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VIA ELECTRONIC MAIL

22 May 2012

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Dear Dr. de la Torre and Mr. Savage:

Please find attached Decision regarding the Hospital Conversion Applications of the following Transacting Parties: Steward Health Care System, LLC, Steward Medical Holdings, LLC, Blackstone Medical Center, Inc., Blackstone Rehabilitation Hospital, Inc., and Jonathan N. Savage, Esq, in his capacity as the court-appointed Special Master for Landmark Health Systems, Inc., Landmark Medical Center, and Northern Rhode Island Rehab Management Associates, L.P. d/b/a Rehabilitation Hospital of Rhode Island.

Please be advised that pursuant to 23-17.14-34 of the Rhode Island General Laws "*any transacting party aggrieved by a final order of the department of health under this chapter may seek judicial review in the superior court in accordance with § 42-35-15.*"

Sincerely,

Michael Fine, MD
Director of Health

Attachment

Rhode Island Department of Health

DECISION

Regarding Hospital Conversion Applications of Steward Health Care System, LLC, Steward Medical Holdings, LLC, Blackstone Medical Center, Inc., Blackstone Rehabilitation Hospital, Inc. and Jonathan N. Savage, Esq., in his capacity as the court-appointed Special Master for Landmark Health Systems, Inc., Landmark Medical Center and Northern Rhode Island Rehab Management Associates, L.P. d/b/a Rehabilitation Hospital of Rhode Island.

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I. Introduction and Background

The first step in traversing the Hospital Conversions Act is the filing of an initial application with the Department of Attorney General ("RIAG") and Department of Health (the "Department"). The Transacting Parties filed their initial application ("Initial Application") on October 14, 2011. The Transacting Parties to the Initial Application are identified below:

- **Landmark Medical Center** ("LMC") is a Rhode Island non-profit corporation that operates a 214 licensed bed acute care hospital located in Woonsocket, Rhode Island.

- **Northern Rhode Island Rehab Management Associates, L.P., doing business as Rehabilitation Hospital of Rhode Island** ("RHRI") is a Delaware limited partnership operating a rehabilitation hospital located in North Smithfield, Rhode Island.

- **Landmark Health Systems, Inc.** is a Rhode Island non-profit corporation and the parent of Landmark Medical Center and Rehabilitation Hospital of Rhode Island.

- **Steward Health Care System, LLC** ("Steward") is a Delaware for-profit limited liability company operating 10 hospitals in the Commonwealth of Massachusetts and various other affiliated entities.

- **Steward Medical Holdings, LLC** is a Delaware for-profit limited liability company and a subsidiary of Steward holding certain Steward hospitals.

- **Blackstone Medical Center, Inc.** ("BMC") is a Delaware for-profit corporation and a subsidiary of Steward Medical Holdings that was formed to purchase the assets of Landmark Medical Center.

- **Blackstone Rehabilitation Hospital, Inc.** ("BRH") is a Delaware for-profit corporation and a subsidiary of Steward Medical Holdings that was formed to purchase the assets of Rehabilitation Hospital of Rhode Island.

In its simplest form, the structure of the transactions proposed in the Initial Application (the "Proposed Transaction") is a sale of the assets of LMC and RHRI, respectively, to Blackstone Medical Center and Blackstone Rehabilitation Hospital.

Procedural History

The plight of LMC and the RHRI dates back to at least 2008 when it became apparent that, due to the financial situation at the hospitals, it was necessary to search for a strategic partner in order to continue operations. According to interviews conducted by the Department and RIAG, as well as the review of the documents submitted in the Initial Application, a strategic partner was not located in a timeframe that could guarantee the continued viability of LMC, and therefore, the Board of Directors of LMC voted to place the hospital in Special Mastership. Accordingly, on June 25, 2008, the petition of then Chief Executive Officer of LMC, Gary Gaube, was filed with the Superior Court for the County of Providence for appointment of a Special Master to

oversee the operation of LMC[1]. Shortly thereafter similar petitions were brought and granted with regard to LHS and the RHRI[2]. The Court appointed attorney Jonathan Savage to act as Special Master for the three entities.

Special Mastership is a form of receivership whereby the Court appoints an individual to, in essence, take over a business and operate it. A matter is designated as a special mastership as opposed to a receivership based upon the role that the public interest plays in the proceeding[3]. While the role of a receiver in a typical business receivership is to preserve assets for the ultimate benefit of creditors, the role of a Special Master has as its ultimate concern the public interest.

With the Court's supervision, the Special Master became the sole governing authority for LMC, LHS and RHRI[4] (collectively, "Landmark"). Therefore, once the mastership was initiated, any then-existing governing body at Landmark was disbanded and the search for a strategic partner began[5]. There were several interested entities throughout 2008 through 2010. On August 27, 2010, as a result of negotiations, an Asset Purchase Agreement ("APA") was signed with CCHC Healthcare, Inc., a Rhode Island affiliate of Caritas Christi, a Catholic-affiliated organization operating six (6) community hospitals in Massachusetts[6]. For reasons that are not entirely certain, Caritas Christi walked away from the Landmark deal in late 2010. During this same timeframe, the assets of Caritas Christi were purchased by Steward effective November 2010. As a result, the Caritas Christi hospitals became the first hospital assets of Steward[7].

After the split with Caritas Christi, the Special Master began the work of seeking other bidders for Landmark. This was done using a formal bidding process through the Court. Because of the numerous conditions in the Caritas Christi APA and the resulting difficulties of dealing with

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[1] Gaube v. Landmark Medical Center P.M. No.: 08-437 ("Landmark Special Mastership").

[2] Gaube v. Landmark Health Systems C.A. No.: 08-5893 ("LHS Special Mastership") and Charest v. Northern Rhode Island Rehab Management Associates, Limited Partnership PB No.: 08-7186 ("RHRI Special Mastership").

[3] See, Landmark Special Mastership Transcript at pg. 18 (May 17, 2010) where Justice Michael A. Silverstein refers to receivership cases involving health care facilities as "tinged with the public interest and the public health."

[4] Certain jurisdictions allow a receiver to act as the governing body of the business. The Court in this matter has proceeded upon such a precedent. *See,* 65 Am. Jur. 2d Receivers § 89:

> "[A]uthority holds that the appointment of a receiver suspends the authority of the corporation and of its directors and officers over its property and effects and over its functions because that authority passes to the receiver. In this respect, a receivership is equivalent to an injunction to restrain the officers and agents of the corporations from intermeddling with the property of the corporation in any way. The appointment operates to suspend the incidental powers of the board of directors necessary to carry on the corporate business. The authority of the receiver, as executive in control, is subject to the court alone."

