# REPORT OF THE COMMITTEE

# OF THE

# HEALTH SERVICES COUNCIL

# ON THE APPLICATIONS OF

# STEWARD HEALTH CARE SYSTEM, LLC

# FOR CHANGES IN EFFECTIVE CONTROL OF:

# LANDMARK MEDICAL CENTER AND

# REHABILITATION HOSPITAL OF RHODE ISLAND

Project Review Committee-I
Victoria Almeida (Ex-Officio)
John X. Donahue
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Theresa Jeremiah
Amy Lapierre
Steven Lonardo
Thomas M. Madden
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Submitted to the
Health Services Council
8 May 2012

Adopted as submitted by the
Health Services Council
8 May 2012

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## I. SYNOPSIS

Project Review Committee-I of the Health Services Council recommends that the applications of Steward Health Care System, LLC (Cerberus Capital Management, L.P.) and subsidiaries for change in effective control of: 1) Landmark Medical Center, a licensed hospital in Woonsocket and 2) Northern Rhode Island Rehab Management Associates, LP d/b/a Rehabilitation Hospital of Rhode Island, a licensed rehabilitation hospital center in North Smithfield be approved.

## II. PROPOSAL DESCRIPTION

### Cerberus Capital Management, L.P.

Cerberus Capital Management, L.P. (Cerberus) is one of the largest private equity investment firms in the United States. The firm is based in New York City. Cerberus is the ultimate parent entity of Steward Health Care System, LLC (Steward).

### Steward Health Care System, LLC

Steward is a controlled affiliate of Cerberus (the financial sponsor) and was formed in March of 2010 for the purposes of owning and operating community-based hospitals and related health care entities. Steward commenced its principal operations in November of 2010 when it acquired the Caritas Christi community-hospital system in Massachusetts. Steward is headquartered in Massachusetts. Currently, Steward owns a total of 10 hospitals in Massachusetts and is also seeking to acquire New England Sinai Hospital, a 212-bed post-acute care hospital in Stoughton. Dr. Ralph de la Torre is the CEO of Steward.

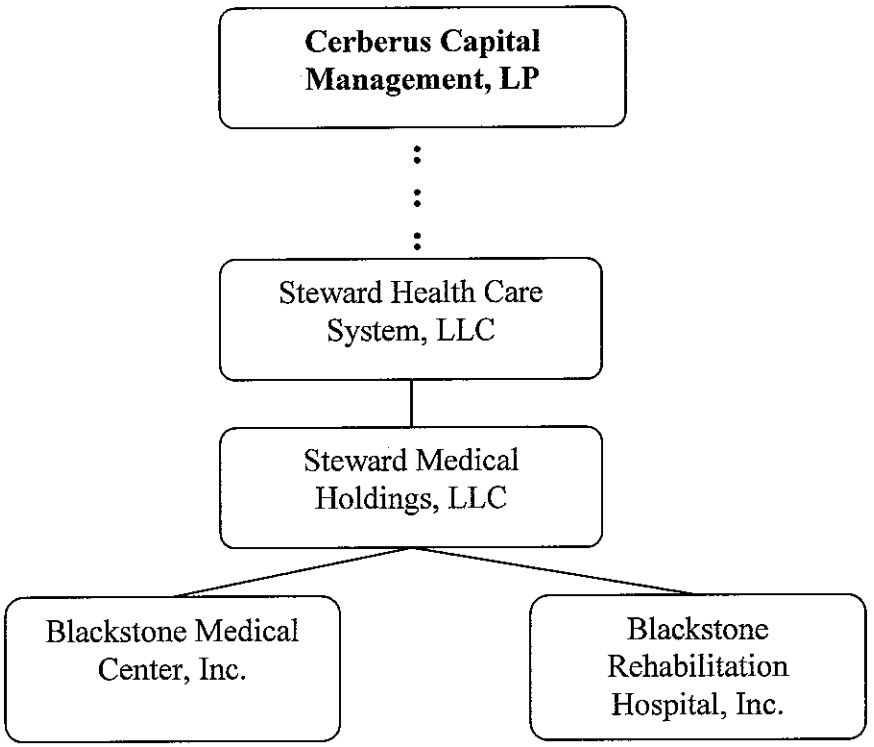
### Landmark Medical Center and Rehabilitation Hospital of Rhode Island

Landmark Medical Center (LMC) is a licensed hospital in Woonsocket and Rehabilitation Hospital of Rhode Island (RHRI) is a licensed rehabilitation hospital center in North Smithfield. In 2008, the Superior Court for the County of Providence appointed a Special Master (Jonathan Savage, Esq.) to oversee the operations of these hospitals. These hospitals presently have no governing body, trustees, or other executives empowered to direct the Special Master or to undertake actions not delegated or approved by the Special Master. Steward is an advisor to the Special Master through the Agreement for Advisory Services which was entered into on 26 May 2011.

### Conversion to For-Profit

Steward through subsidiaries is seeking to acquire and convert two hospitals in Rhode Island: Landmark Medical Center (non-profit) and Rehabilitation Hospital of Rhode Island (for-profit). The two hospitals would then be both for-profit and be renamed Blackstone Medical Center, Inc. and Blackstone Rehabilitation Hospital, Inc.

**Proposed Ownership Structure:**




## III. INTRODUCTION

Pursuant to the requirements of Chapter 23-17 of the General Laws of Rhode Island entitled "Licensing of Health Care Facilities," the applicant filed for changes in effective control of the subject-licensed facilities. This request is made because the statute requires that any proposed change in owner, operator or lessee of a licensed health care facility be reviewed by the Health Services Council and approved by the state-licensing agency prior to implementation.

Staff reviewed the applications, and after corrections of deficiencies, found them to be acceptable in form, and notified the applicants and the general public by a notice on the Department's website and via direct mail and e-mail that the review would commence on 13 March 2012. The notice also advised that all persons wishing to comment on the applications submit their comments to the state agency by 12 April 2012, when practicable. Comments were received from:

- Atlas Pallet Corporation on 13 April 2012 (letter attached – Tab 1),
- Lifespan on 27 March 2012 (letter attached – Tab 1),
- NRI Community Services, Inc. on 26 April 2012 and 1 May 2012 (letters attached – Tab 1),
- Radiation Therapy Services, Inc. d/b/a 21st Century Oncology on 30 April 2012 (letter attached – Tab 1) and oral comments were made by Mr. Russo representing Radiation Therapy Services at the 1 May 2012 meeting,

- Oral comments were made at the 3 April 2012 meeting by Charles Jones, President/CEO of Thundermist Health Center about the action taken by Thundermist to partner with Women & Infants,
- Oral comments in opposition were made at the 10 April 2012 meeting by Ms. Whitman (copy attached – Tab 1),
- Oral comments in support were made at the 10 April 2012 meeting by Christopher Callaci, General Counsel for the Northern Rhode Island United Nurses & Allied Professionals, Local 5067, and
- Oral comments in support were made at the 24 April 2012 meeting by Matt Wojcik, Director of Economic Development for Woonsocket.

The Project Review Committee assigned to review this proposal met on 20 March 2012, 27 March 2012, 3 April 2012, 10 April 2012, 17 April 2012, 24 April 2012 and 1 May 2012 with the applicant and its legal counsel in attendance at each meeting.

The Committee was also aware of the hospital conversion reviews of LMC and RHRI being conducted by the Department of Health and the Department of Attorney General, pursuant to the requirements of RIGL 23-17.14 (The Hospital Conversions Act).

At the meeting of 20 March 2012, representatives and legal counsel of Steward presented the application and answered Committee's questions. Special Master also addressed the Committee.

At the meeting of 27 March 2012, representatives and legal counsel of Steward reviewed partial responses to follow up questions.

At the meeting of 3 April 2012, Dr. Ralph de la Torre, CEO, made a presentation about Steward and representatives and legal counsel of Steward discussed the proposal and answered Committee's questions. Charles Jones, President/CEO of Thundermist Health Center spoke about the action taken by Thundermist to partner with Women & Infants.

At the meeting of 10 April 2012, Justine M. Carr, MD, Chief Medical Officer and Senior Vice President of Quality and Safety made a presentation and representatives and legal counsel of Steward answered Committee's questions. Public comments in opposition to the proposal were made by Ms. Whitman. Public comments in support of the proposal were made by Mr. Christopher Callaci, General Counsel for the Northern Rhode Island United Nurses & Allied Professionals, Local 5067.

At the meeting of 17 April 2012, representatives and legal counsel of Steward reviewed responses to follow up questions and answered Committee's questions.

At the meeting of 24 April 2012, Michael Kraten, PhD, CPA, President of Enterprise Management Corporation, financial consultant to the Department of Health made a presentation regarding Steward Health Care System, LLC based on the information in the FY 2011 audited financial statements (report attached). Public comments in support of the proposal were made by Matt Wojcik, Director of Economic Development for Woonsocket.

At the meeting of 1 May 2012, the representatives and legal counsel of Steward reviewed responses to follow up questions and answered Committee's questions. Oral comments were made by Mr. Russo representing Radiation Therapy Services, Inc. Comments in support were made by the Special Master.

At the meeting of 1 May 2012, the Committee voted eight in favor, and none opposed (8-0) to recommend that the applications be approved subject to the conditions of approval contained in section VI of this report and submission by Steward of unaudited financial statements for the second quarter of FY 2012 and a detailed update to the status of the outstanding conditions to the APA for the Health Services Council meeting.

## IV. FINDINGS

Section 23-17-14.3 of the licensing statute and section 4.5 of the Rules and Regulations for Licensing of Hospitals (R23-17 HOSP) requires the Health Services Council to consider specific review criteria in formulating a recommendation for a change in effective control. The applicants addressed relevant considerations referred to in these review criteria.

The Committee's comments and findings on each of the criteria follow:

**A. The character, competence, commitment, and standing in the community of the proposed owners, operators or directors of the health care facility.**

**Governance**

The Management Board of Steward (Board) is made of seven members, four of which are representatives of Cerberus (see biographies – Tab 2). To a concern regarding Cerberus' representatives controlling a majority of the Board and ability of the Board to act independently of Cerberus, Steward stated that as with any board, the members of the Board owe traditional fiduciary duties of loyalty and care to each other and to Steward. All members of the Board are required to act in the best interest of Steward when serving on the Board. Steward further represented that Cerberus has no role in the operations of the hospitals because all operations and management control is contained either in the local Board of Directors or the Management Board of Steward. Steward also represented that Cerberus has no ability to affect the decision making of the Board and has no direct influence on the decisions made by the Board or in the provision of healthcare throughout the Steward system. Steward stated that it is the members of the Board who are responsible for populating the board. And if there is a vacancy on the Board, the rest of the members of the Board will vote to fill the vacancy. Cerberus, the sole members of Steward, has no role in selecting the Board.

