating to this Stipulation and Agreement including after confirmation of a chapter 11 plan for the Debtors, or the conversion, dismissal and/or closing of the Debtors' chapter 11 cases.

22. Nothing in this Stipulation and Agreement shall be construed as limiting the liability of Buyers for any overpayments incurred subsequent to the Closing Date or of CMS in respect of any payments or underpayments arising from services provided by Buyers subsequent to the Closing Date.

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23. This Stipulation and Agreement may be executed in counterparts by the parties, each of which may be transmitted by electronic mail or facsimile, and each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Dated: New York, New York
November 5, 2013

UNITED STATES ATTORNEY FOR THE SOUTHERN DISTRICT OF NEW YORK
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By: /s/Tomoko Onozawa
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Dated: New York, New York
November 5, 2013

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Dated: New York, New York
November 5, 2013

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SO ORDERED:
Dated: New York, New York
November ___, 2013

____
HON. ROBERT D. DRAIN
UNITED STATES BANKRUPTCY JUDGE

EXHIBIT A

Medicare Debt Owed By Seller Determined As of November 4, 2013.

Outstanding Determined Cost Report Debt:	
Mt. Vernon – 2009 Revised Final Settlement	($2,183,977)
Mt. Vernon – 2010 Final Settlement	($433,992)
Sound Shore – 2012 As Filed	($17,893)
Schaeffer Extended Care Center – 2012 as Filed	($272,352)
Interest on Cost Report Debt	($12,251)
Net Estimated Reimbursement on Open Cost Reports	
Sound Shore Cost Reports 2009 – 2012	($22,944)
Mt. Vernon Cost Reports 2011 -2012	($544,867)
Outstanding RAC Receivables	($657,707)
Outstanding non-RAC Part A Claim Receivables	($751,580)
Total	($4,897,563)