Change in Effective Control Application

Version 09.2011

Name of Applicant: **Steward Health Care System LLC, Steward Medical Holdings LLC and Blackstone Medical Center, Inc.**
Name of Facility: **Landmark Medical Center**
Date Application Submitted: January 26, 2012
Amount of Fee: $20,000

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788

Please have the appropriate individual attest to the following:

"I hereby certify that the information contained in this application is complete, accurate and true."

1/20/12

signed and dated by the President or Chief Executive Officer

1/20/12

signed and dated by Notary Public

Name of Applicant: **Steward Health Care System LLC, Steward Medical Holdings LLC and Blackstone Rehabilitation Hospital, Inc.**
Name of Facility: **Rehabilitation Hospital of Rhode Island**
Date Application Submitted: January 26, 2012
Amount of Fee: $20,000

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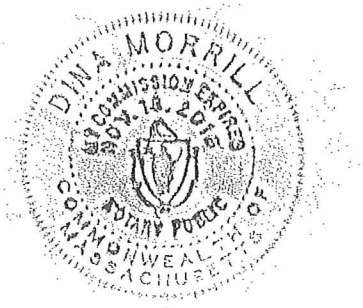
1/28/12

signed and dated by the President or Chief Executive Officer

1/20/12

signed and dated by Notary Public



Name of Applicant: **Jonathan N. Savage in his capacity as the court-appointed Special Master for Landmark Medical Center**
Name of Facility: **Landmark Medical Center**
Date Application Submitted: January 26, 2012
Amount of Fee: $20,000

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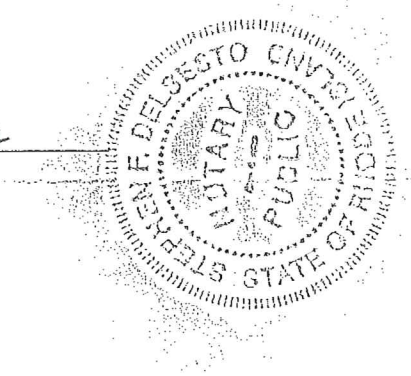

Name of Applicant: **Jonathan N. Savage in his capacity as the court-appointed Special Master for Northern Rhode Island Rehab Management Associates, L.P. d/b/a Rehabilitation Hospital of Rhode Island**
Name of Facility: **Rehabilitation Hospital of Rhode Island**
Date Application Submitted: January 26, 2012
Amount of Fee: $20,000

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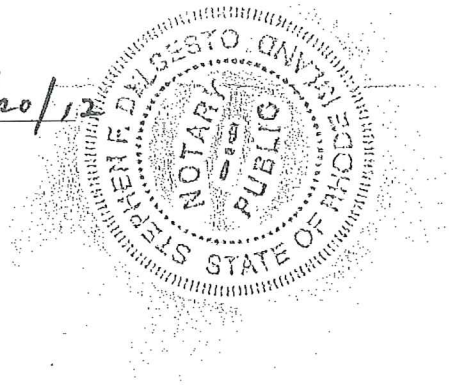

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1. Please provide an executive summary describing the nature and scope of the proposal. Additionally, please include the following: (1) identification of all parties, (2) description of the applicant and its licensure track record, (3) the type of transaction proposed including description of the transaction and relevant costs, (4) summary of all transfer documents, and (5) summary of the organizational structure of the applicant and its affiliates.

This application will outline the proposed acquisition of Landmark Health Systems, Inc. ("LHS") and Landmark Medical Center ("LMC") by Blackstone Medical Center, Inc. f/k/a Steward Medical Holdings Subsidiary Four, Inc. ("Blackstone Medical") and the proposed acquisition of Northern Rhode Island Rehab Management Associates, L.P. d/b/a Rehabilitation Hospital of Rhode Island ("RHRI") by Blackstone Rehabilitation Hospital, Inc. f/k/a Steward Medical Holdings Subsidiary Four Rehab, Inc. ("Blackstone Rehab"). Steward Health Care System LLC ("SHCS") and Steward Medical Holdings LLC ("SMH") are also applicants to this application and shall be referred to collectively with Blackstone Medical and Blackstone Rehab throughout this application as "Steward". The acquisitions are pursuant to an Asset Purchase Agreement entered into by order of the Superior Court for the County of Providence on June 8, 2011 between Jonathan N. Savage, solely in his capacity as the Court-appointed Special Master ("Special Master") for LHS, LMC and RHRI (the "Sellers" or the "Landmark Entities"), and SHCS and Blackstone Medical (the "Buyers"). Steward and the Landmark Entities shall be collectively referred to as the "Applicants" within this application. Please note that when information is provided in this application for LMC and RHRI for the period post-closing, it is understood that at that time the facilities will be licensed under the names Blackstone Medical and Blackstone Rehab, respectively.

Steward Health Care System
Organization

SHCS is a Delaware limited liability company formed on March 18, 2010. It is the parent company of SMH, a Delaware limited liability company, Steward Hospital Holdings, a Delaware limited liability company ("SHH"), and other entities that together form a broad health care system in Massachusetts. See Confidential Exhibit 12(a) in the Hospital Conversion Application submitted by the Applicants and accepted for review on January 17, 2012 ("HCA"). Both Blackstone Medical and Blackstone Rehab are Delaware for-profit corporations, and are direct subsidiaries of SMH, and indirect subsidiaries of SHCS.

SHH is the parent company of 6 community hospitals in Massachusetts that are bound by the Ethical and Religious Directives for Catholic Health Care Services, which were acquired on November 6, 2010. In addition to Blackstone Medical and Blackstone Rehab, SMH is also the parent company of 4 additional community hospitals located in Massachusetts, which SMH acquired on May 1, 2011 and September 30, 2011. All of the hospitals held by SHH and SMH are treated in this application as "affiliate hospitals", where that term is used and applicable.

Landmark Health System
Organization

Woonsocket Hospital ("WH") was established as a non-profit charity in 1873. It continued to operate in this form, as amended from time to time, until the late 1980s. In 1987, WH was

reorganized under a newly created parent corporation known as Woonsocket Community Health ("WCH") for the purpose of advancing the hospital's mission. Shortly thereafter WH merged and consolidated with John Fogarty Memorial Hospital ("Fogarty Hospital"), a similar facility located in North Smithfield, Rhode Island. The newly combined entity was known as Woonsocket Hospital Corporation ("WHC"), which changed its name to Landmark Medical Center on September 8, 1988. Currently, LMC is licensed as a 214-bed general acute care hospital located in Woonsocket, Rhode Island.

At the same time that WH and FH merged, WH's parent corporation, WHC, merged and consolidated with the parent of Fogarty Hospital, Fogarty Health Systems, Inc. The consolidated entity, Fogarty-Woonsocket Health Care Corporation, changed its name to Landmark Health Systems on September 8, 1988. LHS is a tax-exempt organization and sole corporate member of LMC. LHS was formed to own, manage, and operate both hospital facilities, merge their operations and otherwise advance their missions. With LHS as the sole operator of both hospitals, the two facilities improved the integration and efficiency of their operations, and continued to serve communities in northern Rhode Island and southeastern Massachusetts with the same high quality health care that these facilities had traditionally provided.

LHS subsequently formed a joint venture with Braintree Rehabilitation Hospital in Braintree, Massachusetts for the purposes of converting and operating the facilities of the former Fogarty Hospital as a specially licensed rehabilitation hospital. This facility is RHRI, which is a for-profit rehabilitation hospital located in North Smithfield, Rhode Island.

In 2003, LHS subsequently formed a Joint Venture with LMC known as Northern Rhode Island Rehab Management Associates (NRIRMA). NRIRMA is a Delaware Corporation formed for the purposes of acquiring full ownership of and operating RHRI and its facilities.

In 2008, NRIRMA sold certain properties and facilities of RHRI to Medistar Rhode Island, LLC; a Texas limited liability company. NRIRMA leased back these properties from Medistar and continues to operate and manage RHRI.

LHS, LMC, NRIRMA and their organizational predecessors have created various subsidiary and/or affiliated entities which relate or related to serving the respective missions of each organization. Most of such affiliated entities no longer exist, or are no longer active. Exhibit 1(a) identifies all Landmark-related corporations and the current status of each. An organizational diagram is provided at Exhibit 15. Corporate documents and certificates for all active entities are provided among the documents in this submission.

Court Supervision and Governance

On June 26, 2008, the Superior Court for the County of Providence appointed the Special Master to oversee the operations of LHS, LMC and RHRI. The Special Master, under the supervision the Court and in his capacity as Special Master, is the sole governing and operational authority for LMC, LHS, and NRIRMA. The Landmark entities 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.

The body of senior managers involved in the daily operations of the Landmark entities, all of whom report to the Special Master, has been extensively reduced and consolidated since 2008, and is described and detailed in various documents included in this submission.

Bid Process

Throughout the mastership proceeding, the Special Master, with the oversight of the Court-designated health care expert Pricewaterhouse Coopers, LLP ("PwC"), diligently searched for a strategic partner for the acquisition of the assets and business of the Landmark Entities. Despite receiving a significant amount of interest from numerous parties between 2008 and 2010, none of those interested parties completed a transaction for the purchase of the assets and business of the Landmark Entities.

In or about January 2011, in an effort to identify prospective purchasers for the Landmark Entities, with the recommendation of PwC, the Special Master retained Joshua Nemzoff of Nemzoff & Company, LLC to act as a Hospital Acquisition Advisor. Following Mr. Nemzoff's retention by the Special Master, he identified approximately fifteen (15) entities interested in bidding on the assets and business of the Landmark Entities. In response to the growing interest in the acquisition of the assets and business of the Landmark Entities, the Superior Court for the State of Rhode Island sitting in Providence County entered an Order (attached as Exhibit 1(b)) outlining a process pursuant to which (i) those entities interested in purchasing the assets and business of the Landmark Entities could submit bids for the same, (ii) the Special Master and the Court could consider those bids submitted, and (iii) the Court could eventually make a decision relative to the bids submitted (the "Bid Process").