The Boards of Blackstone Medical Center, Inc. and Blackstone Rehabilitation Hospital, Inc. are proposed to be made up of seven to eleven members, three of which are from Steward (see table below), two to three physicians on the hospital's medical staff or with ties to the service area, and the remainder consisting of community and healthcare leaders and/or prominent local business executives with an interest in revitalizing the hospitals and with ties to the service area:

| Officers | Steward Health Care System, LLC | Blackstone Medical Center, Inc. | Blackstone Rehabilitation Hospital, Inc. |
|---|---|---|---|
| Ralph de la Torre, M.D.<br>President | √ | √ | √ |
| James Renna<br>Treasurer | √ | √ | √ |
| Joseph Maher, Jr. Esq.<br>Secretary | √ | √ | √ |
| **Directors** | **Steward Health Care System, LLC** | **Blackstone Medical Center, Inc.** | **Blackstone Rehabilitation Hospital, Inc.** |
| Ralph de la Torre, M.D.<br>Chairman & CEO<br>Steward Health Care System, LLC | √ | √ | √ |
| James Lenehan<br>Senior Operations Advisor<br>Cerberus Capital Management, LP | √ | | |
| James Karam<br>President<br>First Bristol Corporation | √ | | |
| Ruben King-Shaw, Jr.<br>Chairman & CEO<br>Mansa Equity Partners, Inc. | √ | | |
| W. Brett Ingersoll<br>Co-Head of Private Equity & member of Investment Committee<br>Cerberus Capital Management, LP | √ | | |
| Arthur Halper<br>Senior Operations Executive<br>Cerberus Operations & Advisory Company, LLC | √ | | |
| Lisa Gray<br>General Counsel<br>Cerberus Operations Advisory Company, LLC | √ | | |
| Michael Callum, M.D.<br>President<br>Steward Medical Group, Inc. | | √ | √ |
| Mark Rich<br>Executive VP of Corporate Strategy & Management<br>Steward Health Care System, LLC | | √ | √ |

## Impact on Services and Staffing

Steward did not provide any specific plans for services at LMC and RHRI and in its applications stated that it has not yet made final determination with regards to services and departments. Steward did acknowledge that it might eliminate the obstetric services unless Steward could reach an acceptable agreement with the Thundermist Health Center. Steward also noted that plans to close psychiatric service are no longer being considered at this time. However,

Steward noted that should market forces change or psychiatric clients be redirected in the future, Steward reserves its right to curtail or eliminate services at a future date if necessary.

As part of Amendment No. 8 to the Asset Purchase Agreement (APA), Steward eliminated the requirement that it not undertake any employee reductions in force for a one (1) year period after the employee reductions made by the Special Master before the Closing. According to Steward, this change was necessary due to the loss of obstetrics volume when Thundermist shifted maternity patients away from LMC to Women and Infants Hospital. [Steward noted that it has negotiated the terms of a collective bargaining agreement with the employee union that provides a mutually acceptable mechanism for potential job restructuring.]

**Steward's Conditions to the Asset Purchase Agreement**

Steward included a number of conditions to the APA that could be invoked by Steward so as not to proceed with the acquisitions. Steward categorized some of the conditions as being routine closing conditions. The conditions also included those related to changes in the Hospital Conversions Act legislation and on-going negotiations with third parties, such as Thundermist Health Center, RehabCare, and Radiation Therapy Services, Inc. Steward acknowledged that some of these conditions would not be resolved prior to closing.

Steward would not provide an absolute guarantee to the Committee that it would still go ahead with the acquisitions if all of the conditions were not met prior to closing.

As a condition to the recommendation of approval, the Committee requested that Steward provide a detailed update to the status of the outstanding conditions to the APA for the Health Services Council meeting.

**Steward's Commitments to Rhode Island and Caveats to those Commitments**

According to Steward, it has invested $7 million into the Rhode Island facilities, which includes a $5 million line of credit for operating needs.

In response to written questions, Steward stated that it currently has no plans to sell the land, buildings and equipment of the Rhode Island facilities.

Steward projected $55 million in investments to fund projected capital needs over the 2012-2016 time period for LMC and RHRI (list attached – Tab 3). This amount includes the $30 million capital commitment for new projects. In addition, Steward is projecting to spend another $4.5 million for physician development during the first 5 years after closing on physicians recruitment. A significant portion of these recruitment funds will be allocated to primary care development. According to Steward, it has invested heavily in the infrastructure needed to be successful in health care delivery through an accountable care organization model. The ACO is built around a primary care-centric delivery system, and is prepared to make the investments needed to ensure that the LMC patient community has access to sufficient primary care services, as well as specialty services. At this time, Steward does not know the specific numbers of physicians needed, nor the details regarding all of the specialties that the

community needs. These needs will not be known until Steward has the opportunity to put the time and the resources into an extensive analysis of the needs of the patient community. Within the system as a whole, Steward both employs physicians directly, and contracts with practice-based physicians located in the community through the Steward Health Care Network. Steward noted that it plans to maintain and improve upon the services currently offered at Landmark.

[The Committee was aware of Steward's commitments/conditions to approval for the acquisition of its Massachusetts hospitals included donating any unspent capital expenditures to charity, and funding a closing payment and a five year assessment/monitoring by AG and DPH, including assessment/monitoring of the transaction on health care costs. Steward provided a table comparing its commitments/conditions to approval in Massachusetts to those proposed for the Rhode Island facilities (checklist - Tab 4).]

During the course of the review, including at the meeting of 17 April 2012, the Committee made inquiries regarding Steward funding an escrow account to demonstrate commitment to $30 million for capital expenditures and for the period of time between regulatory approvals and the closing.

Steward would not commit to funding to an escrow to demonstrate commitment to capital expenditures and for the period of time between regulatory approvals and the closing. Steward also identified that the Special Master could seek enforcement of the APA through the Court and that the Court has indicated that after the Special Mastership is dissolved, it will designate the Department of Attorney General to bring enforcement actions to the Court in the event of a breach of the APA.

**Steward's Model of Health Care Delivery**

At the meeting of 3 April 2012, Dr. de la Torre presented the Steward model of health care delivery. He noted that Steward is a health system that includes hospitals and community-based physicians. In written responses to Committee questions, Steward stated that its model is to deliver value in the form of high quality care at an affordable cost. To achieve this, Steward continues to build the infrastructure for clinical integration and care coordination. Steward's Accountable Care Organization (ACO) model addresses care across the continuum, including home, office, hospital and post-acute care. In keeping with the medical home model, Steward is moving to team-based care so that more care can be delivered in the community both as an alternative to hospitalization and to prevent the need for hospitalization. The team includes physicians, pharmacists, nurse care managers, home care nurses and educators.

According to the applicant, where appropriate, clinical care pathways are followed for a condition across the continuum, from hospital to post-acute care to home. Pharmacists visit patients in their homes and evaluate medications and coach medication adherence. Nurse care managers coordinate care for populations with chronic conditions – with high-risk or at-risk. In addition, Steward actively partners with post-acute care facilities. Home care nurses visit patient in their homes and stay in tough through telehealth monitoring of key indicators on a daily basis through remote monitoring. By creating these teams and providing infrastructure, patients not only receive optimum care, but also can receive care at lower cost. For example,

when a patient's heart failure exacerbation can be managed at home, there is a 25% drop in cost of care.

Steward further stated that it has embraced the model of accountable care. Steward noted that it was selected to be one of the thirty national pioneer ACO pilots. Steward noted that at the system level, it is investing heavily in the development and operation of an integrated care network necessary to an ACO with the purpose of promoting community-based care. Steward stated its vision is a system in which patients and their physicians drive decisions in complete coordination and care is delivered at the right time, in the right setting and at the right cost. Steward represented that it will most likely take steps toward eventually operating an ACO within Rhode Island, utilizing the same type of infrastructure and provider network as the ACO in Massachusetts.

Steward stated that one of the main driving forces behind Steward is the goal to provide high quality care at lower costs. One of the ways to control costs is through economies of scale. Steward has the capacity to centralize many administrative functions, resulting in a streamlined, coordinated system. In addition, Steward has invested in an electronic medical records system that is used throughout the entire system, and which will be used at LMC and RHRI post-closing. This centralized system helps providers efficiently coordinate care and results in fewer medical errors and less duplication of services.

As a fully integrated community care organization, Steward's model is designed to increase care coordination among providers to enhance quality and lower cost. This means making sure that all patients receive the appropriate care, at the appropriate time, and in the appropriate setting. Working closely with physicians and health care providers in Woonsocket and surrounding communities, Steward will strengthen primary and preventative care in Landmark's service area in order to improve the overall health of patients, and ultimately help curbe over-usage of the ED.

**Recent Reported Steward Activities in the Massachusetts:**

In April of 2012, Steward sold off a portfolio of buildings (worth ~$100 million) which included Taunton's Northwoods Medical Center as well as a St. Anne's-affiliated building. The buildings are then leased back (from new owner Healthcare Trust of America which is based in Arizona). It was stated that the proceeds from the sale are going to be invested back into Steward.

In April of 2012, staff at St. Anne was laid off. This was the second round of lay offs within a year. In response to follow up questions, Steward identified that in April of 2012 it laid off an additional 23.51 FTEs.

In April of 2012, Bill Walczak, President of Carney Hospital, exited after 14 months on the job.

In April of 2012, Steward announced plans to acquire New England Sinai Hospital, a 212-bed "post-acute care" site in Stoughton.

The Committee considered the totality of the record, including the applicant's presentations, filed documents and responses to questions, and public comments.

**Finding: The Committee finds that the applicant satisfies this criterion at the time, place and circumstances as proposed.**

**B. The extent to which the facility will provide, without material effect on its viability, safe and adequate treatment for those individuals receiving the facility's services.**

**Financial Analysis of Steward**

At the meeting of 24 April 2012, Michael Kraten, PhD, CPA, President of Enterprise Management Corporation (EMC), financial consultant to the Department of Health, presented an analysis of Steward based on the information in the FY 2011 audited financial statements (financial analysis – Tab 5). The analysis noted "red flags" which raise questions regarding the financial health of Steward with regards to working capital shortfall, total equity value of the organization, good will and its impact on the equity value of the organization, revolving credit facility, underfunded pension plan, deficit of net cash used in operating activities, and potential Stark Law violations. Dr. Kraten noted his analysis did not reveal any "smoking guns".