[5] Because the Special Masterships have been in effect for nearly four years at the time of this Decision, this overview is merely a summary of relevant events to this Decision. Numerous related events transpired during this time and the Department of Attorney General has participated, as appropriate, in the Special Masterships throughout.

[6] This Asset Purchase Agreement was signed only by CCHC Healthcare, Inc. and was not placed before the Court for approval.

[7] The Caritas Christi hospitals consist of: Carney Hospital, Norwood Hospital, Good Samaritan Medical Center, Holy Family Hospital, St. Anne's Hospital and St. Elizabeth's Medical Center.

those conditions, a deal was sought with no conditions, other than regulatory approval, to avoid a bidder being chosen that could not close due to contingent issues.

Several bidders presented themselves as interested in purchasing Landmark's assets[8]. On April 14 and 15, 2011, detailed bid hearings were held to review the bids. The Court heard testimony from all bidders and their representatives were subject to cross-examination. As a result of the bid hearings, the Court gave the bidders additional time to "satisfy any and all of their respective contingencies to closing other than court and regulatory approval." *See,* Landmark Special Mastership Order at Para. 1 (April 29, 2011). An additional hearing was held on May 10, 2011. At that hearing, it was evident that all bidders had outstanding issues that the Court would like resolved before rendering a decision choosing a bidder.

During the time the bid hearing process was pending, it was disclosed that Caritas Christi, now Steward, was possibly interested in coming back into the deal and that the Special Master had been in discussions with them to return to the table. Because the bid hearings were still pending and because Steward did not participate in the formal bid hearing, the Court instructed the Special Master not to conduct any further negotiation with Steward, but to continue to concentrate on the pending bids. *See,* Id., at Para. 5. Surprisingly, after the bid hearings, but before the decision, one by one, each bidder withdrew its bid leaving no bidder for Landmark.

Days later, on May 27th, 2011 a Petition was filed to approve an APA for the purchase of Landmark by Steward. It was represented to the Court at that time that Steward has utilized former bidder Regional Healthcare's APA as its template. *See*, Landmark Special Master Transcript at pg. 3, line 5-13 (May 31, 2011). Because the Steward APA was based upon the Regional Healthcare APA, it did not have the numerous conditions of its previous deal through Caritas Christi and was not subject to the any of the contingencies that were seemingly fatal to the other bidders.[9] The Court approved the Steward APA on May 31st, 2011, finding Steward's bid the most promising and authorized the Special Master to execute the APA.

Once the APA was signed, the next step in the process was the filing of an Initial Application pursuant to the Hospital Conversions Act. The Initial Application includes information necessary to address the statutory review criteria of the Department and RIAG, as well as other information relevant to a hospital conversion in general. The information requested represents the minimum amount of information required. Because each hospital conversion transaction is unique, additional follow-up requests are made in response to information included in the Initial Application or information generated during the investigation. Although the importance of a speedy review and decision by the Department and RIAG was repeatedly emphasized throughout this process by the Special Master and Steward, the Initial Application was not filed until October 14, 2011, nearly 4 ½ months after the APA was filed with the Court. On November 10, 2011, the Department and RIAG deemed the Initial Application incomplete as several required items were not included resulting in follow-up questions on 51 out of the 73 questions on the application. After a second attempt filed by the Transacting Parties, the Initial Application was again deemed incomplete on December 22, 2011, but this time with only a handful of issues.

[8] One bidder, HealthSouth was only interested in purchase of the assets of Rehabilitation Hospital of Rhode Island.
[9] For example, Regional Healthcare did not have a Collective Bargaining Agreement with the Union; Steward did not have such issue.

Finally, the Transacting Parties provided the requested information and the Initial Application was deemed complete on January 17, 2012 and the review process began. Several follow-up questions were sent to the Transacting Parties who responded in writing as supplements to the Initial Application. During the pendency of the review, four (4) sets of supplemental questions were sent and responded to by the Transacting Parties.

The APA that was approved by the Court had a provision that allowed termination by Steward if a closing on the Transaction was not completed by December 31, 2011. Because it was clear since the hospital conversions application was not filed until October and was not accepted for review until after December 31st, the APA was amended until shortly after such date. During the pendency of the review, in late 2011, the Department and RIAG were informed that Steward would agree to extend the APA for a longer period of time only upon several additional conditions to the Proposed Transaction. Both Departments were informed numerous times throughout by the Special Master and Steward's representatives in Rhode Island that Steward might walk away from the deal for a variety of reasons, including if these new conditions were not met. After numerous short extensions of the APA and much banter about the conditions, an Emergency Petition for Instructions was filed on March 2, 2012 requesting an Amendment to the APA to add the following conditions to the deal:

- The addition in the term of a "Material Adverse Effect" of the following: (i) "the Buyer is prohibited by law from acquiring additional not for profit hospitals within the same calendar year of the Closing" and (ii) "that changes in law or regulations impose additional burdens or obligations or requirements applicable to operations of for profit hospitals in the state."

- An additional provision regarding Thundermist Health Center: "Buyer shall have entered into a mutually acceptable Memorandum of Understanding with Thundermist Health Center, in a form which is acceptable to Buyer in its sole discretion, which provides for (a) the alignment of Buyer and Thundermist Health Center concerning the areas of primary care, specialty care, laboratory services and diagnostic imaging and (b) an understanding concerning a future relationship between the parties in the area of OB/GYN."

- An additional provision regarding the Cancer Center: "Buyer shall have entered into a definitive agreement with Radiation Therapy Services, Inc. (the entity which holds a 62% membership interest in the Cancer Center) in a form which is acceptable to Buyer in its sole discretion, which definitive agreement sets forth (a) the terms upon which Buyer or an Affiliate thereof would acquire Radiation Therapy Services, Inc.'s membership interest in the Cancer Center, including (i) that the purchase price for such membership interest shall be determined in a manner consistent with current industry valuation methodologies and practice and (ii) timing for the closing of such transaction which takes into account applicable Department of Health certificate of need or other approval requirements and (b) the manner in which all outstanding arrangements between Landmark Medical Center, the Cancer Center and/or Radiation Therapy Services, Inc. would be restructured."

- A change from the original language regarding reductions in force from no additional reductions in force to the following:

  (c) in addition to the implementation on or prior to the Closing Date of any reduction in force as contemplated by the Advisory Agreement, Buyer shall not be restricted or otherwise limited in any way from (i) implementing any further reductions in force of the Transferred Employees at either the Hospital or the Rehab Facility after the Closing Date or (iii) making employment decisions with respect to the transferred Employees after the Closing Date as determined in Buyers' sole discretion.

- Section 10.3 in the original Asset Purchase Agreement regarding Maintenance of Services was deleted. It read as follows:

  Maintenance of Services. From the Closing Date until the date which is two (2) years after the Closing Date, Buyer agrees not to discontinue any clinical service being provided by the Hospital or the Rehab Facility as of the date of this Agreement (so long as such Clinical service is still being provided by the Hospital or the Rehab Facility, as applicable, immediately prior to the Closing Date).