As a result of the Bid Process, five (5) entities submitted bids for the assets and business of the Landmark Entities and the Court held several lengthy hearings relative to those bids submitted. Subsequent to those hearings, the Court on at least two (2) occasions directed the bidders to improve their respective bids and/or provide greater detail with regard to certain issues presented in their bids. Prior to a scheduled bid selection hearing, in or about late May 2011/early June 2011, Steward presented the Special Master with a bid which the Special Master deemed superior to all other bids that had been submitted to the Court. The Special Master presented the bid to the Court requesting authorization to accept the Steward bid. At the conclusion of a lengthy hearing, the Court determined that none of the previously submitted bids were acceptable or viable, that the Steward bid was acceptable and viable and that the Special Master was authorized to execute the Asset Purchase Agreement and Agreement for Advisory Services with Steward.

Proposed Change in Effective Control

The Court approved the Asset Purchase Agreement on June 8, 2011. Under the Asset Purchase Agreement, the Sellers propose to sell all right, title and interest in all assets, both real and personal, and both tangible and intangible, associated with owning, leasing, managing and operating LMC and RHRI, free and clear of all claims, liens and encumbrances. The assets include the business operations and any other assets located at the following addresses:

a. 115 Cass Avenue, Woonsocket, Rhode Island (the "Main Campus");
b. 116 Eddie Dowling Highway, North Smithfield, Rhode Island ("RHRI Campus");
c. 196 Cass Avenue, Woonsocket, Rhode Island (the "Business Office");
d. 186 Cass Avenue, Woonsocket, Rhode Island (the "Heart Center");
e. 206 Cass Avenue, Woonsocket, Rhode Island (the "Vacant Suite");
f. 219 Cass Avenue, Woonsocket, Rhode Island (the "Medical Office Bldg");
g. 20 Cumberland Hill Road, Woonsocket, Rhode Island (the "Drawing Station");
h. 115 Cass Avenue, Woonsocket, Rhode Island, Suite 2 (the "Oncology Practice");
i. 355 Cass Avenue, Woonsocket, Rhode Island ("Parking");
j. 63 Eddie Dowling Highway, North Smithfield, Rhode Island ("OB Practice"); and
k. 1526 Atwood Avenue, Johnston, Rhode Island ("Atwood Therapy Services") (Site closed as of August 2011).

Under the Asset Purchase Agreement, the Buyers will pay a total purchase price of Forty Million One Hundred Thousand Dollars ($40,100,000) (subject to various adjustments), plus the value of Net Working Capital determined by the parties. The Purchase Price will be payable as follows:

(a) $30,000,000 shall be paid for capital expenditures during the first five (5) years following the Closing;

(b) $2,000,000 shall be deemed paid at Closing by virtue of Steward, as successor-in-interest to Caritas Christi, providing evidence that Sellers' outstanding indebtedness to Caritas Christi is cancelled;

(c) $1,600,000 shall be payable at Closing in satisfaction of Sellers' indebtedness to CRB Holdings, Inc.;

(d) $2,000,000 shall be payable at Closing in satisfaction of Sellers' indebtedness to Blue Cross Blue Shield; and

(e) $3,500,000 shall be payable at Closing by payment of the premium for the "tail" insurance contemplated in the Asset Purchase Agreement.

The transaction shall be funded entirely through equity and Steward will not take on any new debt commitments. The $30,000,000 investment in capital is intended to be used in connection with the operation of the facilities as well as needed updates to the facilities, such as investments in technology or expansion of services. In addition, Steward plans to spend $4,500,000 in the first 5 years following closing for the purposes of physician recruitment to meet the needs of the community. Finally, Steward anticipates that 2.5% of annual net patient revenues will be allotted for routine capital expenditures.

Steward Health Care System has developed a preliminary capital expenditure plan for Blackstone

Medical and Blackstone Rehab. The current plan includes upgrades to clinical equipment such as diagnostic imaging and cardiovascular equipment, facilities and infrastructure investments, including renovations of the emergency department, information technology improvements across the facilities, and investments to foster the growth of primary and specialty care.

Please note, that this is a preliminary plan and is subject to change. Steward values the input of local management and board members. After the transaction is concluded the capital plan will be further evaluated and finalized.

All capital for the transaction is fully funded by 100% owner's equity. Please see Confidential Exhibit 43(a)(1) of the HCA for more information about SHCS's financial position and available cash.

The Closing is scheduled to occur on January 31, 2012, subject to approval of this proposed change in effective control. As of the filing of this application, Steward anticipates that the senior managers at LMC and RHRI will remain in their positions immediately after the effective date of the change in effective control. Robert Guyon, former COO of SHCS, will serve as Chief Restructuring Officer immediately upon closing. As part of his responsibilities he will be evaluating all current management in their roles and determining where changes and/or additions need to be made.

Benefit of the Proposed Change in Effective Control

The goal of the Special Mastership is to sell the assets of LMC, LHS, and RHRI, excepting cash and accounts receivables, to a buyer who will maintain the full medical services provided by the LMC and RHRI. An additional benefit of the change in effective control is the maintenance of a critical component of the northern Rhode Island and state economies. The proposed change in effective control will be the conclusion of over 3 years of efforts by the Special Master, with considerable assistance from the Department of Health and the Attorney General's office, to find an appropriate buyer for LHS, LMC and RHRI.

As noted above, LMC and RHRI provide valuable services to a traditionally underserved and medically needy patient population, but they are struggling to survive and have needed the protection of the Special Mastership in order to continue providing services. The appropriate buyer must be both financially capable of making many needed investments into the infrastructure of LMC and RHRI, and also have experience with managing and operating community hospitals. Steward plans to maintain and improve upon the services currently offered. If the change in effective control is not approved, and the Special Master is unable to find another buyer for the Landmark Entities, the Rhode Island health care delivery system would become unbalanced and the LMC and RHRI service areas would lose vital health care providers. Steward will be able to infuse much-needed capital into the facilities, and bring its experience with operating 10 community hospitals in Massachusetts to Rhode Island.

2. Name and address of the applicant:

Name: **Steward Health Care System LLC**	Telephone: **(617) 789-2500**
Steward Medical Holdings LLC	
Blackstone Medical Center, Inc.	
Blackstone Rehabilitation Hospital, Inc.	
Address: **500 Boylston Street, Boston, MA**	Zip Code: **02116**

Name: **Landmark Medical Center**	Telephone: **(401) 769-4100**
Address: **115 Cass Avenue, Woonsocket, RI**	Zip Code: **02895**

Name: **Northern Rhode Island Rehab Management Associates, L.P. d/b/a Rehabilitation Hospital of Rhode Island**	Telephone: **(401) 766-0800**
Address:**116 Eddie Dowling Highway, North Smithfield, RI**	Zip Code: **02896**

3. Name and address of facility (if different from applicant):

Name: **Landmark Medical Center**	Telephone: **(401) 769-4100**
Address: **115 Cass Avenue, Woonsocket, RI**	Zip Code: **02895**

Name: **Rehabilitation Hospital of Rhode Island**	Telephone: **(401) 766-0800**
Address:**116 Eddie Dowling Highway, North Smithfield, RI**	Zip Code: **02896**

4. Information of the President or Chief Executive Officer of the applicant:

Steward Health Care System LLC
Steward Medical Holdings LLC
Blackstone Medical Center, Inc.
Blackstone Rehabilitation Hospital, Inc.

Name: **Ralph de la Torre, MD**	Telephone: **(617) 419-4701**
Address: **500 Boylston Street, Boston, MA**	Zip Code: **02116**
E-Mail: **Ralph.delatorre@steward.org**	Fax: **(617) 419-4800**

Jonathan N. Savage in his capacity as the court-appointed Special Master for
Landmark Medical Center
Northern Rhode Island Rehab Management Associates, L.P.
d/b/a Rehabilitation Hospital of Rhode Island

Name: **Richard R. Charest**	Telephone: **(401) 769-4200 ext. 2000**
Address: **115 Cass Avenue, Woonsocket, RI**	Zip Code: **02895**
E-Mail: **rcharest@landmarkmedical.org**	Fax: **(401) 766-5488**

5. Information for the person to contact regarding this proposal:

Name: **Jeffrey F. Chase-Lubitz, Esq.**	Telephone: **(401) 454-0400**
Address: **Donoghue, Barrett & Singal PC** **Ten Weybosset Street, Suite 602** **Providence, RI**	Zip Code: **02903**
E-Mail: **jfcl@dbslawfirm.com**	Fax: **(401) 454-0404**

6. A. **EXISTING ENTITY:**

License category: **Hospital Premise**			
Name of Facility: **Landmark Medical Center**		License #: **HOS00117**	
Address: **115 Cass Avenue, Woonsocket, RI 02895**		Telephone: **(401) 769-4100**	
Type of Ownership: ___ Individual	___ Partnership	**_X_ Corporation**	__ Limited Liability Co.
Tax Status: ___ For Profit	**_X_ Non-Profit**		

License category: **Rehab Hospital Center**			
Name of Facility: **Rehabilitation Hospital of Rhode Island**		License #: **RHC02102**	
Address: **116 Eddie Dowling Hwy, North Smithfield, RI 02896**		Telephone: **(401) 766-0800**	
Type of Ownership: ___ Individual	**_X_ Partnership**	___ Corporation	__ Limited Liability Co.
Tax Status: **_X_ For Profit**	___ Non-Profit		

B. **PROPOSED ENTITY:**

License category: **Hospital Premise**			
Name of Facility: **Blackstone Medical Center, Inc.**		License #: **TBD**	
Address: **115 Cass Avenue, Woonsocket, RI 02895**		Telephone: **(401) 769-4100**	
Type of Ownership: ___ Individual	___ Partnership	**_X_ Corporation**	__ Limited Liability Co.
Tax Status: **_X_ For Profit**	___ Non-Profit		

License category: **Rehab Hospital Center**			
Name of Facility: **Blackstone Rehabilitation Hospital, Inc.**		License #: **TBD**	
Address:**116 Eddie Dowling Hwy, North Smithfield, RI 02896**		Telephone: **(401) 766-0800**	
Type of Ownership: ___ Individual	___ Partnership	**_X_ Corporation**	__ Limited Liability Co.
Tax Status: **_X_ For Profit**	___ Non-Profit		

7. Does this proposal involve a nursing facility? Yes __ **No _X_**

- If response to Question 7 is 'Yes', please complete Appendix C.