Steward provided written responses to the questions posed by the financial analysis. Steward noted that, as of March 2012, it had a working capital surplus of $41 million, that its outstanding revolving line of credit debt is down to $40 million, and that a Steward Board-approved plan calls for positive Net Income in FY 2012 and also calls for positive free cash flow by 4th quarter FY 2012. Steward also pointed out that EMC's emphasis in its report on so-called "red flags" misses the point that Steward received an unqualified audit opinion from Ernst & Young. By raising the various issues in the Steward audited financials and requesting that additional information be provided to assess the significance of these issues, Steward noted that EMC is suggesting that Steward's capacity to address these issues was not considered as part of the audit. That is simply not the case. Yearly audits of financial conditions are not restricted to the numbers that existed simply at year end. Auditors are required to take into account Steward's plans and abilities to continue as a going concern and to improve the financial health of the enterprise. An unqualified opinion reflects confidence in Steward's ongoing financial health. With regards to working capital, Steward stated that it views the working capital deficits to be short-term in nature primary driven by the structure in which Steward affects some, but not all, of its acquisitions. It is not unusual for companies in a rapid growth mode to show transient working capital shortfalls. The numbers reviewed in the financial analysis by EMC are from FY11, which ended on September 30, 2011. Any shortfall in working capital was indicative of the position Steward was in at a specific point in time, i.e. the acquisition of both the assets and liabilities of 8 struggling community hospitals. As noted in prior responses, Steward has decreased costs while improving quality at those hospitals.

As a condition to the recommendation of approval, the Committee requested that Steward provided unaudited financial statements for the second quarter of FY 2012 for the Health Services Council meeting.

**Investments/Capital Expenditures**

Steward projected $55 million in investments to fund projected capital needs over the 2012-2016 time period for LMC and RHRI (list attached – Tab 3). This amount includes the $30 million capital commitment for new projects. In addition, Steward is projecting to spend another $4.5 million for physician development.

**Financial Projections**

Steward provided the following 5-year projections for the Rhode Island facilities:

| Blackstone Medical Center & Physician Office Services | | | | | |
|---|---|---|---|---|---|
| | FY13 | FY14 | FY15 | FY16 | FY17 |
| Total Revenue | $130,567,488 | $135,240,352 | $ 140,550,159 | $ 144,640,596 | $148,812,994 |
| Operating Expense | $132,328,036 | $135,678,767 | $ 139,868,752 | $ 144,019,417 | $148,315,995 |
| **EBITDA** | **$(1,760,548)** | **$ (438,415)** | **$ 681,407** | **$ 621,179** | **$ 496,999** |
| Depreciation/Amortization | $ 4,902,521 | $ 6,378,235 | $ 7,853,949 | $ 8,084,405 | $ 8,314,861 |
| Interest | $ 27,080 | $ 24,936 | $ 24,936 | $ 24,936 | $ 24,936 |
| Total Expenses | $137,257,637 | $142,081,938 | $ 147,747,637 | $ 152,128,758 | $156,655,792 |
| **Operating Profit** | **$(6,690,149)** | **$ (6,841,586)** | **$ (7,197,478)** | **$ (7,488,162)** | **$ (7,842,798)** |
| | | | | | |
| Blackstone Rehabilitation Hospital, Inc. | | | | | |
| | FY13 | FY14 | FY15 | FY16 | FY17 |
| Revenue | $ 14,326,118 | $ 15,076,807 | $ 15,663,137 | $ 16,114,819 | $ 16,575,552 |
| Expenses | $ 14,474,470 | $ 14,655,660 | $ 15,094,337 | $ 15,543,953 | $ 16,006,992 |
| **Operating Profit** | **$ (148,352)** | **$ 421,147** | **$ 568,800** | **$ 570,866** | **$ 568,559** |

Steward noted that while Blackstone Medical Center would continue to show an operating loss, it would have a positive cash flow by FY 2015.

The Committee considered the totality of the record, including applicant's presentations, filed documents and responses to questions, and public comments.

**Finding: The Committee finds that the applicants satisfy this criterion at the time, place and circumstances as proposed.**

**C. The extent to which the facility will provide safe and adequate treatment for individuals receiving the health care facility's services.**

At the meeting of 10 April 2012, Justine M. Carr, MD, Chief Medical Officer and Senior Vice President of Quality and Safety, made a presentation regarding quality and safety. Dr. Carr reviewed safety initiatives undertaken and compared quality and patient experience track records of Steward's hospital to Rhode Island Hospital (from Q2 2010 to Q1 2011). Dr. Carr reviewed recognitions achieved by various Steward hospitals.

In a report developed by Steward "2011 A Year in Review", it reviewed its actions in 2011 to revitalize and update the hospitals in Massachusetts, as well as its effort to connect with providers all over Massachusetts in order to offer the hospitals' patients the optimal level of care. This report stated that: "*we have achieved a 19.2% reduction in mortality rates and major reductions in hospital-acquired infections, including an 80% reduction in infections due to antibiotic-resistance organisms in the original hospitals. Our hospitals have won numerous quality awards, including Saint Elizabeth's Medical Center being named one of the best 100 hospitals in the U.S. by Thomson Reuters, and Good Samaritan Medical center and Norwood Hospital being included in the list of the top 5% of U.S. hospitals by the Leapfrog Group.*"

Additionally, Steward identified that all of its hospitals are in substantial compliance with requirements of Massachusetts Department of Public Health, the Joint Commission and Massachusetts Medicaid.

According to Steward, the hospitals By-Laws of Steward licensed hospitals state that all physicians on their medical staffs be board-certified in their specialty. Steward is willing to consider active members of the medical staff who are not board-certified to be grandfathered into the new Steward medical staff.

The Committee considered the totality of the record, including applicant's presentations, filed documents and responses to questions, and public comments.

**Finding: The Committee finds that the applicant satisfies this criterion at the time, place and circumstances as proposed.**

**D. The extent to which the facility will provide appropriate access to traditionally under-served populations.**

Pursuant to the Rules and Regulations Pertaining to Hospital Conversions (R23-17.14-HCA), hospitals must provide full charity care (i.e., a 100% discount) to patients/guarantors whose annual income is up to and including 200% of the Federal Poverty Levels, taking into consideration family unit size. Hospitals must also provide partial charity care (i.e., a discount less than 100%) to patients/guarantors whose annual income is between 200% and up to and including 300% of the Federal Poverty Levels, taking into consideration family unit size.

The table below shows charity care levels over the past five years of Landmark Medical Center and affiliates:

| Year | Charity Care (Costs Foregone) | Net Patient Revenue | % of Net Patient Revenue |
|---|---|---|---|
| 2007 | $ 1,728,000 | $ 133,380,098 | 1.3% |
| 2008 | $ 1,300,000 | $ 130,964,822 | 1.0% |
| 2009 | $ 1,500,000 | $ 129,829,304 | 1.2% |
| 2010 | $ 1,700,000 | $ 133,640,716 | 1.3% |
| 2011 | $ 1,900,000 | $ 132,000,814 | 1.4% |

Steward did not specifically identify any short term or long terms plans, nor any commitments to maintaining and improving access to charity care. Steward did not provide charity care policies that would be utilized at Blackstone Medical Center and Blackstone Rehabilitation Hospital. Steward did indicate that charity care policies would be in compliance the Rhode Island requirements. According to the financial statements, in 2011 Steward provided 1.9% of charity care at its hospitals in Massachusetts.

The Committee considered the totality of the record, including applicant's presentations, filed documents and responsse to questions, and public comments.

**Finding: The Committee finds that, based on the evidence presented and representations made by the applicant, the applicant satisfies this criterion at the time, place and circumstances as proposed.**

## V. RECOMMENDATION

After considering each of the review criteria as required by statute and the representations made by the applicant, the full Health Services Council recommends that these requests for a change in effective control be approved subject to the conditions of approval contained in section VI of this report. Approval and implementation of these applications will result in (1) the termination of the existing hospital license issued to Landmark Medical Center and the issuance of a new hospital license to Blackstone Medical Center, Inc.; (2) the termination of the existing rehabilitation hospital center license issued to Northern Rhode Island Rehab Management Associates, LP d/b/a Rehabilitation Hospital of Rhode Island and the issuance of a new rehabilitation hospital center license to Blackstone Rehabilitation Hospital, Inc., both of which are owned and controlled by Steward Health Care System, LLC (ultimately owned by Cerberus Capital Management, L.P.), as identified in this report.

## VI. CONDITIONS OF APPROVAL

The Committee recommends that approval of the instant applications shall be subject to the following conditions:

1. that services at the facilities be provided in conformance with the requirements of the Rules and Regulations for Licensing of Hospitals (R23-17-HOSP), Rules and Regulations for Licensing Rehabilitation Hospital Centers (R23-17-REHAB), and Rules and Regulations Pertaining to Hospital Conversions (R23-17.14-HCA), as applicable;

2. that services at the facilities be provided to all patients without discrimination including payment source or ability to pay; and that the facilities shall accept Medicare and Medicaid patients;

3. that the facilities shall provide charity care in compliance with Rhode Island law;

4. that the applications be implemented as approved;

5. that data, including but not limited to finances, utilization and demographic patient information be furnished to the state agency upon request;

6. that subject to applicable review and approval of the Department of Health, Steward shall expend $30 million plus an amount equal to 2.5% of annual net patient revenue on capital expenditures at the hospitals in first 5 years after the closing;

7. that Steward shall expend $4.5 million for physician recruitment in first 5 years after the closing;

8. that Steward shall not sell either facility to any person or legal entity unaffiliated with Steward for 5 years after the closing as provided in and subject to the Asset Purchase Agreement;

9. that Steward shall offer at-will employment to LMC's and RHRI's non-union employees, except for employees identified by Steward pursuant to the Asset Purchase Agreement. For union employees, employment decisions are subject to the collective bargaining agreement with United Nurses and Allied Professionals;

10. that Steward shall honor naming commitments to past donors; and

11. that composition of each facilities' Board of Directors shall be as follows:

    - Between 7-11 members
        - Includes 3 members who serve by virtue of their positions at Steward Health Care System, LLC.
        - 2-3 physicians on the Hospital medical staff or with ties to service area.
        - Community and healthcare leaders and/or prominent local business executives with an interest in revitalizing the Hospital and with ties to the service area.