II. The Department's Standards and Process for Review Under the Act

While the Act requires the Department's consideration of certain statutory criteria set forth below, it also contemplates that the Director may consider matters related to the viability of a safe, accessible and affordable health care system that is available to all the citizens of the State and matters otherwise related to protecting the public health and welfare.

The Department's additional statutory criteria include:

1. Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed Transacting Parties are satisfactory;
2. Whether sufficient safeguards are included to assure the affected community continued access to affordable care;
3. Whether the Transacting Parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;
4. Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;
5. Whether the Transacting Parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce;
6. Whether the Transacting Parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring;

7. Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state; and
8. Whether the acquiror has demonstrated that it has satisfactorily met the terms and conditions of approval from any previous conversion pursuant to an application submitted under § 23-17.14-6.
9. In addition, under the Rules and Regulations Pertaining to Hospital Conversions (R23-17.14-HCA), Section 4.2(i), the Director shall also consider issues of market issues, including market share, especially as they affect quality, access, and affordability of services.

Other State Regulatory Processes

Health Services Council ("Council") Review under the Health Care Facility Licensing Act of Rhode Island

On March 13 2012, in accordance with the requirements of RIGL 23-17, applications submitted by Steward for changes in effective control of LMC, and RHRI were deemed complete for processing before the Council. The Council reviewed these applications at eight consecutive weekly meetings attended by the Transacting Parties and their legal counsel held between March 20, 2012 and May 8, 2012. At the meeting of May 8, 2012, the Council recommended that the Applications be approved subject to conditions. The written report of the Council, including all findings and recommendations, was transmitted to the Director of Health. The entirety of the record of the Council review, including but not limited to applications, written information provided by the applicant, representations made by the applicant both in writing and verbally before the Council, public comments, third party advisories and recordings of meetings of the Council and the Council's written report to the Director, including its findings and recommended conditions of approval are hereby incorporated within the record of the Department's review under the Act.

RIAG Review Under the Hospital Conversion Act

As previously indicated, the Act requires both the Department and RIAG to review and approve a hospital conversion application. The review criteria for each Department are separately set forth in the Act and each Department independently and separately issues its decision pursuant to the Act.

Application and Other Documents Supplied by Transacting Parties

The Transacting Parties submitted documents in response to an application form that gathers information for the review by the Department and the RIAG. The application form consists of 73 questions and requests for information (42 required by the Act) and 4 required appendices, including, but not limited to: requests for a detailed description of each of the Transacting Parties and their affiliates; the proposed governance and organization of the hospitals; consultant reports concerning the affiliation, including due diligence reports; agreements, contracts, and conflict of interest policies and statements related to the proposed affiliation; plans for use of charitable

assets and restricted funds; licensure status and related performance reviews of the Transacting Parties; recent or pending citations or lawsuits; description of the type, amount, and location of services provided by the Transacting Parties and the population currently served; proposed changes to the type, amount or location of services, and population served, including services to be eliminated, reduced, expanded, or consolidated; staffing plans; information on current and planned quality and performance improvement initiatives and related measurements, including patient satisfaction, quality of care, and health outcomes; plans for electronic medical records and health information interfaces; a description of efficiencies planned as a result of the consolidation; past financial information for each Transacting Party and future financial projections under the proposed affiliation; impact of the proposed affiliation on the hospital's market share and on the cost of health care; history of and proposed provision of charity care and community benefits; and the impact of the proposed affiliation on access to care, including primary care.

Public Process and Public Record

Particularly important to the Department was seeking and obtaining input from the communities and populations affected by the proposal. In pursuit of this objective, the Department attempted to make the process as open and transparent as possible and to provide the public with as much information about the proposed affiliation as possible.

The Act contemplates that the Department and RIAG maintain both a public and a confidential record to support the Department's decision on the conversion Application. On February 28, 2012 the RIAG made its determination, as required by the Act, as to what portions of the Application were confidential and/or proprietary. Upon this determination, the Department posted the entire public portion of the Application on the Department's website in order to provide public access to the non-confidential portions of the Application.

The Department is required under statute to hold an informational public meeting. The Department and RIAG agreed to jointly hold two public informational meetings to provide opportunity for public comment on the Application. A notice of these public informational meetings appeared in *The Providence Journal* on February 28, 2012. The two meetings were held on April 9, from 2:00PM to 4:00 PM and again from 6:00PM to 8:00PM, at the Woonsocket City Hall. The Department and RIAG jointly moderated each of these meetings. At each of these meetings, the Transacting Parties were provided an opportunity to present a summary of the key points of the proposed affiliation for the attendees. The public was invited to participate and provide comment at the conclusion of the presentation. Fifty-two individuals spoke at the meeting. Fifty-one of the 52 speakers spoke in support of the proposal and one speaker spoke in opposition to the proposal.

Other Public Comment

In addition to providing opportunities for comment at the public meetings, the Department and RIAG established a written public comment period, where the public and interested parties were invited to submit written comments until April 16, 2012. This opportunity to provide comment

was advertised in *The Providence Journal*. The Department received and considered a number of written public comments.

Investigations and Other Testimony

The Department and RIAG conducted a number of joint investigatory meetings in order to obtain information to inform the Department's review and decision. Investigatory meetings were held with representatives of the Transacting Parties, United Nurses and Allied Professionals and Thundermist Health Center. In addition, the Department requested additional written information from the Transacting Parties to assist the Department in its review.

Use of Experts / Recognition of Reports, Studies and Other Publications

The Department engaged Enterprise Management Corporation to provide expertise to assist in the Department's review. The Department asked this firm to conduct a financial analysis of the proposal, with a focus on financial viability of Steward.

III. Historical Perspectives and Policy Considerations

Statement on Powers and Purposes

The Department of Health is rendering this decision not only under the specific authority granted by The Hospital Conversions Act ("the Act") RIGL 23-17.14, but also under the general authority granted in RIGL 23-1 which establishes the functions of the Department, and in accordance with all the applicable purposes established by the General Assembly under Title 23 RIGL.

Under the delineation of its general functions, it is declared, *inter alia*, that the "[t]he department shall take cognizance of the interests of life and health among the peoples of the state; shall make investigations into…the sources of mortality, the effect of localities, employments and all other conditions and circumstances on the public health, and do all in its power to ascertain the causes and the best means for the prevention and control of diseases or conditions detrimental to the public health, and adopt proper and expedient measures to prevent and control diseases and conditions detrimental to the public health in the state." RIGL 23-1-1

"Conditions detrimental to the public health" are affected not only by the traditional areas of public health concern such as drinking water and food safety; prevention of communicable diseases; and the safeguarding of professional practice standards. Public health is also affected by the impact of health services on the health of Rhode Islanders, and, perhaps even more significantly, by the impact of social programs and policies on the health of individuals and the measured health of the population. The Department's understanding of public health increasingly appreciates the importance of these social factors which include, but are not limited to, local and state economic conditions, education, employment, housing and the environment.