8. Will the facility be operated under management agreement with an outside party? Yes___ **No _X_**

- If response to Question 8 is "Yes", please provide copies of that agreement.

9. Will the proposal involve the facility/ies providing healthcare services under contract with an outside party? Yes___ **No _X_**

- If response to Question 9 is "Yes", please identify and describe those services to be contracted out.

10. Estimate the date (month and year) for the proposed transfer of ownership, if approved:

January 2012.

11. Please provide a concise description of the services currently offered by the licensed entity and identify any services that will be added, terminated, expanded, or reduced and state the reasons therefore:

LMC offers general acute care inpatient and outpatient hospital services. LMC also offers specialized services through its experts in cardiac care, cancer care, pain management and neck and spine injuries. RHRI is a licensed rehabilitation hospital and provides a complete range of inpatient and outpatient rehabilitation services, including general physical therapy, neurorehabilitation, stroke recovery, amputee rehabilitation, spinal cord rehabilitation and orthopedic rehabilitation. Please see attached Exhibit 11(a) for information on services currently offered at LMC and RHRI.

Steward is currently reviewing all departments, and medical, clinical, social and administrative services provided by LMC and RHRI, but has not yet made final determinations regarding whether such departments and/or services may need to be changed, by eliminating, significantly reducing or enhancing such departments and/or services in the interest of operational efficiency following the change in effective control.

Based on the prior acquisitions of struggling community hospitals, Steward anticipates that certain of the hospitals' administrative departments will need to be consolidated at a corporate level, in the interest of maximizing the efficiencies of these departments, as well as cost savings. Steward anticipates that certain financial and support services will most likely be consolidated for greater efficiency and cost savings. Additional consolidations may occur in areas such as information technology and reimbursement but Steward has not made any further decisions at this time. Further, while some of the administrative departments will most likely be managed at a higher, corporate level, Steward recognizes that the functions performed locally by such departments are necessary for hospital operations and in many cases some local representatives will be maintained.

There are currently no plans in place to change or eliminate medical, clinical or social services. The assessment of such services can only be done on an ongoing basis, once Steward has the opportunity to collect sufficient data and determine the most efficient way to operate the hospitals, post-closing. Steward's responses to Appendix B emphasize that any currently contemplated changes or reductions to departments or services will have minimal impact on patient care.

It is important to note that the growth of services and the significant capital investment Steward will put into the Landmark Entities will inevitably bring more jobs to the community. Exhibit 11(b) outlines a sample of the economic impact Steward has had in Massachusetts through its acquisition of the 6 Caritas Christi hospitals, as well as Merrimack Valley Hospital and Nashoba Valley Medical Center.

If the Applicants develop any further plans regarding changing or eliminating any departments or services at LMC and RHRI during the review of this application, the Applicants will provide

supplemental information to the Department of Health and the Department of the Attorney General.

12. Please identify the long-term plans of the applicant with respect to the health care programs and health care services to be provided at the facility:

Please see the response to Question 11 for information regarding the Applicants' long-term plans with respect to the health care programs and health care services provided at LMC and RHRI.

13. Does the entity seeking licensure plan to participate in Medicare or Medicaid (Titles XVIII or XIX of the Social Security Act)?

MEDICARE: **Yes** X No___ MEDICAID: **Yes** X No___

- If response to Question 13 for either Medicare and/or Medicaid is 'No', please explain.

14. Please provide all appropriate signed legal transfer documents (i.e. purchase and sale agreement, affiliation agreement); **NOTE**: these documents must cause both parties to be legally bound.

See Confidential Exhibit 18(a) of the HCA.

15. Please provide organization charts of both agencies (existing entity and the applicant) for prior to transfer and post transfer, identifying all "parent" legal entities with direct or indirect ownership in or control, all "sister" legal entities also owned or controlled by the parent(s), and all "subsidiary" legal entities.

See Confidential Exhibit 12(a) of the HCA and attached Exhibit 15.

16. If the proposed owner, operator or director owned, operated or directed a health care facility (both within and outside Rhode Island) within the past five years, please demonstrate the record of that person(s) with respect to access of traditionally underserved populations to its health care facilities.

Since its initial acquisition of the 6 Caritas hospitals in Massachusetts in November 2010, Steward has understood the need to provide care to traditionally underserved populations. Steward has expanded its hospital network to 10 community hospitals within Massachusetts and also provides care through its hospital satellites and home health care agency. Please see attached Confidential Exhibit 32(a) of the HCA for information about uncompensated care provided in the Steward community hospitals in Massachusetts.

Steward anticipates that charity care will continue to play a role in the care delivered at LMC and RHRI. Currently, LMC and RHRI have charity care policies in place, as required by Rhode Island law. Blackstone Medical and Blackstone Rehab plan to establish charity care policies in compliance with applicable Rhode Island law and generally consistent with those currently in existence at LMC and RHRI.

17. Please identify the proposed immediate and long-term plans of the applicant to ensure adequate and appropriate access to the program and health care services to be provided by the health care facility/ies to traditionally underserved populations.

The acquisition of LMC and RHRI will have a positive impact on the health care delivery system in the state of Rhode Island as a whole, and particularly in Woonsocket, North Smithfield and the surrounding communities. At issue in this proposed transaction is the continuation of the provision of vital medical services to an underserved and medically needy community within Rhode Island. LMC provides a substantial percentage of all hospital care required by residents of Providence County on any given day. This includes approximately 65% of all acute hospital care required by residents of Woonsocket. A high proportion of these residents lack health insurance and other economic resources. Moreover, this population displays a greater than average need for health services as the city and nearby suburbs are home to an older, more isolated and more disabled population that other areas of the state. The area also has one of the highest poverty rates and lowest median incomes in the state and the area populace, as a whole, lacks the ability to provide charitable contributions to support LMC. (See Exhibit 17(a)).

Unable to develop an endowment, LMC is one of the most disadvantaged hospitals in the state. LMC operates one of the state's busiest emergency rooms providing over 40,000 emergency visits per year. Roughly 25% of these patients arrive at the hospital by ambulance. LMC also treats a higher proportion of complex cases than most other Rhode Island facilities reporting the third highest Medicare case-mix index of all hospitals in the state. (See Exhibit 17(b))

Many services provided by LMC are not uniformly available at other area hospitals. Important examples include emergency interventional cardiac care and on-site radiation therapy. Ready availability of services such as these positively impact survival rates and outcomes for area residents. (See Exhibit 17(b)).

RHRI, LMC's sister hospital, is the only freestanding hospital facility in Rhode Island that focuses exclusively on patients who cannot be discharged from an acute hospital to their home or to a community setting because of special rehabilitation needs. RHRI provides a more specialized but lower cost alternative for treatment of these patients (600-700 annually) who would otherwise require extended stays in acute facilities.

This transaction will benefit the service areas by ensuring that LMC and RHRI continue to operate. LMC is the only acute care hospital in its service area (see Exhibit 17(c)) and it is essential for the residents of the community that LMC continue to serve this market. The hospitals have been struggling financially for several years and Steward has made a commitment to put much needed capital improvements into the facilities. Some of the key proposed investments include emergency department renovations, upgrades to imaging equipment, and new information technology that will improve the delivery of care.[1]

Furthermore, third-party studies (referenced above) report that there is a significant concern regarding whether patients in the LMC service community can safely receive care outside of the

[1] All capital spending must be approved by the local management team and board.

service area. Nearby hospitals are already operating above 80% capacity and even more concerning is the potential domino effect the longer drive times would have for EMS services in the area.

The statistics show that the Woonsocket community is economically disadvantaged. Not only is the median income significantly below the state average, but the unemployment rate, which has grown considerably since 2000, is also significantly higher than the rest of the state.

Estimated median household income in 2009: $39,964 (it was $30,819 in 2000)
Woonsocket: $39,964
Rhode Island: $54,119

Unemployment in March 2011:
Here: 12.9%
Rhode Island: 11.5%

In areas such as this, it is even more important to keep community care local. A study done by Vector Group LLC in 2010 (attached at Exhibit 17(b)) cited the fact that "Industry studies have consistently shown the close relationship between proximity and access to care – especially among lower income persons". Keeping market share at LMC and RHRI will have a positive impact on maintaining the health status of the patients in these communities.

18. Please provide a copy of charity care policies and procedures and charity care application form.

Currently, LMC and RHRI have charity care policies in place, as required by Rhode Island law, which are attached as Exhibit 18. SHCS, through Blackstone Medical and Blackstone Rehab, plans to establish charity care policies in compliance with applicable Rhode Island law and generally consistent with those currently in existence at LMC and RHRI.

19. After the proposed change in effective control, will the facility/ies provide medically necessary services to patients without discrimination, including the patients' ability to pay for services? Yes X No___.

- If response to Question 19 is 'No', please explain.

20. Please provide a copy of the Quality Assurance Policies (for the services) and a detailed explanation of how quality assurance for patient services will be implemented at the facility/ies by the applicant.

SHCS has developed a strong system-wide quality assurance program, which it has implemented in 10 Massachusetts hospitals. The program will be adapted for use at LMC and RHRI, taking into consideration the unique needs of each of the facilities, as well as any legal requirements for quality assurance programs within the State of Rhode Island. See Exhibit 20 for the Steward Quality Assurance Policies.

21. Please provide a detailed description about the amount and source of the equity and debt commitment for this transaction. (**NOTE**: If debt is contemplated as part of the financing, please complete Appendix E). Additionally, please demonstrate the following:

A. The immediate and long-term financial feasibility of the proposed financing plan;

B. The relative availability of funds for capital and operating needs; and

C. The applicant's financial capability.

As discussed in the response to Question 1, above, under the Asset Purchase Agreement, the Buyer will pay a total purchase price of Forty Million One Hundred Thousand Dollars ($40,100,000) (subject to various adjustments), plus the value of Net Working Capital determined by the parties. The Purchase Price shall be funded entirely through equity and Steward will not take on any new debt commitments.