# Tab 1

# ATLAS PALLET CORPORATION

RECEIVED
APR 13 2012
RI DEPT OF HEALTH
OFFICE OF
HEALTH SYSTEMS DEVELOPMENT

*April 13, 2012*

*Mr. Michael Dexter*
*Office of Health System Development*
*Department of Health*
*Three Capital Hill, Room 404*
*Providence, RI 02908*

*Re: Sale of Landmark to Steward*

*Dear Mr. Dexter,*

*I am writing today to express my support of the sale of Landmark Medical to Steward Healthcare Systems. As you may know, in order to run a successful business in the State of Rhode Island, it is essential that your business operates a competent and effective Workers Compensation program. Mr. Scott Brodeur and his team from Landmark Occupational Health have been key ingredients in helping Atlas Pallet realize a more stable and cost-effective program. It would certainly be detrimental to our business to lose all of the benefits of Occupational Health; their close proximity and prompt service would be hard to replace.*

*I would be happy to answer any further questions you may have.*

*Sincerely,*

*Heather Ross, Atlas Pallet Corp.*

*Cc: Mr. Scott Brodeur, Landmark Occupational Health*

# Lifespan

George A. Vecchione
*President and*
*Chief Executive Officer*

RECEIVED
MAR 27 2012
RI DEPT OF HEALTH
OFFICE OF
HEALTH SYSTEMS DEVELOPMENT

March 27, 2012

Victoria M. Almeida, Chair
Rhode Island Health Services Council
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

Dear Ms. Almeida:

We were provided with an audio recording of the meeting of the Health Services Council on Tuesday, March 20, 2012. I am writing to provide you and the Council with clarifying information.

Between 2008 and 2011, we met with Jonathan Savage, in his capacity as Special Master representing Landmark Medical Center (Landmark) on numerous occasions, at his request. During that time, we toured Landmark, examined documents, interviewed Landmark representatives, and performed other analyses of Landmark's operation. We concluded that Landmark was not economically sustainable as it was configured and with its full array of services.

Also during that time, we met with representatives of Thundermist Health Center in Woonsocket. The Chief Executive Officer of Thundermist at that time, Maria Montanaro, was concerned about the impact on the health of the community in the event that Landmark was to close. We worked collaboratively with Thundermist to develop the basic contours of a plan that could address essential health care needs in northern Rhode Island in the event of Landmark's closure. We believed that a more robust alignment of providers aimed at improving health status and lowering costs could be a model for health care delivery reform in Rhode Island. A copy of that plan is attached.

We discussed the attached with Mr. Savage. As in previous meetings, we shared with him our concerns, as well as the conclusion we reached about the non-viability of Landmark as a full-service hospital. We told him that we could consider operating Landmark with a different array of services, which would provide needed health services to the people of northern Rhode Island, built around a primary care delivery model based at Thundermist and relating in innovative ways to Landmark and other Rhode Island hospitals. We outlined for him a vision of an institution

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that would provide a hospital emergency department, an expanded urgent care center, outpatient surgical services, short-stay inpatient medical services, inpatient psychiatric services, rehabilitation services, and appropriate diagnostic and ambulatory health services.

We envisioned the establishment of a wide array of community-based services oriented to help improve the health status of the residents of northern Rhode Island. These, together with access to specialty physician services and coordinated with other hospitals for more complex inpatient medical and surgical services, would ensure that the health care needs of northern Rhode Island would be met. Mr. Savage advised us that it was imperative that Landmark be operated as a "full service," acute-care hospital. Accordingly, we did not submit a proposal to acquire Landmark.

In closing, I would like to assure you and members of the Council that we were direct about our concerns and opinions regarding Landmark at all times, and that our conversations and review of the opportunities with Landmark were conducted in good faith. I hope that this letter clarifies the tenor of our conversations with Mr. Savage.

Very truly yours,

George A. Vecchione

gav:ems

Attachment

Thundermist
HEALTH CENTER

To: Jonathan Savage, Special Master, Landmark Medical Center

From: Maria Montanaro, President and CEO, Thundermist Health Center

April 10, 2009

At your request, I have outlined Thundermist's plan for how key health services could be delivered in Woonsocket in the event that Landmark Medical Center were to close. Let me start by saying that, as you know, Thundermist has been concerned, from the very onset of Landmark's financial problems, with how essential services in the community could be maintained. Our first thought was to try to foster an affiliation between Landmark and Lifespan, believing that such an affiliation would provide financial stability to Landmark while at the same time improving its administrative efficiency and the overall quality of care provided to the community. Thundermist has been interested in playing a collaborative role in the delivery of care provided at the hospital in order to more fully integrate primary care services with secondary and tertiary care and in doing so, improve health care access, reduce costs and improve outcomes for our patients and all populations in the community. With Lifespan, we have made a careful study of the financial and operational situation at Landmark. As discussed with you two weeks ago, the unfortunate reality is that a viable way to sustain Landmark hospital given its current financial and operational burdens does not appear to exist. We realize that you and the court will soon be faced with the necessity of making decisions and that you will have to consider all options. If you identify a viable option that would continue hospital services in Woonsocket, it would be my hope and expectation that Thundermist would be included in those discussions at the first opportunity. However, should you and the State authorities determine that a hospital is not viable, Thundermist, in collaboration with Lifespan, would be able to develop a system of ambulatory care that would preserve the most essential health services in the community efficiently and effectively.

The service model that Thundermist envisions would be comprised of the following elements:

- **A free-standing emergency facility:** along with a robust transport system and triage protocols that would ensure the ER could effectively treat, stabilize and transport cases as needed.
- **An urgent care center:** that would reduce the number of inappropriate visits to the ER and provide care to patients for non-emergent medical conditions.
- **An outpatient, free-standing surgical center:** where specialists would provide a variety of same-day surgical procedures, both diagnostic and therapeutic, so that patients could continue to receive these services in the community.
- **Outpatient specialty care clinical services:** to deliver specialty care in the community in an outpatient setting. These specialists could provide continuity of care for patients locally and serve their in-patient needs at hospitals where these specialists hold privileges.
- **Ancillary Services- Laboratory, Radiology and Pharmacy** : to support the emergent, urgent, surgical and specialty services being provided.

- **Coordination of Care with 21st Century Cancer Center**: to make cancer care truly comprehensive by linking it to the surgical oncology and hemolytic oncology programs at Lifespan.
- **The option for the development of other community-based health services in collaboration with other community based providers** :to facilitate the planning with local organizations that may see an advantage to integrating and co-locating health services on a single campus.

There are a growing number of instances where failing community hospitals are reworking their model of care in a manner consistent with what I have outlined above. I have attached an article concerning the Hubbard Regional Hospital in Southbridge, Massachusetts (http://www.mhalink.org/public/news/2009/attach/Harrington%20to%20integrate%20healthcare%20campuses%20-%20final.doc), which has recently taken a similar approach. There is also a community health center in East Boston that has been operating a similar constellation of services for the past decade (www.ebnhc.org ). A detailed search would provide you with other such examples across the country.

If invited, we would be happy to work with all of the State authorities and constituencies that would necessarily be involved in the development of such a model. Whatever model is chosen, the development of a detailed transition plan that assures continuity of care for existing patients and identifies the parties responsible for implementing those service components that will remain, should be the first order of business.

In closing, while the fate of Landmark is not in our hands, Thundermist has a deep concern for our community and the quality of the health care services established in it. We are ready, willing and able (with Lifespan's help) to assist the State in developing a solution to the health care needs of the community should the State determine the hospital is no longer the best option. Whatever decision the State makes, Thundermist will remain a vital and interested stakeholder in the community and would expect to be both consulted and involved in whatever decisions the State makes regarding Landmark. As always, I am at your disposal, should you or others wish to discuss things further.

Caring for Community
NRI Community Services, Inc
*A Non-Profit Provider of Mental Health & Substance Abuse Treatment*

www.NRICommunityServices.org
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April 26, 2012

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APR 27 2012
RI DEPT OF HEALTH
OFFICE OF
HEALTH SYSTEMS DEVELOPMENT

Mr. Michael Dexter
RI Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 404
Providence, RI 02908-5097

Dear Mike:

I herein submit written testimony from NRI Community Services, Inc., the licensed and accredited community mental health center in northern Rhode Island, regarding the acquisition and ownership of the northern Rhode Island nonprofit Landmark Medical Center by the for-profit Steward Health Care System.

As President/CEO for 30 years, I have witnessed a significant improvement in community-based behavioral health care and the shift of psychiatric inpatient care from Eleanor Slater Hospital to Landmark Medical Center. NRICS considers LMC as our preferred provider for emergency room, psychiatric inpatient and other inpatient services for our acute and long term psychiatric clients' hospital needs.

The merger of Fogarty and Woonsocket Hospitals was approved by the Health Services Council, conditional on Landmark Medical Center collaborating with NRI Community Services, the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and local MDs and mental health professionals to keep care in the community. Specifically, LMC agreed to maintain a psychiatric unit, apply for and maintain status as an involuntary care facility, and coordinate closely with NRI Community Services, as the only CMHC licensed and funded to provide mental health emergency services, hospital diversion and step down, discharge planning, care coordination, and long term care in northen Rhode Island.

I am pleased to report LMC's Emergency Room and psychiatric units' collaboration with NRI Community Services. Landmark Medical Center's senior staff have pledged to re-examine NRICS' role in the Emergency Room and improve discharge planning from the psychiatric unit as part of Rhode Island's Medicaid Health Home demonstration. Currently LMC gets applause from health plans for appropriately diverting many psychiatric emergencies to NRICS' Acute Stabilization Unit. The majority of our clients choose LMC over psychiatric specialty hospitals and other Providence community hospitals, when they need inpatient care.

We would assert that, regardless of the ownership and tax status of LMC, the delivery of efficient, collaborative and cost effective behavioral health requires a high level of collaboration between the RI Division of Behavioral Healthcare, Steward and NRI Community Services.

Other nonprofit hospital groups and nonprofit CMHCs are most interested in preserving inpatient psychiatric services in Providence. NRICS, Steward and LMC need DBH to monitor the impact of losing SSTAR as a resource.

NRI Community Services is the local, credible CMHC with a vested interest in LMC's survival and in LMC collaboration. This fact is clearly recognized by local agencies, referral sources, and former patients. NRICS is positioned and funded to meet LMC's needs.

Psychiatric inpatient care needs to be fiscally viable. Ironically, the DBH contract with the Providence Center/Charter effects LMC payor mix. Our clients want local care; our staff want local care; our Board of Directors wants local care. We look forward to an entrepreneurial and business minded look at acute psychiatric services.

Thank you for the opportunity to support the preservation of our community hospital and to assert our belief that LMC/Steward needs to collaborate with us on the behavioral health needs of local residents.

Sincerely,

Christian L. Stephens, MS
President, CEO

CLS:vcd

cc: Ms. Valentina Adamova, RI DOH
Jonathan Savage, Special Master, Landmark Medical Center
Richard Charest, President, Landmark Medical Center
Dr. Ralph de la Torre, Chairman & CEO, Steward Health Care System
Ed Wojcik, Dir. of Human Services & Economic Dev., City of Woonsocket

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May 1, 2012

Mr. Michael Dexter
RI Department of Health
Office Health Systems Development
3 Capitol Hill, Room 404
Providence, RI 02908-5097

Dear Mr. Dexter:

As follow-up to my prior correspondence, I would like to be clearer as to the recommendations of the Board of Directors and current management of NRI Community Services, Inc. (NRICS). In approximately 1988 the HSC required of the new Landmark Medical Center that it become an involuntary care facility and coordinate with NRI Community Services, Inc. and the RI Department of Mental Health, Retardation and Hospitals (now the RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)) in diverting state hospital admissions.