This review takes administrative notice of the totality of the circumstances known to presently exist, including those "other conditions and circumstances" within which the application for conversion resides.

The legislature's charge to the Department under the Act is itself a clear example of this principle, and one which should guide this and all future determinations rendered under its authority.

The Act directs the Department to specific criteria for consideration, while reserving for the Department broad discretion in assigning relative weight to those criteria on a case by case basis. The Act focuses on preserving the safety net for hospital and other health care services, on protecting collective bargaining agreements, and on providing for the retraining of hospital workers impacted by hospital conversions. The Act does not direct consideration of local economic impact, of the economic competitiveness or directly, of statewide organization of health care services (except insofar as it asks for consideration of the impact of a specific conversion on a "balanced" health care system) or of the statewide cost of health care.

The Departments notes that the Act was enacted in response to perceived threats to the non-profit hospitals' mission to serve as community assets and provide a safety net of acute care. It was not designed to confront the complex challenges facing regulators in a period of both hospital over capacity and over utilization. The Department and the public it serves await the means necessary to effectively guide the transformation of the health care system into the population based, patient-centered, vertically integrated approach to care essential to affording all Rhode Islanders better health, better health care outcomes and affordability, and better lives.

Historical Context: the Evolving Role of Hospitals in the Health Care Market

In applying the law it is noted that the Act was adopted in 1997, and that while the legislative purposes enumerated in the statue continue to guide the decision-making process, those goals must be applied in a context of significantly changed conditions compared to those of 15 years ago. The Department is aware of material changes over this time period to health care systems both not-for-profit and for-profit; to health care cost drivers and outcomes; and to Rhode Island's and Woonsocket's economic prospects as reflected in both employment opportunities and in public sector fiscal health.

In 1997 the phenomenon of for-profit hospitals was relatively new. Rhode Island's was a not-for-profit hospital system comprised entirely of institutions founded as charities that had been successfully developed and maintained through the ongoing contributions of endowment earnings, new donors, volunteers and taxpayers. While that is still more than nominally the case, the distinctions in character and functions between for-profit and not-for-profit hospitals are no longer so obvious.

Today, non-profit hospitals are more likely to pay management large salaries once typical only of the for-profit sector, and to allow many multiples of salary levels between their lowest and highest paid employees, again reflecting private sector practice. Many non-profit hospitals compete aggressively for market share in service lines, also a private sector market driven

strategy. Few non-profit hospitals focus as they once did on the health of the population of their service area by devoting themselves to the care of the indigent and the underserved with the charitable zeal that once characterized non-profit hospitals' charitable mission. To be fair, all non-profit Rhode Island hospitals do care for the indigent without regard to ability to pay, providing needed emergent and life saving care without discrimination. But in an increasingly competitive, profit-driven market, it is harder to maintain this mission and achieve the benefit of improved population-based outcomes.

Additionally, the responsibility of providing all needed health services to a population has shifted. What was once recognized as a hospital responsibility has become a collaborative one, with many other services providers -- community health centers and other primary care practices, home health agencies, mental health agencies, and many others -- each having significant roles, roles which have been and will be increasing coordinated by state agencies.

Perhaps even more significant are the effects these changes in hospital mission are having on our wider care delivery systems. Fifteen years ago, our health care system was built around hospitals which provided lifesaving emergent care to the acutely ill, specialty care to the indigent through specialty clinics, and primary care through house staff-run clinics supervised by volunteer attending physicians. This type of voluntary physician participation was part of a social contract that exchanged service time for hospital admitting privileges. Admitting privileges themselves were essential for physicians to be able to build a practice and even to be credentialed by insurance companies, and our non-profit hospitals organized that voluntary participation, providing a locus and a direction to that charitable work. Further, hospitals served as organizational and institutional homes for Rhode Island's physicians, whose intuitional affiliation and loyalty was central to their practices, and even, to some degree, to their professional and sometimes personal identities.

In 1997, for-profit hospitals and hospital conglomerates, on the other hand, used market mechanisms to extract profit from a delicately balanced, safety net focused health care market, and threatened to collapse that safety net by their behavior. In 1997, for-profit hospitals cherry-picked more profitable procedures and populations, exploiting profitable service lines that had been designed to cross subsidize unprofitable lines of business maintained by safety net institutions, or designed to encourage the non- profits to move into the provision of new kinds or levels of care, to care for new populations, or to treat diseases and conditions not previously addressed, while continuing their safety net function. Some for-profit hospitals refused to open or maintain emergency rooms, for fear of attracting the indigent and being obligated to care for the excluded or underserved; other for-profits turned the indigent away, refusing them lifesaving treatment, so that profit margins could be preserved. ["Transfers To A Public Hospital," The New England Journal Of Medicine, Robert L. Schiff, M.D., et. al., Feb. 27, 1986.]

Unlike today, in 1997, the culture, tradition and ethos of providing health care was more motivated and more informed by non-profit values. For example, Rhode Island still had a not-for-profit health maintenance organization ("HMO"), the Rhode Island Group Health Association (RIGHA), built by a partnership between organized labor and the medical profession, which made primary care and specialized care available to thousands of employed Rhode Islanders, while institutionalizing the focus and goal of that care on health maintenance,

without emphasis on profit-taking. In the 1990's RIGHA merged with Harvard Community Health Plan, a Massachusetts non-profit staff model HMO.

Now, after half a generation of market driven systemic change, the differences between for-profit and not-for-profit hospitals that existed when the Hospital Conversions Act was adopted -- in terms of costs per patient per procedure; outcome quality measurements; and executive compensation -- to a large degree no longer apply.

In addition, there have been changes in the behavior of for-profit hospitals and for-profit hospital corporations. For-profit conglomerates that might then have been seen as threatening to extract and export wealth out of Rhode Island economy can sometimes be viewed as capital infusers; what were viewed as potential monopolies can now also be seen as potential community health care integrators; and what were then seen only as expropriators of community assets, are now looked at as potential community tax payers.

More than our hospitals and hospital systems have evolved. In 1997, our concept of health care had less scope and depth. Primary care had not yet been recognized as having the impact we now know it does on population-based health outcomes and global costs. Our notions of community care, charity care and traditionally underserved communities are changing with demographic changes in our communities themselves.

As the Rhode Island Department of Labor and Training report "State of the State, A Statistical Profile of Rhode Island's Cities and Towns" (December 2011) notes: "During the past fifteen years, Rhode Island and its people have experienced significant social and economic change." Cognizance of this type of change informs this decision, as future changes should inform future decisions under the Act.