The Purchase Price will include $30,000,000 for capital expenditures during the first five (5) years following the Closing. The $30,000,000 investment in capital is intended to be used in connection with the operation of the facilities as well as needed updates to the facilities, such as investments in technology or expansion of services. In addition, Steward plans to spend $4,500,000 in the first 5 years following closing for the purposes of physician recruitment to meet the needs of the community. Finally, Steward anticipates that 2.5% of annual net patient revenues will be allotted for routine capital expenditures.

22. Please provide legally binding evidence of site control (e.g., deed, lease, option, etc.) sufficient to enable the applicant to have use and possession of the subject property, if applicable.

See Confidential Exhibit 18(a) of the HCA.

23. If the facility is not-for-profit and/or affiliated with a not-for-profit, please provide written approval from the Rhode Island Department of Attorney General of the proposal.

The parties will be concurrently seeking approval of the proposed transaction from the Rhode Island Department of Attorney General through the Hospital Conversion Act review process.

24. Please provide each of the following documents applicable to the applicant's legal status:

- Certificate and Articles of Incorporation and By-Laws (for corporations)
- Certificate of Partnership and Partnership Agreement (for partnerships)
- Certificate of Organization and Operating Agreement (for limited liability corporations)

If any of the above documents are proposed to be revised or modified in any way as a result of the implementation of the proposed change in effective control, please provide the present documents and the proposed documents and **clearly identify** the revisions and modifications.

Exhibit 24(a), LMC Organizational Documents
Exhibit 24(b), LMC By-Laws

Exhibit 24(c), RHRI Organizational Documents
Exhibit 24(d), RHRI Partnership Agreement

Exhibit 24(e), SHCS Organizational Documents
Confidential Exhibit 10(g)(2) of the HCA, SHCS Fourth Amended and Restated Limited Liability Company Agreement

Exhibit 24(f), SMH Organizational Documents
Confidential Exhibit 10(i) of the HCA, SMH Limited Liability Company Agreement

Exhibit 24(g), Blackstone Medical Organizational Documents
Confidential Exhibit 10(k) of the HCA, Blackstone Medical By-Laws (to replace the LMC By-Laws)

Exhibit 24(h), Blackstone Rehab Organizational Documents
Confidential Exhibit 10(m) of the HCA, Blackstone Rehab By-Laws (to replace the RHRI Partnership Agreement)

25. If the applicant and/or one of its parent companies (or ultimate parent) is a publicly traded corporation, please provide copies of its most recent SEC 10K filing.

NOT APPLICABLE

26. Please provide audited financial statements (which should include an income statement, balance sheet and cash flow statement) for the last three years for the applicant, and/or its ultimate parent, and for the existing facility.

Audited financials are not yet available for Steward because the system completed its first fiscal year on September 30, 2011. Please see Confidential Exhibit 43(a)(1) of the HCA for Steward FY11 financial information.

See Confidential Exhibit 43(a)(2) of the HCA for the audited financials for LMC and Confidential Exhibit 43(a)(3) of the HCA for the audited financials for RHRI.

27. All applicants must complete Appendix A, D, F and G.

APPENDIX A

All applicants must complete this Appendix.

1. Please indicate the financing mix for the capital cost of this proposal. **NOTE**: the Health Services Council's policy requires a minimum 20 percent equity investment in CEC projects.

Source	Amount	Percent	Interest Rate	Terms (Yrs.)
Equity*	$	%		
Debt**	$	%	%	
Lease	$	%	%	
TOTAL	**$**	**100%**		

* Equity means non-debt funds contributed towards the capital cost related to a change in owner or change in operator of a healthcare facility which funds are free and clear of any repayment or liens against the assets of the proposed owner and/or licensee and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged.

** If debt financing is indicated, please complete Appendix E.

2. Please identify the total number of FTEs (full time equivalents) and the associated payroll expense (with fringe benefits) required to staff this proposal in the last full year and as projected in the first full year after the implementation of the proposal.

See Attachment A

	CURRENT YEAR 20___		<-- FIRST FULL OPERATING YEAR 20__ -->			
	EXISTING		ADDITIONS/(REDUCTIONS)		NEW TOTALS	
PERSONNEL	Number of FTEs	Payroll W/Fringes	Number of FTEs	Payroll W/Fringes	Number of FTEs	Payroll W/Fringes
Medical Director		$		$		$
Physicians		$		$		$
Administrator		$		$		$
RNs		$		$		$
LPNs		$		$		$
Nursing Aides		$		$		$
PTs		$		$		$
OTs		$		$		$
Speech Therapists		$		$		$
Clerical		$		$		$
Housekeeping		$		$		$
Other :(_____)		$		$		$
(_____)		$		$		$
(_____)		$		$		$
TOTALS		**$**		**$**		**$**

APPENDIX A (CONT.)

3. Please complete the following table for the facility for the last full year, the current year and for the first year after the implementation of the proposal. Round all amounts to the nearest dollar.

See Attachment A

	ACTUAL PREVIOUS YEAR 20__	BUDGETED CURRENT YEAR 20__	<-- FIRST FULL OPERATING YEAR 20__ -->		
			CEC DENIED	CEC APPROVED	INCREMENTAL DIFFERENCE
REVENUES:					
Net Patient Revenue	$	$	$	$	$
Other: (_____)	$	$	$	$	$
Total Revenue	$	$	$	$	$
EXPENSES:	$	$	$	$	$
Payroll w/Fringes	$	$	$	$	$
Bad Debt	$	$	$	$	$
Supplies	$	$	$	$	$
Office Expenses	$	$	$	$	$
Utilities	$	$	$	$	$
Insurance	$	$	$	$	$
Interest	$	$	$	$	$
Depreciation/Amortization	$	$	$	$	$
Leasehold Expenses	$	$	$	$	$
Other: (_____)	$	$	$	$	$
Other: (_____)	$	$	$	$	$
Total Expenses	$	$	$	$	$
OPERATING PROFIT:	$	$	$	$	$

4. Please provide utilization statistics (both as a dollar value and percentage) for the existing facility by completing the table below for the requested years.

See Attachment A

	ACTUAL (PAST 3 YEARS)						BUDGETED	PROJECTED (IF CEC APPROVED)					
PAYOR SOURCE:	FY 20___		FY 20___		FY 20___		CURRENT FY 20___	FY 20___		FY 20___		FY 20___	
Medicare	$	%	$	%	$	%	$ %	$	%	$	%	$	%
Medicaid	$	%	$	%	$	%	$ %	$	%	$	%	$	%
Blue Cross	$	%	$	%	$	%	$ %	$	%	$	%	$	%
Commercial	$	%	$	%	$	%	$ %	$	%	$	%	$	%
HMO's	$	%	$	%	$	%	$ %	$	%	$	%	$	%
Self Pay	$	%	$	%	$	%	$ %	$	%	$	%	$	%
Other: (_____)	$	%	$	%	$	%	$ %	$	%	$	%	$	%
TOTAL	$	%	$	%	$	%	$ %	$	%	$	%	$	%
Charity Care*	$	%	$	%	$	%	$ %	$	%	$	%	$	%

*Charity Care does not include bad debt, and is based on costs (not charges). For Home Nursing Care Providers the statewide community standard shall be one percent (1%) of net patient revenue earned on an annual basis.

ATTACHMENT A

LANDMARK MEDICAL CENTER
CEC APPENDIX A

QUESTION 2:

	CURRENT YEAR FY11		<--FIRST FULL OPERATING YEAR FY12-->			
	EXISTING		ADDITIONS/(REDUCTIONS)		NEW TOTALS	
PERSONELL	NUMBER of FTEs	PAYROLL W/FRINGES	NUMBER of FTEs (1)	PAYROLL W/FRINGES	NUMBER of FTEs	PAYROLL W/FRINGES
Medical Director	1.0	$ 292,129	0.0	$ 61	1.0	$ 292,190
Physicians	12.5	$ 4,756,372	0.0	$ 371,569	12.5	$ 5,127,941
Administrator	1.0	$ 531,144	0.0	$ 110	1.0	$ 531,254
RNs	202.5	$ 22,197,974	2.6	$ 406,607	205.1	$ 22,604,581
LPNs	10.8	$ 783,960	(2.5)	$ (184,854)	8.3	$ 599,106
Nursing Aides	67.3	$ 3,550,726	(1.4)	$ (55,533)	65.9	$ 3,495,193
PTs	0.0	$ -	0.0	$ -	0.0	$ -
Ots	0.0	$ -	0.0	$ -	0.0	$ -
Speech Therapists	0.0	$ -	0.0	$ -	0.0	$ -
Clerical	143.9	$ 8,004,605	(23.2)	$ (1,248,548)	120.7	$ 6,756,057
Housekeeping	0.0	$ -	0.0	$ -	0.0	$ -
Other Professional	156.8	$ 13,100,640	(27.6)	$ (2,222,223)	129.2	$ 10,878,417
Support Staff	100.0	$ 4,792,723	(30.3)	$ (1,280,746)	69.7	$ 3,511,977
Management	70.8	$ 8,068,441	(6.5)	$ (611,331)	64.3	$ 7,457,110
TOTALS	766.6	$ 66,078,714	(88.9)	$ (4,824,888)	677.7	$ 61,253,826

QUESTION 3:

	ACTUAL PREVIOUS YEAR FY10	BUDGETED CURRENT YEAR FY11 (2)	<--FIRST FULL OPERATING YEAR FY12-->		
			CEC DENIED (3)	CEC APPROVED	INCREMENTAL DIFFERENCE
REVENUES:					
Net Patient Revenue	$ 113,573,038	$ 119,628,523	$ 114,354,659	$ 114,354,659	$ -
DSH Payment	$ 6,469,486	$ 5,499,708	$ 5,074,833	$ 5,074,833	$ -
Other Operating Revenue	$ 3,461,444	$ 3,382,866	$ 3,059,429	$ 3,059,430	$ 0
TOTAL REVENUE	$ 123,503,968	$ 128,511,097	$ 122,488,921	$ 122,488,922	$ 0
EXPENSES:					
Payroll w/Fringes	$ 64,494,549	$ 66,807,999	$ 65,209,499	$ 61,253,826	$ (3,955,673)
Bad Debt	$ 15,724,028	$ 16,610,857	$ 14,347,333	$ 14,319,612	$ (27,721)
Supplies	$ 18,518,255	$ 19,543,949	$ 20,908,581	$ 21,532,879	$ 624,298
Office Expense	$ 1,011,859	$ 1,043,966	$ 1,024,008	$ 1,054,260	$ 30,252
Utilities	$ 1,625,728	$ 1,589,293	$ 1,714,943	$ 1,765,814	$ 50,871
Insurance	$ 3,963,957	$ 2,560,189	$ 2,616,013	$ 2,687,116	$ 71,103
Interest	$ 530,787	$ 424,417	$ 416,353	$ 27,560	$ (388,793)
Depreciation/Amortization	$ 2,154,836	$ 1,987,886	$ 1,918,860	$ 3,394,574	$ 1,475,714
Leasehold Expenses	$ 76,099	$ 39,993	$ 32,232	$ 32,232	$ -
Purchased Services	$ 19,148,219	$ 16,732,502	$ 17,657,432	$ 16,497,065	$ (1,160,367)
Professional Fees	$ 1,064,917	$ 1,480,099	$ 800,155	$ 800,155	$ -
Hospital License Fee	$ 5,503,873	$ 5,568,862	$ 5,585,024	$ 5,585,024	$ -
Other Expenses	$ 667,442	$ 830,553	$ 701,089	$ 737,691	$ 36,602
TOTAL EXPENSES	$ 134,484,549	$ 135,220,565	$ 132,931,523	$ 129,687,808	$ (3,243,715)
OPERATING PROFIT:	$ (10,980,581)	$ (6,709,468)	$ (10,442,602)	$ (7,198,886)	$ 3,243,716

Note: LMC & LPOS Consolidated

(1) Please note that as of the date of this application, no final determinations have been made regarding staffing additions or reductions. The numbers used in this column are proxy numbers representing approximately 7% anticipated reductions in expenses for payroll with fringes.

(2) Preliminary analysis shows Actual Total Revenue for FY11 at $122,333,000 and Actual Operating Profit/Loss at $(10,895,288).

(3) The numbers in the CEC Denied column are based on the assumption that Landmark Medical Center will continue operating in its current manner even if this application is denied.

REHABILITATION HOSPITAL OF RHODE ISLAND
CEC APPENDIX A

QUESTION 2:

	CURRENT YEAR FY11		<--FIRST FULL OPERATING YEAR FY12-->			
	EXISTING		ADDITIONS/(REDUCTIONS)		NEW TOTALS	
PERSONELL	NUMBER of FTEs	PAYROLL W/FRINGES	NUMBER of FTEs (1)	PAYROLL W/FRINGES	NUMBER of FTEs	PAYROLL W/FRINGES
Medical Director	1.0	$ 195,784	0.0	$ 2,333	1.0	$ 198,117
Physicians	0.0	$ -	0.0	$ -	0.0	$ -
Administrator	0.0	$ -	0.0	$ -	0.0	$ -
RNs	10.2	$ 1,114,179	(0.3)	$ (43,901)	9.9	$ 1,070,278
LPNs	0.4	$ 27,595	0.3	$ 19,221	0.6	$ 46,816
Nursing Aides	16.9	$ 914,485	0.5	$ 16,907	17.4	$ 931,392
Physical Therapists	13.4	$ 1,498,907	(0.0)	$ (99,976)	13.4	$ 1,398,931
Occupational Therapists	8.4	$ 947,237	(1.4)	$ (199,282)	7.0	$ 747,955
Speech Therapists	2.6	$ 255,322	0.2	$ 7,527	2.8	$ 262,849
Clerical	16.6	$ 955,834	(0.6)	$ (51,482)	16.0	$ 904,352
Housekeeping	0.0	$ -	0.0	$ -	0.0	$ -
Other Professional	12.9	$ 1,114,017	(3.1)	$ (255,793)	9.8	$ 858,224
Support Staff	0.0	$ -	0.0	$ -	0.0	$ -
Management	14.2	$ 1,841,822	0.9	$ 120,152	15.1	$ 1,961,974
TOTALS	96.5	$ 8,865,182	(3.5)	$ (484,294)	93.0	$ 8,380,888

FY11 are projected for October through December using data after RIF.

QUESTION 3:

	ACTUAL PREVIOUS YEAR FY10	BUDGETED CURRENT YEAR FY11	<--FIRST FULL OPERATING YEAR FY12-->		
			CEC DENIED (2)	CEC APPROVED	INCREMENTAL DIFFERENCE
REVENUES:					
Net Patient Revenue	$ 13,158,260	$ 13,093,818	$ 12,765,603	$ 12,701,004	$ (64,599)
DSH Payment	$ -	$ -	$ -	$ -	$ -
Other Operating Revenue	$ 676,938	$ 676,764	$ 757,069	$ 757,069	
TOTAL REVENUE	$ 13,835,198	$ 13,770,582	$ 13,522,672	$ 13,458,073	$ (64,599)
EXPENSES:					
Payroll w/Fringes	$ 8,841,399	$ 9,282,110	$ 8,380,888	$ 8,380,888	$ -
Bad Debt	$ 130,998	$ 131,140	$ 185,972	$ 185,031	$ (941)
Supplies	$ 169,629	$ 129,337	$ 123,897	$ 123,897	$ -
Office Expense	$ 81,158	$ 83,004	$ 100,579	$ 100,579	$ -
Utilities	$ 228,857	$ 236,028	$ 206,413	$ 206,413	$ -
Insurance	$ 259,738	$ 259,752	$ 255,823	$ 255,823	$ -
Interest	$ 3,297	$ 3,300	$ 10,636	$ -	$ (10,636)
Depreciation/Amortization	$ 13,796	$ 13,801	$ 13,593	$ 13,593	$ -
Leasehold Expenses	$ 4,595	$ 4,595	$ 4,424	$ 4,424	$ -
Purchased Services	$ 4,150,173	$ 3,828,120	$ 4,086,036	$ 4,036,577	$ (49,459)
Professional Fees	$ 64,534	$ 204,240	$ 91,280	$ 91,280	$ -
Hospital License Fee	$ -		$ -	$ -	$ -
Other Expenses	$ 218,084	$ 230,980	$ 256,661	$ 256,661	$ -
TOTAL EXPENSES	$ 14,166,258	$ 14,406,407	$ 13,716,203	$ 13,655,167	$ (61,036)
OPERATING PROFIT:	$ (331,060)	$ (635,825)	$ (193,531)	$ (197,094)	$ (3,563)

Note: RHRI Only

(1) Please note that as of the date of this application, no final determinations have been made regarding staffing additions or reductions. The numbers used in this column are proxy numbers representing approximately 7% anticipated reductions in expenses for payroll with fringes.

(2) The numbers in the CEC Denied column are based on the assumption that the Rehabilitation Hospital of Rhode Island will continue operating in its current manner even if this application is denied.

Landmark Medical Center
Payor Mix
FY 2008 - 2014
October - September

	ACTUAL (PAST 3 YEARS)						BUDGETED CURRENT		PROJECTED (IF CEC APPROVED)					
PAYOR SC	FY 2008		FY 2009		FY 2010		FY 2011		FY 2012 (9 mos)		FY 2013		FY 2014	
Medicare	$108,535,119	30.7%	$105,310,267	30.2%	$116,112,985	31.5%	$124,345,270	31.4%	$93,894,640	31.4%	$125,192,853	31.4%	$125,192,853	31.4%
Medicaid	$25,672,578	7.2%	$17,953,077	5.1%	$15,966,504	4.4%	$21,254,578	5.3%	$12,570,397	4.2%	$16,760,529	4.2%	$16,760,529	4.2%
Blue	$104,436,989	29.4%	$93,793,746	26.9%	$90,455,420	24.7%	$98,394,848	24.8%	$68,798,429	23.0%	$91,731,238	23.0%	$91,731,238	23.0%
Commerci	$17,379,586	4.9%	$21,008,121	6.0%	$26,031,077	7.1%	$28,200,142	7.1%	$21,359,352	7.2%	$28,479,137	7.2%	$28,479,137	7.2%
HMO's	$73,873,731	20.8%	$86,117,708	24.7%	$92,265,076	25.2%	$99,918,583	25.1%	$81,105,168	27.2%	$108,140,224	27.2%	$108,140,224	27.2%
Self Pay	$16,630,022	4.7%	$17,562,579	5.0%	$18,517,119	5.1%	$16,805,919	4.2%	$13,759,546	4.6%	$18,346,061	4.6%	$18,346,061	4.6%
Other: (	$8,328,137	2.3%	$7,473,738	2.1%	$7,251,820	2.0%	$8,474,186	2.1%	$7,060,052	2.4%	$9,413,403	2.4%	$9,413,403	2.4%
TOTAL	$354,856,162	100.0%	$349,219,236	100.0%	$366,600,001	100.0%	$397,393,526	100.0%	$298,547,584	100.0%	$398,063,445	100.0%	$398,063,445	100.0
Charity Car	$1,237,101	1.0%	$1,453,230	1.2%	$1,671,861	1.4%	$1,687,927	1.3%	$1,526,075	1.7%	$2,034,767	1.7%	$2,034,767	1.7%

Charity Care is a percentage of net patient service revenue.

* Charity Care does not include bad debt, and is based on costs (not charges). For Home Nursing Care Providers the statewide community standard shall be one percent (1%) of net patient revenue earned on an annual basis.