Despite assurances fom LMC on behalf of Steward Health Care System, I would respectfully request that the HSC reaffirm the importance of the LMC psychiatric unit for the local system of psychiatric care. Regardless of the Division of Behavioral Healthcare contracts with other healthcare providers for uninsured inpatient care, we believe NRICS and collaborating organizations like Family Resources Community Action, Thundermist Health Center, and Seven Hills need the local community hospital psychiatric unit for our insured clients.

Optimizing local NRICS services for the health plans and for the Division of Behavioral Healthcare involves NRICS recognizing the parochial nature of northern Rhode Island residents. They choose Landmark Medical Center over other hospitals; we pledge to collaborate with Steward Health Care System to make client length of stays appropriate and their discharge plans individualized.

We have confidence that the HSC and the RI DOH recognize our unique local needs and regional patient demographics. The local hospital's rapid stabilization of Medicaid covered and RIteCare covered psychiatric referrals has proven cost effective for local agencies and for our clients' recovery.

Thank you for the opportunity to submit this testimony.

Sincerely,

Christian L. Stephens, MS
President, CEO

CLS:vcd

FERRUCCI RUSSO
BUSINESS LITIGATION
RECEIVERSHIP
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*W. Mark Russo*
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April 28, 2012

***Via e-mail (michael.dexter@health.ri.gov)***
***via first-class mail***

Michael Dexter, Chief
Office of Health Systems Development
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

***RE: Applications of Steward Healthcare System, LLC***

Dear Mr. Dexter:

This office represents Radiation Therapy Services, Inc. d/b/a "21st Century Oncology" ("21st Century Oncology"). In addition thereto, this office has represented 21st Century Oncology in the Special Mastership proceedings entitled *Gary J. Gaube, Chief Executive Officer and Trustee v. Landmark Medical Center*, PB No. 08-4371.

21st Century Oncology felt it important to bring to your attention that representatives of 21st Century Oncology were in attendance at the last meeting of the Health Services Council regarding the above-entitled Applications.

At that hearing, Council Member, Wallace Gernt posed a question to Joshua Putter, Chief Operating Officer of Steward Healthcare System, LLC. The inquiry focused on the status of certain contingencies identified in the Asset Purchase Agreement relative to the Landmark Special Mastership. In addition to other contingencies, the APA contains a contingency relative to the Southern New England Regional Cancer Center, LLC ("SNERCC"). Steward has indicated that it will not purchase the assets of Landmark absent an agreement to purchase 21st Century Oncology's membership interest in SNERCC.

By way of placing Mr. Gernt's inquiry in context, Steward was aggressively pushing for a vote and Mr. Gernt inquired about the status of other contingencies which may impact the timeline. Mr. Putter indicated that progress on the contingencies was being made. Mr. Gernt concluded by stating that depending upon the resolution of those contingencies, the Council may have other materially relevant questions.

Despite Mr. Putter's testimony, 21st Century Oncology hereby submits that 21st Century Oncology was presented with an offer by which Steward would purchase 21st Century Oncology's membership interest in SNERCC. However, that offer was deemed unacceptable.

21st Century Oncology presented a counteroffer which carried a specific timeframe for a response, so that 21st Century Oncology could not only make business decisions, but decisions that impact healthcare provided to the residents of Northern Rhode Island.

Suffice to say, that 21st Century Oncology did not receive a response from Steward or the Special Master with regard to the counteroffer.

With the timeframe having expired on April 11, 2012, 21st Century Oncology has now been presented with off- the-cuff remarks in the hallway that Steward intends to use the Special Mastership proceeding in a manner to leverage an acquisition of 21st Century Oncology's assets.

21st Century Oncology would urge the Health Services Council to ensure that this issue is resolved prior to any final action on these pending Applications or any HCA proceedings. 21st Century Oncology has nothing to do with the Landmark Mastership. SNERCC is a separately licensed facility. The Special Mastership has no bearing on SNERCC. If Steward's unilateral contingency is to be resolved, it must be accomplished (if at all) through an arms-length transaction.

21st Century Oncology is under no legal obligation to sell its membership interest in SNERCC. Moreover, 21st Century Oncology has remained committed to cancer care on the Landmark campus in Woonsocket despite a challenging environment presented by a Mastership that has dragged out for years. In the interest of healthcare for the people of Northern Rhode Island, 21st Century Oncology has indicated a willingness to sell its interest in SNERCC, provided that 21st Century Oncology receives equitable consideration.

Sincerely,

W. MARK RUSSO

WMR/was

Dee Dee Witman
64 Hazard Avenue
Providence, Rhode Island 02906
dwitman@gmail.com

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April 4, 2012

## Statement to the Project Review Committee

RI Dept. of Health

My name is DeeDee Witman and I have the unique vantage point of familiarity with both the RI Hospital Community and Steward Health Care. As a RI native, I have been an active civic and community leader as well as vice chair of the Miriam Hospital Foundation. My husband, Dr. Gary Witman, directed the evening ER department for Steward's Good Samaritan Hospital in Brockton, MA for the last decade. I am speaking for both of us because Dr. Witman is unable to join us today.

I am here to voice concern about Steward's application for control of Landmark and the RI Rehabilitation Hospital and the state's willingness to change the law to accommodate Steward's takeover of the hospitals. First and foremost, Steward must prove that not only will it be a responsible and caring provider of health care but also a responsible employer and good corporate citizen particularly given the under served communities involved. I especially have grave concerns about Steward's potential ownership of the RI Rehabilitation Hospital.

To add to perspective, Dr. Witman suffered a spinal cord injury in late August 2010 resulting in his becoming a quadriplegic. Although he has obvious physical limitations, his intellect and medical knowledge are still superior. He is in demand and called upon for his medical expertise on matters and issues across the country. This is relevant because although he has been on a leave of absence from Good Samaritan as a result of his injury, for the last several months, ready to return to work, he has been trying to coordinate with Steward to identify and define a new role for himself at the hospital especially in light of the many administrative positions of which Dr. Carr speaks. Recently, he received a fairly impersonal letter, after many of Dr. Witman's communiqués, that he was terminated – the letter was dated March 29 with termination effective March 31. In that letter Human Resource refers to the following "To be clear SMG is not terminating your employment because you sustained an injury. SMG is terminating your employment because your leave of absence continues to be open ended and you are presently unable to return to work in your current position, with or without a reasonable accommodation." This is simply untrue; Dr. Witman has asked the president of Good Samaritan for the opportunity to return to the hospital in any position where his years of experience and skill are utilized. After all, even our congressman from Rhode Island, Jim Langevin, is a quadriplegic and working. I hope all of you can understand

what we see as irony that Steward fires a disabled physician while expressing interest in owning a rehabilitation hospital that cares for the injured and disabled.

And ask yourselves; is this the action of a conscientious and trustworthy employer? Although he can't return to his former position in the ER Dept, Dr. Witman would be invaluable in a different capacity since he has much to offer medically and can assume a variety of responsibilities and tasks. Dr. Witman still has the pulse of the hospital, given that he has presented Grand Rounds, been involved with Dept of Pharmacy and Therapeutic meetings and visits and communicates regularly with his medical colleagues.

As you may know, Steward is part of the portfolio owned by Cerebus Capital Management which means as an equity investor, it can be assumed that Cerebus' priority is the bottom line -- the profit-making aspect of all of the hospitals in the Steward Medical Group

Unquestionably, the members of the Good Samaritan medical staff are concerned about the apparent changes since Steward's ownership and continuing a commitment to the community without financial implications guiding decisions about patient care. A non-profit and a for profit hospital approaches patient care very differently. Steward and Cerebus are all about the bottom line – financial concerns first; patient concerns second. This is echoed by many of Dr. Witman's Good Samaritan colleagues who see this firsthand.

It goes without saying throughout the country; the independent community hospital is becoming a dinosaur for many reasons, most of which are financial. It is our responsibility to care about how all the communities in RI will be served by health care providers, not just in our own backyard. When the hospitals are swallowed up by large entities, without careful stewardship, the personal touch, and concern for community erode. We need to look carefully and dissect Steward's application for RI – what happens when the hospitals do not meet the financial criteria demanded by Cerebus? Will the less fortunate patients receive proper treatment? Will RI Rehabilitation Institute continue patient focused care, which can be very expensive, or will that patient community suffer greatly. Will employees be treated fairly? Or will decisions be made that repeat the termination of Dr. Witman just because he is disabled.

Ironically, stewardship is an ethic that embodies responsible planning and management of resources…I hope you all join me in the questioning whether Steward will live up to its name and establish the priority of health care provision to the RI communities based on need and not exclusively on financial guidance. I urge this committee to protect the citizens of RI from the potential of eroding quality patient care. It is for these reasons that I urge the committee not to recommend Steward the opportunity to purchase both hospitals up for sale.

# Tab 2

**Sixth Supplemental Exhibit 2(b)**

**James T. Lenehan**

James T. Lenehan is a Senior Operations advisor to Cerberus Capital Management, L.P. Prior to Cerberus, he was Vice Chairman and President of Johnson & Johnson. Mr. Lenehan held various executive positions at Johnson & Johnson during his 28-year tenure, including President of McNeil Consumer Products Company and Worldwide Chairman, Consumer Pharmaceuticals & Professional Group. Mr. Lenehan served on the Foundation Board of Abington Hospital in Abington, Pennsylvania. He also was a member of the Quality and Safety Committee of the hospital from 2004 to 2008. Mr. Lenehan earned his B.A. in economics from the University of Akron and his M.B.A. from Northwestern University.

**James J. Karam**

James J. Karam is President and founder of First Bristol Corporation, a developer of retail shopping centers, office buildings and hotels throughout southern New England. As a general partner and co-developer of several major award-winning residential developments, he has been recognized for his contribution to three Massachusetts award-winning historic rehabilitation projects, and in 2007 one of his hotel developments was selected as the "Outstanding Hotel Conversion" in the United States by Hilton Hotels. Mr. Karam is also the co-owner of WSAR and WHTB, radio stations serving the South Coast region of Massachusetts. He has devoted significant time to civic and charitable organizations by acting as the Chairman of the Board of Governors of Caritas Christi until its sale, and is the Chairman of the Board of Trustees for the University of Massachusetts, Co-Chairman of the Southcoast CEO Group, and Southcoast Economic Development partnership. Mr. Karam is an alumnus of the University of Massachusetts at Dartmouth.