Compared to 15 years ago, the state of Rhode Island is more Hispanic, elderly, and unemployed and underemployed. As global health care costs have steadily risen above the monetary inflation rate while real-dollar wages have stagnated, health insurance has become less and less affordable for more individuals and employers. Consequently, barriers to access based on un-insurance and underinsurance have grown, challenging the charity care capacity of hospitals, and further changing the profile of traditionally underserved communities.

At the same time, primary care practices and community health centers, supported by community based free standing specialty groups and services, have assumed new and significant roles in the provision of all health care services, and reduced, to a certain degree, the public role of hospitals, so that hospitals are now safety net providers of urgent, emergent and lifesaving care to all Rhode Islanders, while primary care practices and community health centers have shown themselves to be critical collaborators in the care of the underserved and as protectors of the public's health.

In addition, the economic impact of hospital care has changed. In 1997, hospitals were major employers, anchoring the economic health of communities. In 2012, while still critical economic engines for communities, hospitals represent the largest single cost center of the health care system, producing costs that may be driven by over-utilization of hospital emergency rooms and

many other hospital services. The challenge for Rhode Island, then, is to preserve the positive economic impact of Rhode Island's hospitals on Rhode Island jobs and Rhode Island communities, while streamlining hospital costs and shrinking per person hospital utilization. Fewer, not more, hospital services need to be provided per person if there is to be an affordable health care for all of Rhode Islanders. At the same time, Rhode Island hospitals need to be more attractive to people from surrounding states, so that any increase in hospital utilization comes from those states, thereby protecting and growing Rhode Island jobs. The challenge is to make Rhode Island hospitals more efficient, so that health care costs are reduced for Rhode Islanders, while incentivize the hospitals to better compete in an increasingly competitive regional market.

Impact of Hospitals on the Public's Health

Regarding this application, the Department considered the potential impact of approval (and acquisition) on the one hand, or denial (and the possibility, if not probability, of closure) on the other in light of its duty to "take cognizance of the interests of life and health among the peoples of the state." [RIGL 23-1-1] In the consideration of the evidence on the record, and in the study of the health policy literature, a paucity of evidence was noted regarding the effect, if any, of the number and location of hospital services on the measured health of the population. Literature describes the possibility of health status improvements from hospital care, as well as adverse population health outcomes (from over-treatment, physician-induced injury, hospital acquired infections, and local adverse environmental impacts). ["Overtreated: Why Too Much Medicine is Making Us Sicker", Shannon Brownlee, Bloomsbury USA, 2007 and "Crossing the Quality Chasm: A New Health System for the 21st Century", Institute of Medicine, National Academy Press, 2001].

There exists a body of research on regional variations of care that suggests the public health is not influenced by hospital services in a linear way. ["Health Care Spending, Quality, and Outcomes," A Dartmouth Atlas Project Topic Brief, Elliot Fisher, MD, MPH, et. al., February 27, 2009].

The literature does suggest that there are no good or clear correlations between the number and location of hospital services and population health outcomes and health care costs, which appear to be influenced by local medical culture, by the incidence and prevalence of disease in a local population, and by local environmental exposures and other social factors.

The ability to quantify the minimal level of hospital services required to produce best health outcomes is limited. Therefore, and in accordance with the precautionary purpose of the HCA in RIGL section 23-17.14-3 (1) "to assure the viability of a safe, accessible and affordable healthcare system that is available to all of the citizens of the state", the Department adopts an especially cautious approach when considering the potential public health impact of this particular application.

Impact of Hospitals on the Local and State Economy

Statewide, the importance of the hospital sector of Rhode Island's economy is indisputable. According to the Hospital Association of Rhode Island's report, "The Economic Impact of

Hospitals in Rhode Island," "[i]n 2010, the estimated total annual economic impact was $6.3 billion." During a period of deep recession, the impact of hospital (and health care) employment in Rhode Island is especially important in stabilizing communities. In 2010, "[w]ithin the private sector, Health Care & Social Assistance (78,217) employed the most workers, accounting for 20.2 percent of the private sector employment," Rhode Island Department of Labor and Training, "Rhode Island Employment Trends and Workforce Issues 2011." In a period with high unemployment and overall employment decreases, Health Care & Social Assistance recorded 1,305 added jobs, the largest gains of any employment sector.

Looking toward the future, and to which sectors of the Rhode Island economy new jobs are projected to come, for the 2008 – 2018 period, "the largest gains occurred in Health Care & Social Assistance (13,325) and Professional, Scientific & Technical Services (6,332). Within the Health Care & Social Assistance Sector, Ambulatory Health Care Services (4,358), Hospitals (3,113), Social Assistance Services (2,978) and Nursing & Residential Care Facilities (2,876) are all growing at more than twice the statewide rate projected for the 2008 – 2018 period. This sector is expected to account for one third of all new job growth in the state." Rhode Island Department of Labor and Training, "2018 Opportunities."

But while health care is expected to remain one of the more robust areas of our economy, it should be recognized that improvements in our health care delivery systems and practice architecture will lead to fewer traditional jobs within our hospitals themselves. Undue concern about the loss of hospital beds *per se*, especially in a period of overcapacity, is misguided. Rather, we look to improvements in population based health and to more efficient and effective health care delivery as essential to improving the economic wellbeing of our state and its people.

The Department does not accede to the supposition that the conversion review process is ever a binary matter of "conversion or closure." To do so would acquiesce in a *de facto* takeover of the public's review of conversion applications. The Department's charge and responsibility in reviewing proposed conversions is neither to keep open nor to close hospitals, but is rather to consider whether the "*public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.*" [RIGL 23-17.8-8 (7)]. Just as the prospect of exploitive expropriation of community assets was of great concern in 1997, so too must the Department now guard against the tacit expropriation of a regulatory review process performed in the public interest.

The viability of a bankrupt acquiree is a patent factor to consider, and the impacts to the affected community of hospital closure -- job and income loss, increased needs for social services including uncompensated care amongst Rhode Island's other hospitals; and the potential further fiscal strains on local and state government -- are carefully considered in the Department's review. As declared in RIGL section 23-17.14-2 (6) "*There are hospitals in Rhode Island that have provided and continue to provide important services to communities that submit that their survival may depend on the ability to enter into agreements that result in the investment of private capital and their conversion to for-profit status.*"

The value of social capital as being a major contributing factor in population based health is widely recognized. The devaluing of that asset can be expected to result after the closure of a hospital geographically situated as is LMC. In such a case, the loss of the precondition of economic well being that supports the network of interpersonal relations and social networks -- essential components of a healthy community -- can reasonably be expected to itself present serious threat to "the interests of life and health among the peoples of the state." [RIGL 23-1-1]

IV. Discussion and Findings Relative to Statutory and Regulatory Review Criteria

The Department reviewed and considered the totality of the record, including: the completed hospital conversion applications; all written information received from the Transacting Parties; information received by the Department as part of the applications for Change in Effective Control (CEC); public comment provided in writing or within the context of the two public informational meetings; other information gathered by the Department; and other publicly available information and reports.