Rehabilitation Hospital of Rhode Island
Payor Mix
FY 2008 - 2014
January - December

	ACTUAL (PAST 3 YEARS)						BUDGETED CURRENT		PROJECTED (IF CEC APPROVED)					
PAYOR SC	FY 2008		FY 2009		FY 2010		FY 2011		FY 2012 (9 mos)		FY 2013		FY 2014	
Medicare	$9,163,782	2.5%	$10,804,154	3.1%	$11,467,266	3.1%	$12,196,895	3.2%	$9,288,640	3.2%	$12,384,853	3.2%	$12,384,853	3.2%
Medicaid	$1,375,415	0.4%	$1,188,620	0.3%	$1,155,205	0.3%	$1,234,869	0.3%	$618,986	0.2%	$825,315	0.2%	$825,315	0.2
Blue	$8,617,681	2.4%	$7,422,333	2.1%	$8,380,876	2.3%	$8,905,930	2.2%	$5,178,882	1.7%	$6,905,175	1.7%	$6,905,175	1.7%
Commerci	$1,392,106	0.4%	$2,082,350	0.6%	$1,708,623	0.5%	$1,834,209	0.5%	$1,403,926	0.5%	$1,871,901	0.5%	$1,871,901	0.5%
HMO's	$4,959,482	1.4%	$4,624,149	1.3%	$4,998,700	1.4%	$5,421,157	1.4%	$3,372,724	1.1%	$4,496,965	1.1%	$4,496,965	1.1%
Self Pay	$230,911	0.1%	$290,902	0.1%	$150,062	0.0%	$164,299	0.0%	$31,080	0.0%	$41,440	0.0%	$41,440	0.0%
Other: (	$1,214,854	0.3%	$1,114,546	0.3%	$1,215,977	0.3%	$1,334,342	0.3%	$1,118,420	0.4%	$1,491,227	0.4%	$1,491,227	0.4%
TOTAL	$26,954,231	7.5%	$27,527,054	7.8%	$29,076,709	7.9%	$31,091,701	7.9%	$21,012,658	7.1%	$28,016,876	7.1%	$28,016,876	7.1%
Charity Car	$60,739	0.2%	$55,542	0.2%	$78,552	0.3%	$78,637	0.3%	$35,736	0.2%	$47,648	0.2%	$47,648	0.2%

Charity Care is a percentage of net patient service revenue.

* Charity Care does not include bad debt, and is based on costs (not charges). For Home Nursing Care Providers the statewide community standard shall be one percent (1%) of net patient revenue earned on an annual basis.

Appendix B

The applicant forwarded the following Compliance Report to the Massachusetts Department of Public Health on October 24, 2011.

Rhode Island Department of Health
Office of Health Systems Development
Compliance Report

Steward Health Care System LLC has applied for licensure as a healthcare facility in Rhode Island through its subsidiaries Blackstone Medical Center, Inc., and Blackstone Rehabilitation Hospital, Inc. As part of the regulatory requirements to determine the character, competence and other quality related information of the applicant, the Office of Health Systems Development is requesting the following information regarding the health care facilities operated by or affiliated with the applicant, as listed on the attached sheet.

Please answer the following questions.

1. Are the agencies/facilities currently licensed and in substantial compliance with all applicable codes, rules and regulations? Yes__ No__

If the answer to #1 is "NO", please identify the facility(ies) and briefly explain the licensure status.

2. Has there been any enforcement actions against these agencies/facilities in the past five years? Yes__ No__

If the answer to #2 is "YES", please identify the facility(ies) and include any information relevant to those enforcement actions (reason for action, stipulation, fine, etc.). In addition, please furnish a brief description of the outcome of the most recent survey, including any deficiencies cited. Additional pages may be attached, if needed.

Reviewer's Name: _____ Title: _____
Department: _____ State: _____
Telephone_____ E-mail _____
Reviewer's Signature: _____ Date: _____

If you have any questions, please contact Michael Dexter at (401) 222-2788 or e-mail, Michael.Dexter@health.ri.gov Please return the completed form within 15 days to the address below:

Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 404
Providence, Rhode Island 02908

Thank you.
Attachment

Appendix B (CONT.)

Applicant, please provide the following information identifying each facility to the appropriate state agency as an attachment to the letter in the table below, use additional pages if necessary. Please make sure to identify yourself in the cover letter by filling in the blank for 'Name of Applicant'.

State	Facility Name, Address and Contact Information	License Number
Massachusetts	Steward PET Imaging, LLC 800 Washington Street Norwood, MA 02062	4NNJ
Massachusetts	Steward Home Care, Inc. 3 Edgewater Drive Norwood, MA 02062	6243
Massachusetts	Steward Carney Hospital, Inc. 2100 Dorchester Avenue Dorchester, MA 02124	2003
Massachusetts	Steward Good Samaritan Medical Center, Inc. 235 North Pearl Street Brockton, MA 02301	2311
Massachusetts	Steward Good Samaritan Radiation Oncology Center, Inc. 818 Oak Street Brockton, MA 02301	42JN
Massachusetts	Steward Holy Family Hospital, Inc. 70 East Street Methuen, MA 01844	2225
Massachusetts	Steward Norwood Hospital, Inc. 800 Washington Street Norwood, MA 02062	2114
Massachusetts	Steward Saint Anne's Hospital Corporation 795 Middle Street Fall River, MA 02721	2011
Massachusetts	Steward St. Elizabeth's Medical Center of Boston, Inc. 736 Cambridge Street Boston, MA 02135	2085
Massachusetts	Merrimack Valley Hospital, A Steward Family Hospital, Inc. 150 Lincoln Avenue Haverhill, MA 01830	2131
Massachusetts	Nashoba Valley Medical Center, A Steward Family Hospital, Inc. 200 Groton Road Ayer, MA 01432	2298
Massachusetts	Quincy Medical Center, A Steward Family Hospital, Inc. 114 Whitwell Street Quincy, MA 02169	2151

State	Facility Name, Address and Contact Information	License Number
Massachusetts	Morton Hospital, A Steward Family Hospital, Inc. 88 Washington Street Taunton, MA 02780	2022

Appendix B (CONT.)

The applicant forwarded the following Compliance Report to the New Hampshire Department of Health and Human Services on November 8, 2011.

Rhode Island Department of Health
Office of Health Systems Development
Compliance Report

Steward Health Care System LLC has applied for licensure as a healthcare facility in Rhode Island through its subsidiaries Blackstone Medical Center, Inc., and Blackstone Rehabilitation Hospital, Inc. As part of the regulatory requirements to determine the character, competence and other quality related information of the applicant, the Office of Health Systems Development is requesting the following information regarding the health care facilities operated by or affiliated with the applicant, as listed on the attached sheet.

Please answer the following questions.

1. Are the agencies/facilities currently licensed and in substantial compliance with all applicable codes, rules and regulations? Yes__ No__

If the answer to #1 is "NO", please identify the facility(ies) and briefly explain the licensure status.

2. Has there been any enforcement actions against these agencies/facilities in the past five years? Yes__ No__

If the answer to #2 is "YES", please identify the facility(ies) and include any information relevant to those enforcement actions (reason for action, stipulation, fine, etc.). In addition, please furnish a brief description of the outcome of the most recent survey, including any deficiencies cited. Additional pages may be attached, if needed.

Reviewer's Name: _____ Title: _____
Department: _____ State: _____
Telephone_____ E-mail _____
Reviewer's Signature: _____ Date: _____

If you have any questions, please contact Michael Dexter at (401) 222-2788 or e-mail, Michael.Dexter@health.ri.gov Please return the completed form within 15 days to the address below:

Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 404
Providence, Rhode Island 02908

Thank you.
Attachment

Appendix B (CONT.)

Applicant, please provide the following information identifying each facility to the appropriate state agency as an attachment to the letter in the table below, use additional pages if necessary. Please make sure to identify yourself in the cover letter by filling in the blank for 'Name of Applicant'.

State	Facility Name, Address and Contact Information	License Number
New Hampshire	Steward Home Care, Inc. 30 Perwal Street Westwood, MA 02090	03751
New Hampshire	Steward Home Care, Inc. 30 Perwal Street Westwood, MA 02090	03750

Appendix D

Source of Funds

All applicants must complete this Appendix.

I. Please provide the total expenditures necessary to implement this proposal and allocate this amount to the sources of funds categories listed below:

TOTAL PROJECT COST: $ $40,100,000*

SOURCE OF FUNDS	AMOUNT
a. Funded depreciation	$
b. Other restricted funds (specify)	
c. Unrestricted funds (specify)	
d. Owner's equity	40,100,000
e. Sale of stock/other equity	
f. Unrestricted donations or gifts	
g. Restricted donations or gifts	
h. Government grant (specify)	
i. Other non-debt funds (specify)	
j. Sub-Total Equity Funds	40,100,000
k. Subsidized loan (e.g. FHA etc.)	
l. Tax-exempt bonds (specify)	
m. Conventional mortgage	
n. Lease or rental	
o. Other debt funds	
p. Sub-Total Debt Funds	
q. Total Source of Funds	**40,100,000**

* should equal the response for line "q"

Appendix F

Disclosure of Ownership and Control Interest

All applicants must complete this Appendix.

I. Please answer the following questions by checking either 'Yes' or 'No'. If any of the questions are answered 'Yes', please list the names and addresses of individuals or corporations.

A. Will there be any individuals (or organizations) having a direct (or indirect) ownership or control interest of 5 percent or more in the applicant, that have been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX of the Social Security Act? Yes___ **No_X_**

B. Will there be any directors, officers, agents, or managers of the applicant (or facility) who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX of the Social Security Act? Yes___ **No_X_**

C. Are there (or will there be) any individuals employed by the applicant (or facility) in a managerial, accounting, auditing, or similar capacity who were employed by the applicant's fiscal intermediary within the past 12 months (Title XVIII providers only)? Yes___ **No_X_**

D. Will there be any individuals (or organizations) having direct (or indirect) ownership interests, separately (or in combination), of 5 percent or more in the applicant (or facility)? (Indirect ownership interest is ownership in any entity higher in a pyramid than the applicant) **Yes_X_** No___ (Note, if the applicant is a subsidiary of a "parent" corporation, the response is 'Yes')

See Attachment F.I.D.