**Ruben King-Shaw, Jr.**

Ruben King-Shaw, Jr. is Chairman and Chief Executive Officer of Mansa Equity Partners, Inc. The firm specializes in growth companies in the health care services and health care technology sectors as they prepare for expansion, acquisition, privatization or IPO. Mr. King-Shaw served as Deputy Administrator and Chief Operating Officer of the Centers for Medicare and Medicaid Services from 2001 to 2003. He was also Senior Advisor to the Secretary of the Treasury, where he led the Administration's Health Coverage Tax Credit policies to finance coverage for the uninsured. Prior to joining the George W. Bush Administration, Mr. King-Shaw was the Secretary for the Florida Agency for Health Care Administration. Mr. King-Shaw has served on the University of Massachusetts Board of Trustees since September 2005 and currently serves as Vice Chairman of the Board. In addition, Mr. King-Shaw is a member of the Cornell University Council and Cornell's School of Industrial and Labor Relations Advisory Council. Mr. King-Shaw was awarded his B.S. from Cornell University's School of Industrial and Labor Relations. He earned his Master of International Business at the Center for International Studies in Madrid, Spain, and the Chapman Graduate School of Business in Miami, Florida.

**W. Brett Ingersoll**

W. Brett Ingersoll serves as a Co-Head of Private Equity and is a member of the Investment Committee at Cerberus Capital Management, L.P., a private investment firm with over $24 billion in capital under management. He currently serves as a director of ACE Aviation Holdings, AerCap Holdings NV, IAP Worldwide Services, Talecris Biotherapeutics, EnduraCare Therapy Management, Inc. and EntreCap Financial, LLC. Over the course of his investment career, Mr. Ingersoll has served on the boards of over 25 public and private companies in which he has sponsored investments primarily in North America and Europe. Approximately 10 of those companies have been U.S.-based health care services or product companies, while the remainder have focused their business activities on the transportation, aerospace, specialty finance, consumer products, defense/government services and general industrial sectors. Prior to joining Cerberus in 2002, Mr. Ingersoll was a General Partner at JPMorgan Partners, where he headed the investment firm's Healthcare Services investment practice and served as a member of its Investment Committee. Mr. Ingersoll received his M.B.A. from Harvard Business School and received his B.A. from Brigham Young University.

**Arthur H. Halper**

Arthur H. Halper is a Senior Operations Executive at Cerberus Operations and Advisory Company, LLC, a subsidiary of Cerberus Capital Management, L.P. In this capacity, he is responsible for a range of activities relating to the review, acquisition and board oversight of companies in the Cerberus investment portfolio. Prior to joining Cerberus in 2006, Mr. Halper served as President and Chief Operating Officer and a Director of Active Health Management, Inc., an information-driven health care services company. Previously, Mr. Halper served as President and Chief Executive Officer of Tricordia Health, LLC, a health care services industry venture capital firm. Prior to that, Mr. Halper held a variety of financial and executive management positions, including President, Chief Operating Officer, and Director of Merit Behavioral Care Corporation, an $800 million behavioral health care company. Mr. Halper is a Certified Public Accountant and holds a B.A. in business administration from Rutgers University.

**Lisa Ann Gray, Esq.**

Lisa Ann Gray, Esq. is the General Counsel of Cerberus Operations Advisory Company, LLC and a member of its executive team. In this capacity, Attorney Gray is responsible for matters involving the oversight of companies in the private equity portfolio of Cerberus Capital Management, L.P., a leading global investment firm. With special expertise in legal resource management and business strategy, Attorney Gray helps transform underperforming companies into financially and operationally sound organizations. Attorney Gray has served on numerous non-profit and corporate boards and has particular interest and expertise in the field of health care. Attorney Gray was previously a member of the Ethics Committee of United Hospital (now part of Allina Medical Systems). She also served as Vice Chair of the Amherst H. Wilder Foundation Home Care Advisory Board, a private, non-profit health and human services organization dedicated to promoting the social welfare of the most vulnerable residents in the greater St. Paul area. She holds a B.A. in sociology and education from Hamline University and graduated with honors from William Mitchell College of Law. She has also completed graduate coursework in special education at St. Thomas University.

# Tab 3

| | A | B | C | D |
|---|---|---|---|---|
| 1 | The following Capital Expenditure Schedule ("Expenditure Schedule") represents Steward's current plans to fund projected capital needs over the 2012-2016 time period in connection with the acquisition of LMC and RHRI (the "Proposed Conversion"). The Expenditure Schedule is based on current costs and circumstances, including market conditions, Steward's financial projections as to cost and revenues, demand for services, technology, and applicable state/federal laws and regulations (collectively, referred to as "Base Case Factors"). If there is a material change in the Base Case Factors, Steward reserves the right to amend the Expenditure Schedule to reallocate capital between the line items set forth herein, as well as reallocate portions of the $55,000,000 of projected expenditures listed herein to fund the capital needs of LMC and RHRI following the Proposed Conversion which may arise over the 2012-2016 time period. Capital expenditures for LMC and RHRI shall be subject to applicable regulatory approvals under law. | | | |
| 2 | **Capital Needs** | **Source of Funding for Capital Needs** | **Cost of Satisfying Capital Needs** | **Date of Projected Completion*** |
| 3 | **Blackstone Medical Center** | | | |
| 4 | **Clinical** | | | |
| 5 | Sleep Lab | Owners Equity/Working Capital | $50,000 | 2012 |
| 6 | Pharmacy | Owners Equity/Working Capital | $160,000 | 2012 |
| 7 | Imaging - Radiology | Owners Equity/Working Capital | $84,000 | 2012 |
| 8 | Imaging - Nuc Med | Owners Equity/Working Capital | $250,000 | 2013 |
| 9 | Imaging - MRI | Owners Equity/Working Capital | $1,000,000 | 2014 |
| 10 | Imaging - Cath Lab | Owners Equity/Working Capital | $900,000 | 2013 |
| 11 | Imaging - Caritas PET | Owners Equity/Working Capital | $26,500 | 2012 |
| 12 | Imaging - CT | Owners Equity/Working Capital | $750,000 | 2012 |
| 13 | Respiratory - 10 Ventilators | Owners Equity/Working Capital | $300,000 | 2012 |
| 14 | Imaging - MRI | Owners Equity/Working Capital | $1,250,000 | 2012 |
| 15 | Vascular - 3 GE Vivid 5 | Owners Equity/Working Capital | $750,000 | 2012 |
| 16 | Vascular - Cardiac Stress Testing Sys | Owners Equity/Working Capital | $75,000 | 2012 |
| 17 | General Biomed | Owners Equity/Working Capital | $2,405,000 | 2016 |
| 18 | Pharmacy - Implement Smart Pump Technolog | Owners Equity/Working Capital | $737,000 | 2012 |
| 19 | **Sub-Total Clinical** | | $8,737,500 | |
| 20 | | | | |
| 21 | **Facility** | | | |
| 22 | | | | |
| 23 | General Facility Improvements | Owners Equity/Working Capital | $8,000,000 | 2016 |
| 24 | General Facility Improvements | Owners Equity/Working Capital | $4,000,000 | 2014 |
| 25 | Emergency Department | Owners Equity/Working Capital | $5,000,000 | 2013 |
| 26 | Emergency Department | Owners Equity/Working Capital | $10,000,000 | 2014 |
| 27 | **Sub-Total Facilities** | | $27,000,000 | |
| 28 | | | | |
| 29 | **Information Technology** | | | |
| 30 | | | | |
| 31 | IT Systems | Owners Equity/Working Capital | $10,750,000 | 2016 |
| 32 | ARRA Stimulus Funding | Owners Equity/Working Capital | ($4,032,000) | 2016 |
| 33 | **Sub-Total Information Technology** | | $6,718,000 | |
| 34 | | | | |
| 35 | **BMC Total** | | $42,455,500 | |
| 36 | | | | |
| 37 | **Blackstone Rehabilitation Hospital** | | | |
| 38 | **Clinical** | | | |
| 39 | LTAC - Furniture and Fixtures | Owners Equity/Working Capital | $600,000 | 2012 |
| 40 | **Sub-Total Clinical** | | $600,000 | |
| 41 | | | | |
| 42 | **Facility** | | | |
| 43 | | | | |
| 44 | General Facility Improvements | Owners Equity/Working Capital | $2,600,000 | 2014 |
| 45 | LTAC Renovations | Owners Equity/Working Capital | $2,200,000 | 2012 |
| 46 | **Sub-Total Facilities** | | $4,800,000 | |
| 47 | | | | |
| 48 | **BRH Total** | | $5,400,000 | |
| 49 | | | | |
| 50 | Contigency/Misc. Other Projects | Owners Equity/Working Capital | $7,144,500 | 2016 |
| 51 | | | | |
| 52 | Grand Total | | $55,000,000 | |
| 53 | * Dependant on transaction closing date | | | |
| 54 | Please note that the total capital includes both a working capital annual commitment based on estimated depreciation and a $30M Capital Commitment for new projects. The above excludes the $4.5 Million commitment for physician development. | | | |
| 55 | | | | |

# Tab 4

# STEWARD HEALTH CARE SYSTEM LLC
## MASSACHUSETTS CONDITIONS OF APPROVAL

| Condition | Caritas | Morton | Quincy | Proposed for Landmark/RHRI |
|---|---|---|---|---|
| Assuming pension plan liability for X employees. | ✓ | ✓ | | NA |
| Satisfying debt. | ✓ | ✓ | ✓ | ✓ |
| Committing $X in capital expenditures and Y in 1st yr post-closing. | ✓ | ✓ | ✓ | ✓[1] |
| Committing no less than $X in years 6-10 post closing. | | ✓ | ✓ | NA |
| Not closing hospital, maintaining current levels of charity care, "same scope of services". | ✓ | ✓* | ✓* | ✓[2] |
| Maintain community benefit programs/expenditures | ✓ | ✓* | ✓* | NA |
| No close/reduce 14 elder/geriatric BHS/psych beds | | ✓* | ✓* | NA |
| Continue to accept Medicare/caid, ER patients regardless of ability to pay, continue "culturally & linguistically appropriate" services/care. | ✓ | ✓ | ✓ | ✓ |
| Will not close any Caritas hospital or inpatient psychiatric and detox beds within 5 years. | ✓ | | | NA |
| Maintain "Asian outreach". | | | ✓ | NA |
| Maintain local governing board. | ✓ | ✓ | ✓ | ✓[3] |
| No sell/transfer majority interest for X years post-closing | ✓ | ✓ | ✓ | ✓ |
| Preserve Catholic identity. | ✓ | | | NA |
| Offer comparable employment/preserving jobs of X employees | ✓ | ✓ | ✓ | ✓[4] |
| Recognizing bargaining units under CBA | | | ✓ | ✓[3] |
| Honoring (naming) commitments to past donors. | ✓ | ✓ | ✓ | ✓ |
| Adopting debt collection similar to current debt collection practices. | | ✓ | ✓ | NA |
| Maintain location of HQ and maintain current senior mgt. | ✓ | | | NA |
| Comply with "recommended" debt collection practices | ✓ | | | NA |
| Commit that any charity care / "APA provisions" will continue to any successor in interest. | ✓ | ✓ | ✓ | NA |
| AG has right to enforce Pension Transfer Agreement or other provisions of the APA. | ✓ | ✓ | ✓ | NA |
| Any enforcement brought by AG under APA be brought in MA. | ✓ | ✓ | | NA |
| Ensure endowment/charitable assets are appropriately segregated. | ✓ | ✓ | ✓ | NA |
| Commit itself and successor to any investigation by AG, notwithstanding its for-profit status. | ✓ | ✓ | ✓ | NA[5] |
| Commit and fund a closing payment and five year assessment/monitoring by AG and DPH. | ✓ | | | NA[6] |
| Clarifying that existing assessment and monitoring of Steward by AG and DPH includes the impact of the Transaction on health care costs. | | ✓ | ✓ | NA[7] |
| Agree if Steward fails to meet its minimum cap. exp. under APA during first five years post-closing, Steward shall donate such unspent amounts to a charity. | | ✓ | ✓ | NA[8] |
| Commit $4.5M for physician recruitment in first 5 years post-closing. | | | | ✓ |
| Pay 3.5M for premium for "tail" insurance. | | | | ✓ |
| Provide charity care in compliance with Rhode Island law. | | | | ✓ |
| Accept Medicare and Medicaid patients. | | | | ✓ |