Review Criterion 1: Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed Transacting Parties are satisfactory.

Steward Governance

Steward Health Care System, LLC is a controlled affiliate of Cerberus Capital Management, L.P. ("Cerberus"), a private investment firm. The Management Board of Steward (Board) is made of seven members, four of whom are representatives of Cerberus (see Table 1). Cerberus' representatives presently control a majority of the Board. 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 and that all members 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 hospital's 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 the members of the Board who are responsible for populating the Board and that if there is a vacancy on the Board, the rest of the members of the Board will vote to fill the vacancy. Steward stated that Cerberus, the sole member of Steward, has no role in selecting the Board.

Proposed Board Structure of New Hospitals

The Boards of BMC and BRH are proposed to be made up of seven to eleven members, three of whom are from Steward (see Table 1), two to three are 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.

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

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

Steward represented that currently it has no plans to sell the land, buildings and equipment of the Rhode Island facilities.

Steward projects $55 million in investments to fund projected capital needs over the 2012-2016 time period for BMC and BRH. This amount includes a $30 million capital commitment for new projects. In addition, Steward is projecting to spend another $4.5 million during the first five years after closing on physician recruitment. Steward represented that a significant portion of these recruitment funds will be allocated to primary care development.

According to Steward, its operations in Massachusetts have invested heavily in the infrastructure necessary to be successful in health care delivery through an accountable care organization (ACO) model. The ACO is built around a primary care-centric delivery system, and Steward is prepared to make the investments needed to ensure that the BMC patient community has access to sufficient primary care and specialty services, although Steward has not committed to bringing the ACO model to Rhode Island in these applications. At this time, Steward stated it did not know the specific numbers of physicians needed, nor the details regarding all of the specialties that the community needs. Steward stated that 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. According to Steward, 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 LMC. Steward has indicated that it may apply, and eventually expand, this model in Rhode Island. Although unproven, it could be expected that the successful operation of this model would result in appropriate access and balanced service delivery.

Steward's Conditions to the Asset Purchase Agreement

In March 2012, Steward introduced a number of new conditions to the APA that could be invoked by Steward so as not to proceed with the acquisitions. These conditions included those related to changes in the Hospital Conversions Act proposed in 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.

Compliance with Authorities

Steward represented that all of its hospitals and home care agencies are in substantial compliance with requirements of Massachusetts and New Hampshire public health departments (this was independently confirmed in writing from both public health agencies) and The Joint Commission and Massachusetts Medicaid.

There is one federal violation addressed in the FY 2011 audited financial statements of Steward. Subsequent to the Caritas Christi acquisition by Steward in Massachusetts, Steward self-reported certain technical violations of federal law relating to arrangements with physicians during 2008-2010. Steward has been working with CMS to resolve these potential Stark Law violations, which may result in a payment of between $1 million and $35 million to the federal government. The amount of $1 million is reflected in the FY2011 audited financial statements for Steward.

Discussion: The Department received a number of letters supporting these applications. At the two public informational meetings held on April 9, 2012, approximately 50 individuals spoke in support of these applications. Despite testimony from one witness (one other submitted written testimony) critical of Steward, there is no evidence that seriously questions Steward's character since its inception. However, 18 months is a short period to analyze, given the typical complexities and long duration of community involvement of hospitals and hospital systems. During this same time period and prior to closing on the purchase of LMC and RHRI, Steward has invested $7 million in LMC and RHRI to assist with their financial condition. This amount included a $5 million line of credit to assist with operations.

Conversely, Steward has added several conditions to the APA which would give them the opportunity to walk away from the purchase, and has indicated that it would walk away from the purchase unless its conditions were met. "Character" is understood by some to mean a longstanding commitment to a community and its people, and not only to a business arrangement.

Based on the record to date, Steward's character, commitment, competence and standing in the community are adequate.

Finding: Adequate.

Review Criterion 2: Whether sufficient safeguards are included to assure the affected community continued access to affordable care.

Steward's Model of Health Care Delivery

At the Health Services Council's Project Review Committee-I meeting of 3 April 2012, Dr. de la Torre, CEO of Steward, presented the Steward model of health care delivery, which is designed to assure community access to affordable care. He noted that Steward is a health system that includes hospitals and community-based physicians. 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 ACO model coordinates care across the continuum, including home, office, hospital and post-acute care. In keeping with the medical home model, Steward in Massachusetts 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 Steward, in Massachusetts region where they are active, and 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 – whether high-risk or at-risk. In addition, Steward actively partners with post-acute care facilities. Home care nurses visit patients in their homes and stay in touch 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 in its Massachusetts operations. 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. 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 its goal to provide high quality care at lower costs and that 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 BMC and BRH post-closing. This centralized system helps providers efficiently coordinate care and results in fewer medical errors and less duplication of services.

According to Steward, 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 stated it will strengthen primary and preventative care in Landmark's service area in order to improve the overall health of patients, and ultimately help curb over-usage of the Emergency Department.

Financial Health of Steward

Michael Kraten, PhD, CPA, President of Enterprise Management Corporation (EMC), financial consultant to the Department prepared an analysis of Steward based on the information in the FY 2011 audited financial statements. 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's analysis, however, 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 the 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. Steward noted that the numbers reviewed in the financial analysis by EMC are from FY11, which ended on September 30, 2011. Five year financial projections for the new hospitals are in Table 2.

Investments/Capital Expenditures

Steward projected $55 million in investments to fund projected capital needs over the 2012-2016 time period for BMC and BRH. 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.

Discussion: There appear to be no safeguards for access to affordable care in Rhode Island as this is a very high standard to meet and one hospital alone cannot be expected to meet this standard. However, Steward has indicated that its ACO model should improve the affordability in the area, which, if implemented as proposed, should have a positive impact on health care costs and access in Rhode Island. While promising, this development does not constitute a safeguard of assuring access, and is currently a promise yet to be fulfilled.

Finding: Adequate.

Review Criterion 3: Whether the Transacting Parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community.

Charity and Uncompensated Care

Pursuant to 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.

Steward did not specifically identify any short-term or long-terms plans, nor any commitments to maintaining and improving access to charity care for the undocumented and Hispanic populations, which are the Rhode Island populations most likely to be underserved. Steward did not provide charity care policies that would be utilized at BMC and BRH. Steward did indicate that charity care policies would be in compliance with the Rhode Island requirements. According to the financial statements, in 2011, Steward provided 1.9% of charity care at its hospitals in Massachusetts (see Table 3 for Charity care levels of Landmark Medical Center and affiliates).