E. Will there be any individuals (or organizations) having ownership interest (equal to at least 5 percent of the facility's assets) in a mortgage or other obligation secured by the facility? Yes___ **No_X_**

F. Will there be any individuals (or organizations) that have an ownership or control interest of 5 percent or more in a subcontractor in which the applicant (or facility) has a direct or indirect ownership interest of 5 percent or more. (Also, please identify those subcontractors.) Yes___ **No_X_**

G. Will there be any individuals (or organizations) having a direct (or indirect) ownership or control interest of 5 percent or more in the applicant (or facility), who have been direct (or indirect) owners or employees of a health care facility against which sanctions (of any kind) were imposed by any governmental agency? Yes___ **No_X_**

H. Will there be any directors, officers, agents, or managing employees of the applicant (or facility) who have been direct (or indirect) owners or employees of a health care facility against which any sanctions were imposed by any governmental agency? Yes___ **No_X_**

ATTACHMENT F.I.D.

ATTACHMENT F.I.D.

Names and address of any individuals (or organizations) having direct (or indirect) ownership interests, separately or in combination, of 5 percent or more in the applicant (or facility).

- Steward Medical Holdings, LLC (sole member of Blackstone Medical Center, Inc. and Blackstone Rehabilitation Hospital, Inc.)
  500 Boylston Street
  Boston, MA 02116

- Steward Health Care System, LLC (sole member of Steward Medical Holdings, LLC)
  500 Boylston Street
  Boston, MA 02116

Appendix G

Ownership Information

All applicants must complete this Appendix

1. List all officers, members of the board of directors, and trustees, stockholder of the applicant and/or ultimate parent entity. For each individual, provide their home and business address, principal occupation, position with respect to the applicant and/or ultimate parent entity, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

See Attachment G.1.

2. For each individual listed in response to Question 1 above, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, F) any professional accreditation (e.g. JACHO, CHAP, etc.), and G) complete Appendix B 'Compliance Report' and submit it to the appropriate state agency.

See Attachment G.2.

3. If any individual listed in response to Question 1 above, has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.

4. Have any individuals listed in response to Question 1 above been convicted of any state or federal criminal violation within the past 20 years? Yes___ **No_X_**.

- If response to Question 4 is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

5. Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 15 of the application. For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, F) any professional accreditation (e.g. JACHO, CHAP, etc.), and G) complete Appendix B 'Compliance Report' and submit it to the appropriate state agency.

See attached at Appendix B, Attachment G.2 and Attachment G.5.

6. Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 5 above during the last 5-years had bankruptcies and/or were placed in receiverships?
Yes_X_ No___

- If response to Question 6 is 'Yes', please identify the facility and its current status.

As noted in Question 1 of this application, LMC and RHRI have been under the supervision of the court-appointed Special Master since June 26, 2008. The Special Master oversees the operations of LMC and RHRI and, under the supervision of the Court, is the sole governing and operational authority for LMC and RHRI.

ATTACHMENT G.1

Appendix G

Ownership Information

STEWARD HEALTH CARE SYSTEM LLC

Officers

Name and Title	Business Address	Home Address	Phone Number
Ralph de la Torre, M.D. President	500 Boylston St. Boston, MA 02116	60 Howland Road Newton, MA 02465-2938	617-419-4700
James Renna Treasurer	500 Boylston Street Boston, MA 02116	6 Cazenove, Boston MA 02116	617-419-4700
Joseph C. Maher, Jr., Esq. Secretary	500 Boylston Street Boston, MA 02116	10 Whittemore Street West Roxbury, MA 02132-2504	617-419-4700

Directors

Name and Title	Business Address	Home Address	Phone Number
Ralph de la Torre, M.D. Chairman & CEO Steward Health Care System LLC	500 Boylston St. Boston, MA 02116	60 Howland Road Newton, MA 02465-2938	617-419-4700
James Lenehan Senior Operations Advisor Cerberus Capital Management, LP	299 Park Avenue New York, NY 10171	1586 Hampton Road, Rydal, PA 19046	617-419-4700
James Karam President, First Bristol Corporation	10 North Main Street Fall River, MA 02720	49 Nanaquaket Rd. Tiverton, RI 02878	617-419-4700
Ruben King-Shaw, Jr. Chairman and CEO of Mansa Equity Partners, Inc.	135 Nathan Lane Carlisle, MA 01741	135 Nathan Lane, Carlisle, MA 01741	617-419-4700
W. Brett Ingersoll Co-head of Private Equity and member of Investment	299 Park Avenue New York, NY 10171	130 East 70th Street New York,	617-419-4700

Name and Title	Business Address	Home Address	Phone Number
Committee Cerberus Capital Management LP		NY 10021	
Arthur Halper Senior Operations Executive Cerberus Operations and Advisory Company LLC	299 Park Avenue New York, NY 10171	8417 Del Prado Drive Delray Beach, FL 33446	617-419-4700
Lisa Gray General Counsel Cerberus Operations Advisory Company, LLC	299 Park Avenue New York, NY 10171	540 Wentworth Avenue, Mendota Heights, MN 55118	617-419-4700

*John Snow served as a Director of Steward Health Care System LLC until October 21, 2011.

BLACKSTONE MEDICAL CENTER, INC.

Officers

Name and Title	Business Address	Home Address	Phone Number
Ralph de la Torre, M.D. President	500 Boylston St. Boston, MA 02116	60 Howland Road Newton, MA 02465-2938	617-419-4700
James Renna Treasurer	500 Boylston Street Boston, MA 02116	6 Cazenove, Boston MA 02116	617-419-4700
Joseph C. Maher, Jr., Esq. Secretary	500 Boylston Street Boston, MA 02116	10 Whittemore Street West Roxbury, MA 02132-2504	617-419-4700

Directors

Name and Title	Business Address	Home Address	Phone Number
Ralph de la Torre, M.D. Chairman & CEO Steward Health Care System LLC	500 Boylston St. Boston, MA 02116	60 Howland Road Newton, MA 02465-2938	617-419-4700

Name and Title	Business Address	Home Address	Phone Number
Michael Callum, M.D. President, Steward Medical Group, Inc.	500 Boylston Street Boston, MA 02116	11 Eulow Street, Swampscott, MA 01907	617-419-4700
Mark Rich Executive VP of Corporate Strategy and Management Steward Health Care System LLC	500 Boylston Street Boston, MA 02116	21 Flanagan Drive Framingham, MA 01701-3712	617-419-4700

BLACKSTONE REHABILITATION HOSPITAL, INC.

Officers

Name and Title	Business Address	Home Address	Phone Number
Ralph de la Torre, M.D. President	500 Boylston St. Boston, MA 02116	60 Howland Road Newton, MA 02465-2938	617-419-4700
James Renna Treasurer	500 Boylston Street Boston, MA 02116	6 Cazenove, Boston MA 20116	617-419-4700
Joseph C. Maher, Jr., Esq. Secretary	500 Boylston Street Boston, MA 02116	10 Whittemore Street West Roxbury, MA 02132-2504	617-419-4700

Directors

Name and Title	Business Address	Home Address	Phone Number
Ralph de la Torre, M.D.	500 Boylston St. Boston, MA 02116	60 Howland Road Newton, MA 02465-2938	617-419-4700
Michael Callum, M.D. President, Steward Medical Group, Inc.	500 Boylston Street Boston, MA 02116	11 Eulow Street, Swampscott, MA 01907	617-419-4700
Mark Rich Executive VP of Corporate Strategy and Management Steward Health Care System LLC	500 Boylston Street Boston, MA 02116	21 Flanagan Drive Framingham, MA 01701-3712	617-419-4700

ATTACHMENT G.2

CEC Application - Appendix G #2

	Party In Interest	Entity	Relationship to entity	Address of Facility	Medicare Provider Number(s)	Type of Facility License Held	State License #	Professional Accreditations
1	Ralph de la Torre, MD	Steward Health Care System LLC	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
2	Ralph de la Torre, MD	Steward Holy Family Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-008, 22S080, 22-5731	Hospital	2225	See Attached
3	Ralph de la Torre, MD	Steward Carney Hospital, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-0017	Hospital	2003	See Attached
4	Ralph de la Torre, MD	Steward Norwood Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0126	Hospital	2114	See Attached
5	Ralph de la Torre, MD	Steward Good Samaritan Medical Center, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0111	Hospital	2311	See Attached
6	Ralph de la Torre, MD	Steward St. Anne's Hospital Corporation	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0020	Hospital	2011	See Attached
7	Ralph de la Torre, MD	Steward St. Elizabeth's Medical Center of Boston, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0036, 22S036, 22-2303	Hospital	2085	See Attached
8	Ralph de la Torre, MD	Steward Hospital Holdings Subsidiary One, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
9	Ralph de la Torre, MD	Steward Medical Group, Inc.	Director	500 Boylston Street, Boston, MA 02116	multiple*	N/A	N/A	See Attached
10	Ralph de la Torre, MD	Steward Emergency Physicians, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
11	Ralph de la Torre, MD	Steward Good Samaritan Occupational Health Services, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attac
12	Ralph de la Torre, MD	Steward Home Care, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-7203, 22-1518	Home Health/ Hospice	7218,03751,03750	See Attached
13	Ralph de la Torre, MD	Steward Health Care Network, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
14	Ralph de la Torre, MD	Steward New England Initiatives, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
15	Ralph de la Torre, MD	Steward St. Elizabeth's Realty Corp.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
16	Ralph de la Torre, MD	Steward Valley Regional Ventures, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
17	Ralph de la Torre, MD	Steward Research and Specialty Projects Corporation	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
18	Ralph de la Torre, MD	Laboure College, Inc.	Trustee	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
19	Ralph de la Torre, MD	Caritas Por Cristo, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
20	Ralph de la Torre, MD	Nashoba Valley Medical Center, A Steward Family Hospital, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-0098	Hospital	2298	See Attached
21	Ralph de la Torre, MD	Merrimack Valley Hospital, A Steward Family Hospital, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-0174, 22-S174	Hospital	2131	See Attached
22	Ralph de la Torre, MD	Blackstone Medical Center, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
23	Ralph de la Torre, MD	Blackstone Rehabilitation Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
24	Joseph C. Maher, Jr., Esq.	Steward Health Care System LLC	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
25	Joseph C. Maher, Jr., Esq.	Steward Holy Family Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-008, 22S080, 22-5731	Hospital	2225	See Attached
26	Joseph C. Maher, Jr., Esq.	Steward Carney Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0017	Hospital	2003	See Attached
27	Joseph C. Maher, Jr., Esq.	Steward Norwood Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0126	Hospital	2114	See Attached
28	Joseph C. Maher, Jr., Esq.	Steward Good Samaritan Medical Center, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0111	Hospital	2311	See Attac
29	Joseph C. Maher, Jr., Esq.	Steward St. Anne's Hospital Corporation	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0020	Hospital	2011	See Attac
30	Joseph C. Maher, Jr., Esq.	Steward St. Elizabeth's Medical Center of Boston, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0036, 22S036, 22-2303	Hospital	2085	See Attached
31	Joseph C. Maher, Jr., Esq.	Steward Hospital Holdings Subsidiary One, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
32	Joseph C. Maher, Jr., Esq.	Steward Medical Group, Inc.	Officer	500 Boylston Street, Boston, MA 02116	multiple*	N/A	N/A	See Attached
33	Joseph C. Maher, Jr., Esq.	Steward Emergency Physicians, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
34	Joseph C. Maher, Jr., Esq.	Steward Good Samaritan Occupational Health Services, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
35	Joseph C. Maher, Jr., Esq.	Steward Home Care, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-7203, 22-1518	Home Health/ Hospice	7218,03751,03750	See Attached
36	Joseph C. Maher, Jr., Esq.	Steward New England Initiatives, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
37	Joseph C. Maher, Jr., Esq.	Steward St. Elizabeth's Realty Corp.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
38	Joseph C. Maher, Jr., Esq.	Steward Valley Regional Ventures, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
39	Joseph C. Maher, Jr., Esq.	Steward Research and Specialty Projects Corporation	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
40	Joseph C. Maher, Jr., Esq.	Laboure College, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
41	Joseph C. Maher, Jr., Esq.	Caritas Por Cristo, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
42	Joseph C. Maher, Jr., Esq.	Nashoba Valley Medical Center, A Steward Family Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0098	Hospital	2298	See Attached