* During "No-Close Period".

| Condition | Caritas | Morton | Quincy | Proposed for Landmark/RHRI |
|---|---|---|---|---|
| Honor naming commitments to past donors. | | | | ✓ |

**Notes:**

1. Commit $30M plus 2.5% annual net patient revenue to capital expenditures in first 5 years post-closing.
2. Will not sell either hospital to any person or legal entity unaffiliated with Steward for 5 years post-closing, provided, however, that Steward Health Care System may participate in any transaction (i.e., merger, consolidation, reorganization, etc.).
3. Composition of Hospitals' Boards will be as follows:
   - Between 7-11 members
     - Includes 3 representatives from Steward serving *ex officio*.
     - 2-3 physicians on hospital medical staff or with ties to service area.
     - Community and healthcare leaders and/or prominent local business executives with an interest in revitalizing hospitals and with ties to the service area.
4. Offer at-will employment to Landmark's non-union employees, except for employees identified by Steward on Schedule 9.1 of the APA. For union employees, employment decisions are subject to the collective bargaining agreement with UNAP.
5. Commitment was specific to Massachusetts transactions.
6. Commitment was specific to Caritas transaction.
7. Commitment was specific to Morton and Quincy transactions.
8. Commitment was specific to Morton and Quincy transactions.

# Tab 5


# ENTERPRISE MANAGEMENT CORPORATION

24 HONEYSUCKLE LANE, MILFORD, CONNECTICUT 06461 USA, TEL (203) 383-0900, HTTP://AQPQ.ORG

April 23, 2012

Ms. Melinda Thomas
Senior Policy Advisor
Health Systems Planning
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908

Dear Ms. Thomas:

In accordance with our discussion, I have prepared this list of noteworthy observations regarding the Consolidated Financial Statements of Steward Health Care System LLC (Steward) for the year ended September 30, 2011. As you know, these statements were audited by the public accounting firm of Ernst & Young LLP, which issued an unqualified audit opinion regarding the information contained therein.

As we discussed, the statements contain a number of "red flags" that raise questions regarding the financial health of Steward. Because we have not been granted access to the financial business plans of the organization, we cannot assess whether (and, if so, how) Steward is prepared to address these questions.

The purpose of this letter is to list the "red flags" and describe why they raise questions regarding Steward's financial health. I have also attached the extracted source material from the financial statements to this correspondence.

1. According to the Consolidated Balance Sheet, as of September 30, 2011, total current liabilities equaled $286.0 million and total current assets equaled $242.4 million. Thus, the organization's working capital shortfall was $43.6 million. In other words, the total amount of liabilities that Steward expected to pay during the twelve month period following September 30, 2011 exceeded (by $43.6 million) the total amount of assets that Steward owned as of that date and could expect to utilize or liquidate to facilitate the payment of those liabilities.

2. According to the Consolidated Balance Sheet, although the total equity value of the organization was positive $123.9 million as of September 30, 2011, that amount consisted of a pair of offsetting amounts: positive $251.5 million in contributed capital and negative $127.6 million in deficits. In other words, the $251.5 million in capital that was contributed by Steward's owners had already been offset by $127.6 million in deficits by September 30, 2011.

3. According to the Consolidated Balance Sheet, $35.2 million of Steward's assets as of September 30, 2011 was categorized as the intangible asset of Goodwill, reflecting payments made by Steward for previous acquisitions that exceeded the value of the net assets that were acquired by the organization. If not for this intangible asset, the negative $127.6 million of deficits of the organization would have been worse (i.e. more negative) by $35.2 million, and the overall positive $123.9 million equity value of the organization would have been worse (i.e. less positive) by $35.2 million.

4. According to the Consolidated Balance Sheet, Steward owed $96.3 million on its revolving credit facility as of September 30, 2011. Although revolving credit facilities are generally designed to cover temporary shortfalls in working capital, Steward actually incurred a working capital shortfall of $43.6 million (see item 1, above) while this $96.3 million liability was outstanding.

5. According to the Consolidated Balance Sheet, Steward's pension plan was underfunded by $263.9 million as of September 30, 2011. According to the 11th Note to the Consolidated Financial Statements, its benefit obligation as of September 30, 2011 was $598.1 million but the fair value of the plan assets was only $334.2 million. In other words, its pension obligation was less than 56% funded.

6. According to the Consolidated Statement of Operations, Steward incurred a Net Loss of $56.9 million during fiscal 2011. Furthermore, according to the Consolidated Statement of Cash Flows, Steward incurred a deficit of Net Cash Used in Operating Activities of negative $32.9 million in fiscal 2011.

7. According to the 13th Note to the Consolidated Financial Statements, Steward has been working to resolve potential Stark Law violations that occurred during the period 2008 - 2010. Although management at Steward has estimated the exposure at the low and high ends of the potential range of liability to be $1 million and $35 million, respectively, only $1 million of loss contingency has been recorded in the financial statements.

Based on this information, I recommend that the Department of Health request answers to the following questions:

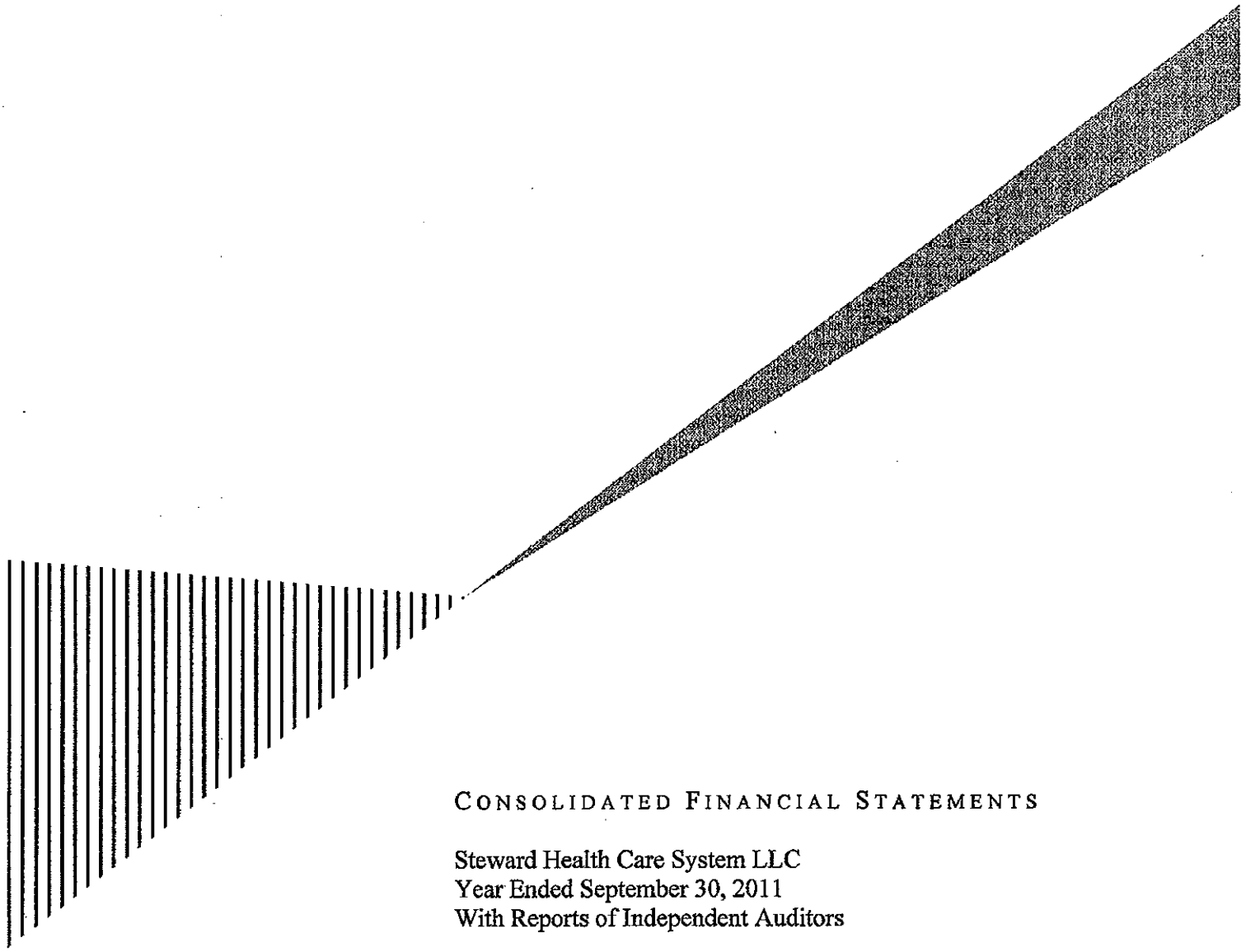
1. Is Steward implementing plans to eliminate its working capital shortfall of $43.6 million?
2. Is Steward implementing plans to eliminate its deficits of $127.6 million?
3. Once the deficits are eliminated, does Steward intend to establish a surplus that exceeds the $35.2 million value of its Goodwill?
4. Is Steward implementing plans to pay down its revolving credit facility of $96.3 million?
5. Is Steward implementing plans to pay down its pension plan liability of $263.9 million?
6. Is Steward implementing plans to eliminate its net loss of $56.9 million and its operating cash flow deficit of $32.9 million?
7. Can Steward absorb a Stark Law violation liability that falls closer to $35 million than $1 million?