Services with Possibility of Closing

Steward did not provide any specific plans for services at BMC and BRH 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 if Steward could not 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.

Discussion: In 1997, when the Hospital Conversions Act was enacted, hospitals provided primary, secondary and tertiary care and physicians had more time to devote to the underserved. In 2012, hospitals provide urgent and emergent care to the underserved rather than the continuum of services that were once provided to the underserved. Steward provided clear and convincing evidence in its statements that it would follow the law and regulations on charity care, community benefit and licensure. Adherence to these laws will assure that Steward will continue to provide services to traditionally underserved populations. It is noted, however, that Steward has not made specific commitments to maintain and improve access to charity care for the undocumented and Hispanic populations, although these population groups have emerged recently as a focus for traditionally underserved populations.

Finding: Satisfactory.

Review Criterion 4: Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital.

There is one potential federal violation addressed in the FY 2011 audited financial statements of Steward. Subsequent to the Caritas Christi acquisition by Steward in Massachusetts, Steward self-reported certain technical violations of federal law relating to arrangements with physicians during 2008-2010. Steward has been working with Centers for Medicare and Medicaid Services

("CMS") to resolve these potential Stark Law violations, which may result in a payment of between $1 million and $35 million to the federal government. The amount of $1 million is reflected in the FY2011 audited financial statements for Steward.

Steward's FY 2011 audited financial statements, at Note 10, indicate that, among other things, certain members of Steward's management team were awarded Class B Interests in Steward Health Care Investors, LLC (the Managing Member of Steward Health Holdings, LLC, which is the sole member of Steward). Steward Health Care Investors, LLC is a controlled affiliate of Cerberus and holder of all the outstanding membership interests of Steward Health Care Holdings, LLC. The Class B Interests vest over a four-year period subject to meeting the time-based and performance-based requirements defined in the individual award agreements. As of September 30, 2011, a total of 13,475,000 Class B Interests had been granted to employees of Steward and 563,000 were vested as of that date.

Discussion: Steward has a code of conduct which prohibits Steward from offering or providing compensation for patient business. In addition, Steward brought to light that Caritas Christi may have violated the Stark Law and brought it to the attention of the Department of Justice. Cerberus is a closely held organization and it is difficult to know if ownership interests are being used. Class B Interests exist and are awarded to employees, but it is not certain that these will not be used for incentives.

Finding: Adequate.

Review Criterion 5. Whether the Transacting Parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce.

In a May 1, 2012 letter from the United Nurses & Allied Professionals, its general counsel, Christopher Callaci, stated that Steward had made a contractual commitment to assure continuation of collective bargaining rights for all employees represented by UNAP. The letter also stated that Steward entered into a four-year bargaining agreement with UNAP to adequately commit to assure retention of the workforce, to appropriately account for employment needs and to address workforce retraining as a consequence of any proposed restructuring. This does not cover non-union staff.

As part of Amendment No. 8 to the APA, Steward eliminated the requirement that it not undertake any employee reductions in force for 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.

Discussion: Steward has committed to maintaining the collective bargaining agreement with the union staff and to assure, among other things, retention of the workforce. This commitment does not cover non-union staff. However, in order to turn around a failing hospital, staff lay-offs may be required. Thus, there is a commitment to assure the continuation of collective bargaining rights, but there is no commitment to assure the retention of the workforce.

Finding: Adequate.

Review Criterion 6: Whether the Transacting Parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring.

In the May 1, 2012 letter from the United Nurses & Allied Professionals, its general counsel, Christopher Callaci, stated that Steward entered into a four-year bargaining agreement with UNAP to adequately commit to assure employment needs and to address workforce retraining as a consequence of any proposed restructuring. This does not cover non-union staff.

Discussion: Steward has committed to assure employment needs and to retrain, to the degree possible, the unionized staff. This commitment does not cover non-union staff. It is noted that the hospital conversions application form does not specifically require an answer as to whether the Transacting Parties have appropriately accounted for employment needs at the facility and have addressed workforce retraining. However, the Transaction Parties did not choose to address this criterion in their application submission on their own accord. It is noted that Steward has not conducted any pre-assessment to determine what, if any, restructuring, may be needed in order to turn around these facilities.

Finding: Adequate.

Review Criterion 7: Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

As described in detail under "Criterion 2," Steward's model of health care delivery is designed to deliver value in the form of high-quality care at an affordable cost. Steward has embraced this model, the ACO, which coordinates care across a continuum of settings and through teams of health care providers. Recently, the CMS selected Steward to be one of 30 of its Pioneer ACO pilots. Steward has indicated that it may apply, and eventually expand, this model in Rhode Island. Although unproven, it could be expected that the successful operation of this model would result in appropriate access and balanced service delivery if and when that model is deployed in Rhode Island.

At the Health Services Council's Project review Committee-I 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 Stewards' 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.*"

As noted in Criterion 1, Steward represented that all of its hospitals and home care agencies are in substantial compliance with requirements of Massachusetts and New Hampshire public health departments (this was independently confirmed in writing from both public health agencies) and the Joint Commission and Massachusetts Medicaid.

Discussion: The impact of Steward on a balanced health care delivery system for the state is unknown. The ACO model has promise in contributing to a balanced delivery system, but it is still an untested model, so its actual impact is unknown. Although there was public testimony supporting the value of having a hospital nearby, there is an absence of medical evidence in the record (and in the health policy literature) that proximity to a hospital is related to the provision of safe and adequate treatment, appropriate access and balanced health care delivery. However, given the location and Woonsocket's lack of immediate access to hospital services, caution argues that the public interest is served by maintaining hospital services in Woonsocket.

Finding: Satisfactory.

Review Criterion 8. Whether the acquiror has demonstrated that it has satisfactorily met the terms and conditions of approval from any previous conversion pursuant to an application submitted under § 23-17.14-3; and R23-17.14-HCA subsection 4.c(i).

The acquiror has not been the subject of any previous conversion pursuant to an application submitted under § 23-17.14-3; and R23-17.14-HCA subsection 4.c(i).

Comment: Not Applicable.

Review Criterion 9: Issues of market share in its review, especially as they affect quality, access, and affordability of services.