I recommend that the Health Systems Planning function of the Department of Health obtain detailed information regarding these plans, and then assess the viability of these plans, before concluding its review of the proposed transaction involving Landmark Medical Center and Affiliates. These seven questions directly address the financial health of Steward Health Care System LLC.

Sincerely,

Michael Kraten

Michael Kraten, PhD, CPA
President



# CONSOLIDATED FINANCIAL STATEMENTS

Steward Health Care System LLC
Year Ended September 30, 2011
With Reports of Independent Auditors

Ernst & Young LLP

ERNST & YOUNG

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Boston, MA 02116
Tel: +1 617 266 2000
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# Report of Independent Auditors

Board of Directors and Member
Steward Health Care System LLC

We have audited the accompanying consolidated balance sheet of Steward Health Care System LLC (Steward or the System) and subsidiaries as of September 30, 2011, and the related consolidated statements of operations, changes in member's equity, and cash flows for the year then ended. These financial statements are the responsibility of the System's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to audit the System's internal control over financial reporting. Our audit included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Steward Health Care System LLC and subsidiaries as of September 30, 2011, and the results of their consolidated operations, changes in member's equity, and cash flows for the year then ended, in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

January 30, 2012



A member firm of Ernst & Young Global Limited

# Steward Health Care System LLC

## Consolidated Balance Sheet

September 30, 2011

*(Amounts in thousands, except for membership interests)*

| | | |
|---|---|---|
| **Assets** | | |
| Cash and cash equivalents | $ | 35,137 |
| Patient accounts receivable, less allowance for uncollectible accounts of $48,444 | | 138,933 |
| Other accounts receivable | | 29,300 |
| Deferred tax assets | | 6,007 |
| Other current assets | | 33,075 |
| Total current assets | | 242,452 |
| Investments of insurance subsidiary | | 54,432 |
| Property and equipment — net | | 470,532 |
| Other assets | | 55,633 |
| Goodwill | | 35,213 |
| Total assets | $ | 858,262 |
| **Liabilities and member's equity** | | |
| Current liabilities: | | |
| Current portion of long-term debt and capital lease obligations | $ | 1,456 |
| Accounts payable and accrued expenses | | 193,646 |
| Accrued compensation and benefits | | 75,448 |
| Estimated settlements with third-party payors | | 8,579 |
| Other current liabilities | | 6,885 |
| Total current liabilities | | 286,014 |
| Long-term debt and capital lease obligations — net of current portion | | 2,004 |
| Revolving credit facility | | 96,331 |
| Estimated settlements with third-party payors — net of current portion | | 9,051 |
| Professional liability costs | | 47,873 |
| Deferred taxes | | 19,725 |
| Pension liabilities | | 263,992 |
| Other liabilities | | 9,418 |
| Total liabilities | | 734,408 |
| Member's equity: | | |
| Common membership interests; 100 interests authorized, issued and outstanding | | – |
| Contributed capital | | 251,516 |
| Accumulated deficit | | (70,487) |
| Accumulated other comprehensive deficit | | (57,175) |
| Total member's equity | | 123,854 |
| Total liabilities and member's equity | $ | 858,262 |

*See accompanying notes.*

# Steward Health Care System LLC

## Consolidated Statement of Operations

Year Ended September 30, 2011
*(Amounts in thousands)*

| | |
|---|---|
| Patient service revenues | $ 1,194,177 |
| Less: provision for bad debts | (52,052) |
| Patient service revenues, net | 1,142,125 |
| Premium revenue | 134,545 |
| Research | 7,299 |
| Other | 43,691 |
| Total revenues | 1,327,660 |
| | |
| Expenses: | |
| Salaries, wages, and fringe benefits | 807,655 |
| Supplies and other expenses | 407,438 |
| Purchased provider services and other expenses related to premium revenue | 61,479 |
| Depreciation and amortization | 64,708 |
| Interest | 1,034 |
| Reorganization expenses | 14,316 |
| Acquisition-related expenses | 25,236 |
| Total expenses | 1,381,866 |
| | |
| Loss before income taxes | (54,206) |
| Income tax expense | 2,706 |
| Net loss | $ (56,912) |

*See accompanying notes.*

# Steward Health Care System LLC

## Consolidated Statement of Changes in Member's Equity

*(Amounts in thousands)*

| | Contributed Capital | Accumulated Deficit | Accumulated Other Comprehensive Deficit | Total Member's Equity |
|---|---|---|---|---|
| Balances, September 30, 2010 | $ – | $ (13,575) | $ – | $ (13,575) |
| Contribution by financial sponsor | 245,931 | – | – | 245,931 |
| Acquired not-for-profit interests | 4,604 | – | – | 4,604 |
| Net loss | – | (56,912) | – | (56,912) |
| Pension liability adjustment, net of tax of $0 | – | – | (57,175) | (57,175) |
| Total comprehensive loss | | | | (114,087) |
| Equity-based compensation expense | 1,200 | – | – | 1,200 |
| Change in not-for-profit interests | (219) | – | – | (219) |
| Balances, September 30, 2011 | $ 251,516 | $ (70,487) | $ (57,175) | $ 123,854 |

*See accompanying notes.*

# Steward Health Care System LLC

## Consolidated Statement of Cash Flows

Year Ended September 30, 2011
*(Amounts in thousands*

| | | |
|---|---|---|
| **Operating activities** | | |
| Net loss | $ | (56,912) |
| Adjustments to reconcile net loss to net cash used in operating activities: | | |
| Depreciation and amortization | | 64,708 |
| Provision for bad debts | | 52,052 |
| Equity-based compensation expense | | 1,200 |
| Other | | (219) |
| (Decrease) increase in cash resulting from a change in: | | |
| Patient accounts receivable | | (81,147) |
| Other current assets | | (24,354) |
| Investments of insurance subsidiary | | (5,371) |
| Accounts payable, accrued expenses and other liabilities | | 13,488 |
| Estimated settlements with third-party payors | | (935) |
| Professional liability costs | | 11,079 |
| Deferred taxes | | 194 |
| Pension liability | | (6,728) |
| Net cash used in operating activities | | (32,945) |
| **Investing activities** | | |
| Purchase of property and equipment | | (141,740) |
| Cash paid for acquisitions, net of cash acquired | | (88,723) |
| Increase in non-current assets | | (42,853) |
| Net cash used in investing activities | | (273,046) |
| **Financing activities** | | |
| Contribution by financial sponsor | | 245,931 |
| Net borrowings under revolving credit facility | | 96,331 |
| Repayments of debt and capital lease obligations | | (1,134) |
| Net cash provided by financing activities | | 341,128 |
| Net increase in cash and cash equivalents | | 35,137 |
| Cash and cash equivalents at beginning of year | | – |
| Cash and cash equivalents at end of year | $ | 35,137 |

Steward Health Care System LLC

Consolidated Statement of Cash Flows (continued)

Year Ended September 30, 2011
*(Amounts in thousands)*

| | |
|---|---|
| **Supplemental disclosure of cash flow information** | |
| Net cash paid for interest | $ 373 |
| Net cash paid for income taxes | $ – |
| **Supplemental schedule of non-cash investing and financing activity** | |
| Purchase of property and equipment financed by capital leases | $ 764 |

*See accompanying notes.*

**11. Employees' Retirement Plans (continued)**

established by the trustees solely to hold the segregated assets. During the transition period, the System is at-risk for any decrease in value of the segregated assets. Also during the transition period, Steward is required to make quarterly payments of $1,625,000 to the RCAB, with the first payment due in April 2011. Upon receipt of the payments, the RCAB is required to deposit the full amount of the payment into the separate trust holding the segregated assets. During the transition period, all benefit payments made to or in respect of participants in the Caritas Plan will be made pursuant to the Plan and paid from the separate trust holding the segregated assets.

Steward has sole discretion to determine the transfer date, provided that the transfer date will be no later than November 6, 2013. As of the transfer date, the segregated assets will be transferred to a trust established by Steward for the benefit of the Steward Pension Plan (yet to be formed) and the Steward Pension Plan will formally assume the Caritas pension obligation.

Steward's obligation to assume the obligations pursuant to the Caritas Plan is unconditional and therefore the System has accounted for this obligation pursuant to the provisions of ASC 715, *Compensation – Retirement Benefits.*

The following table provides a reconciliation of the aggregate benefit obligations, plan assets, and funded status of the Norwood and SGSMC defined benefit plans and the Caritas Plan (collectively, the Plan), and the related amounts that are recognized in the accompanying consolidated balance sheet at September 30, 2011 (in thousands of dollars):

| | |
|---|---|
| Change in benefit obligation: | |
| Benefit obligation at acquisition date | $ (560,821) |
| Interest cost | (24,804) |
| Actuarial loss | (30,318) |
| Benefits paid | 17,794 |
| Benefit obligation at September 30, 2011 | (598,149) |
| | |
| Change in plan assets: | |
| Fair value of Plan assets at acquisition date | 347,276 |
| Actual return on Plan assets | (3,906) |
| Employer contributions | 8,581 |
| Benefits paid from Plan assets | (17,794) |
| Fair value of Plan assets at September 30, 2011 | 334,157 |
| Funded status of the Plan | $ (263,992) |

**13. Contingencies (continued)**

**Workers' Compensation**

Steward is licensed by the Commonwealth of Massachusetts to provide workers' compensation coverage on a self-insured basis. Steward has obtained surety bonds to support its potential obligations for coverage, has purchased excess insurance coverage to limit its exposure in the event of adverse claims experience, and has provided letters of credit in a total amount of $3.1 million to obtain the surety bonds.

**Loss Contingency**

Subsequent to the Caritas acquisition, Steward self-reported certain technical violations of federal law relating to arrangements with certain physicians during the period 2008 – 2010. Steward has been working with the Centers for Medicare and Medicaid Services to resolve these potential Stark Law violations, which may result in a payment to the federal government.

At this time, management cannot predict the amount of its payment obligation, or other terms of a negotiated resolution. The accompanying financial statements at September 30, 2011, include a provision of $1,000,000 related to this matter, representing management's estimate of the low end of the range of the potential settlement amount. Management has estimated the exposure at the high end of the range to be $35,000,000. However, it is not possible at this time to reasonably predict the ultimate amount that may be payable within this range. As of January 30, 2012, no demand for payment has been made by the federal government.

**Asset Retirement Obligation**

Steward maintains a liability primarily related to estimated costs to remove asbestos that is contained within Steward's hospital facilities. The liability, reported in other non-current liabilities in the accompanying consolidated balance sheet, was $8.6 million as of September 30, 2011. Accretion expense was $0.4 million for the year ended September 30, 2011.