Again, as described in detail under "Criterion 2," Steward's model of health care delivery is designed to deliver value in the form of high quality care at an affordable cost. Steward has indicated that this may be applied in Rhode Island, initially in Northern Rhode Island and, later, in other areas of the state. If this plan is implemented, a growing market share of Rhode Islanders would have access to this promising but untested in Rhode Island model of care. As noted in "Criterion 3," Steward did not provide any specific plans for services at BMC and

BRH and in its applications stated that it has not yet made final determination with regards to services and departments. No evidence was provided on the market share impact of this conversion, either, on the global market share of hospitals in Rhode Island, or specifically, on the volume and market share of service lines that might affect the critical volume of services needed to determine procedural or operative proficiency of all hospitals in Rhode Island. It is not known whether the addition or reduction of any service lines at BMC (changes in market share) will have any significant adverse impact on the proficiency and quality of similar services provided at other hospitals.

Discussion: Steward's possible plan to initiate and to expand its innovative delivery system model into Rhode Island may improve access, quality and affordability of health care in the state; however, it is not known whether the addition or reduction of any service lines at BMC (changes in market share) will have any significant impact on the proficiency and quality of similar services provided at other hospitals.

Finding: Adequate.

V. Recommendations and Approvals

Recommendations

As the Department considered the applications, the Department identified two items that would represent effective collaboration between the Department and Steward to improve the health of Rhode Islanders and they are included here as recommendations.

First, the Hospital Acquired Infections Advisory Subcommittee and the ICU Collaborative are statewide initiatives whose goal is to improve the provision of health services in Rhode Island. Since these are voluntary efforts, it is desired that Steward and BMC participate in these initiatives to the greatest extent possible.

Second, the State Loan Repayment Program managed and operated by the Rhode Island Department of Health. The State Loan Repayment Program assists in the recruitment and retention of a primary care workforce by repaying the educational loans of health professionals who agree to provide primary health services in health professional shortage areas, thereby improving access to health care in underserved communities and addressing the health professional shortages that cause disparities in access to health care. These funds may be used to match federal funding for loan repayment, or may be dispersed independent of other funding. It is desired that Steward contribute an amount of $50,000 towards furthering this initiative.

Approvals

Although most of the findings were deemed to be "adequate," the hospital conversions applications of Steward were not without limitations. Accordingly, the Department notes the following. Steward does not have a long-term track record against which to assess its

performance. Steward made a commitment not to sell the Rhode Island facilities for the next five years, but did not make any commitment not to close these facilities. Steward added conditions to the APA which would allow it to not proceed with the acquisitions if the conditions are unmet, and some of these conditions remain outstanding. Concerns categorized as "red flags" (though not "smoking guns") were raised by the financial consultant retained by the state agency regarding Steward. The record reflects the lack of pre-assessment undertaken by Steward with regards to final determination on health care services at the facilities and uncertainty regarding the future of the obstetric services at LMC. It is noted that Steward has not made specific commitments to maintain and improve access to charity care for the undocumented and Hispanic populations, although these population groups have emerged recently as a focus for traditionally underserved populations.

Due to the unique nature of this proposed conversion of Landmark, which is a hospital that is relatively geographically remote and which serves a low-income population in a community facing economic challenges, and the unique structure of Steward, which is a relatively new hospital holding company with somewhat opaque governance but one which is considering bringing a promising model of organizing and managing care to RI, these applications are approved in the hope that a hospital using the ACO model will be able to sustain the safety net for urgent hospital services while it helps stabilize the local economy and reduce the per-person cost of health care in Woonsocket and in RI and helps the Department to improve health outcomes in northern RI. What these applications lack is a firm commitment to preserving a hospital in Woonsocket, a firm commitment to bringing the ACO model to RI and a firm commitment to health care jobs in Woonsocket itself. Requiring those commitments in this decision, however, might have jeopardized the immediate future of Landmark and might have put the immediate economic survival of Woonsocket in jeopardy. Therefore, this approval notes the desirability of these commitments, but does not make approval of this application conditional upon them.

In consideration of all of the above and the totality of the evidence submitted, the Department hereby approves the applications for the conversions of Landmark Medical Center and Rehabilitation Hospital of Rhode Island with conditions directly related to the proposed conversions which are set forth below.

VI. Conditions of Approval

The Director imposes the following conditions of approval in this decision:

1. That Steward and Blackstone Medical Center shall collaborate and coordinate patient care with primary care and maternity providers in its service area, including physicians and community health centers;

2. That Steward and Blackstone Medical Center shall report data annually on forms prescribed by the state agency on equality of treatment, the number of primary care physicians per 10,000 population and the ratio of primary care physicians to specialty physicians in BMC's primary service area;

3. That Steward and Blackstone Medical Center shall participate in current*care* and shall endeavor to enroll all patients presenting for care in current*care* and shall participate in any community health assessments conducted by the Department;

4. That Steward and Blackstone Medical Center shall not unreasonably withhold admitting privileges so as to deprive traditionally underserved populations appropriate access to and continuity of care;

5. That Steward and Blackstone Medical Center shall not use ownership interests as incentives for hospital employees or physicians to refer patients to the hospital;

6. 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;

7. 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;

8. That the facilities shall provide charity care in compliance with Rhode Island law;

9. That the HCA applications be implemented as approved;

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

11. 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;

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

13. 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;

14. 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;

15. That Steward shall honor naming commitments to past donors; and

16. 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.

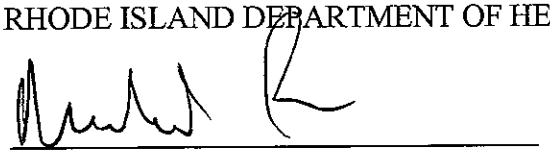
The conditions imposed with respect to the approval of this Application are deemed to be directly related to the proposed conversion. Said conditions and each of them severally are deemed to be related to Department criteria as set forth in R.I.G.L. 23-17.14-8 and 23-17.14-28. The conditions aforesaid shall be enforceable and have the same force and effect as if imposed as a licensure condition in connection with or related to R.I.G.L. 23-17-6, 23-17-7, 23-17-8, 23-17-8.1 and 23-17-21.

The Director shall have the authority to enforce compliance with these conditions and each of them in accordance with any provision of R.I.G.L. Chapter 23-17, which is applicable and pursuant to the authority granted pursuant to R.I.G.L. Chapter 23-17.14. The Director may take appropriate action to enforce compliance with these conditions and each of them as the circumstance may require, provided that such action is directly related to the proposed conversion.

Any conditions or provisions as set forth herein which are deemed invalid or unenforceable shall not affect the validity or enforceability of any other condition or provision contained herein, which shall remain in full force and effect.

This decision is consistent with the findings and decision with respect to the Change in Effective Control decision.

RHODE ISLAND DEPARTMENT OF HEALTH



Michael Fine, MD
Director of Health
Rhode Island Department of Health

May 22, 2012

Table 1

Steward Management Board Members &
Currently Proposed Members of Blackstone Medical Center and Rehabilitation Hospital Boards

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

Table 2
Financial Projections for New Hospitals

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**

Table 3
Charity Care levels 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%