43 Joseph C. Maher, Jr., Esq.	Merrimack Valley Hospital, A Steward Family Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	22-0174, 22-S174	Hospital	2131	See Attached
44 Joseph C. Maher, Jr., Esq.	Blackstone Medical Center, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
45 Joseph C. Maher, Jr., Esq.	Blackstone Rehabilitation Hospital, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
46 Joseph C. Maher, Jr., Esq.	Steward Physician Contracting, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
47 Joseph C. Maher, Jr., Esq.	Morton Hospital, A Steward Family Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	Pending	Hospital	2022	See Attached
48 Joseph C. Maher, Jr., Esq.	Quincy Medical Center, A Steward Family Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	Pending	Hospital	2151	See Attached
49 James Renna	Steward Health Care System LLC	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
50 James Renna	Steward Holy Family Hospital, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-008, 22S080, 22-5731	Hospital	2225	See Attached
51 James Renna	Steward Carney Hospital, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-0017	Hospital	2003	See Attached
52 James Renna	Steward Norwood Hospital, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-0126	Hospital	2114	See Attached
53 James Renna	Steward Good Samaritan Medical Center, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-0111	Hospital	2311	See Attached
54 James Renna	Steward St. Anne's Hospital Corporation	Officer	500 Boylston Street, Boston, MA 02116	22-0020	Hospital	2011	See Attached
55 James Renna	Steward St. Elizabeth's Medical Center of Boston, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-0036, 22S036, 22-2303	Hospital	2085	See Attached
56 James Renna	Steward Hospital Holdings Subsidiary One, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attac'
57 James Renna	Steward Medical Group, Inc.	Officer	500 Boylston Street, Boston, MA 02116	multiple*	N/A	N/A	See Attac.
58 James Renna	Steward Emergency Physicians, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
59 James Renna	Steward Good Samaritan Occupational Health Services, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
60 James Renna	Steward Home Care, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-7203, 22-1518	Home Health/ Hospice	7218,03751,03750	See Attached
61 James Renna	Steward New England Initiatives, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
62 James Renna	Steward St. Elizabeth's Realty Corp.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
63 James Renna	Steward Valley Regional Ventures, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
64 James Renna	Steward Research and Specialty Projects Corporation	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
65 James Renna	Laboure College, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
66 James Renna	Caritas Por Cristo, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
67 James Renna	Nashoba Valley Medical Center, A Steward Family Hospital, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-0098	Hospital	2298	See Attached
68 James Renna	Merrimack Valley Hospital, A Steward Family Hospital, Inc.	Officer	500 Boylston Street, Boston, MA 02116	22-0174, 22-S174	Hospital	2131	See Attached
69 James Renna	Blackstone Medical Center, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
70 James Renna	Blackstone Rehabilitation Hospital, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
71 James Renna	Steward Physician Contracting, Inc.	Officer	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
72 James Renna	Morton Hospital, A Steward Family Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	Pending	Hospital	2022	See Attache'
73 James Renna	Quincy Medical Center, A Steward Family Hospital, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	Pending	Hospital	2151	See Attached
74 James Renna	Steward Good Samaritan Radiation Oncology Center, Inc.	Officer	500 Boylston Street, Boston, MA 02116	0018489	Clinic	4XJN	See Attached
75 Mark Rich	Steward Carney Hospital, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-0017	Hospital	2003	See Attached
76 Mark Rich	Steward Holy Family Hospital, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-008, 22S080, 22-5731	Hospital	2225	See Attached
77 Mark Rich	Steward Norwood Hospital, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-0126	Hospital	2114	See Attached
78 Mark Rich	Steward Good Samaritan Medical Center, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-0111	Hospital	2311	See Attached
79 Mark Rich	Steward St. Anne's Hospital Corporation	Director	500 Boylston Street, Boston, MA 02116	22-0020	Hospital	2011	See Attached
80 Mark Rich	Steward St. Elizabeth's Medical Center of Boston, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-0036, 22S036, 22-2303	Hospital	2085	See Attached
81 Mark Rich	Steward Hospital Holdings Subsidiary One, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
82 Mark Rich	Steward Medical Group, Inc.	Director	500 Boylston Street, Boston, MA 02116	multiple*	N/A	N/A	See Attached
83 Mark Rich	Steward Good Samaritan Occupational Health Services, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
84 Mark Rich	Steward Home Care, Inc.	Director	500 Boylston Street, Boston, MA 02116	22-7203, 22-1517	Home Health/ Hospice	7218,03751,03750	See Attached
85 Mark Rich	Steward Health Care Network, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
86 Mark Rich	Steward New England Initiatives, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached

87 Mark Rich	Steward St. Elizabeth's Realty Corp.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
88 Mark Rich	Steward Valley Regional Ventures, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
89 Mark Rich	Laboure College, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
90 Mark Rich	Blackstone Medical Center, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
91 Mark Rich	Blackstone Rehabilitation Hospital, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
92 Mark Rich	Quincy Medical Center, A Steward Family Hospital, Inc.	Director	500 Boylston Street, Boston, MA 02116	Pending	Hospital	2151	See Attached
95 Michael Callum, MD	Steward Medical Group, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	multiple*	N/A	N/A	See Attached
96 Michael Callum, MD	Steward Hospital Holdings Subsidiary One, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
97 Michael Callum, MD	Steward Physician Contracting, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
98 Michael Callum, MD	Steward Emergency Physicians, Inc.	Officer and Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
99 Michael Callum, MD	Steward Health Care Network, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	N/A	N/A	See Attached
100 Michael Callum, MD	Blackstone Medical Center, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached
101 Michael Callum, MD	Blackstone Rehabilitation Hospital, Inc.	Director	500 Boylston Street, Boston, MA 02116	N/A	Pending	Pending	See Attached

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Issued To	Issued From	Notes
Steward Carney Hospital, Inc. DBA Carney Hospital	AABB: Accreditation for Transfusion Activities	
	Accreditation Council for Graduate Medical Education: Accredited Program*	Carney Hospital Institutional Review Committee
	Accreditation Council for Graduate Medical Education: Accredited Program*	Carney Hospital Internal Medicine
	Accreditation Council for Graduate Medical Education: Accredited Program*	Carney Hospital Transitional Year Review
	American College of Radiology Commission on Quality and Safety: CT	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: MRI	
	American College of Radiology Commission on Quality and Safety: Ultrasound	
	American Diabetes Association : Certificate of Recognition	
	College of American Pathologists: Accredited Lab Certificate	
	Commission on Cancer: Certificate of Accreditation	
	Community Health Accreditation Program: DME	
	Joint Commission : Accreditation Certificate	
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Steward Good Samaritan Medical Center, Inc. DBA Good Samaritan Medical Center	AABB: Accreditation for Transfusion Activities	
	American College of Radiology Commission on Quality and Safety: CT	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: MRI	
	American College of Radiology Commission on Quality and Safety: Stereotactic Breast Biopsy	
	American Diabetes Association : Certificate of Recognition	
	College of American Pathologists: Accredited Lab Certificate	
	Commission on Cancer: Certificate of Accreditation	
	Community Health Accreditation Program: DME	
	Joint Commission : Accreditation Certificate	
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Steward Holy Family Hospital, Inc DBA Holy Family Hospital	AABB: Accreditation for Transfusion Activities	
	American College of Radiology Commission on Quality and Safety: CT	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: Stereotactic Breast Biopsy	
	American College of Radiology Commission on Quality and Safety: Ultrasound	
	American Diabetes Association : Certificate of Recognition	

Issued To	Issued From	Notes
	College of American Pathologists: Accredited Lab Certificate	
	Commission on Cancer: Certificate of Accreditation	
	Community Health Accreditation Program: DME	
	Joint Commission : Accreditation Certificate	
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Steward Home Care, Inc.	Joint Commission : Accreditation Certificate	Steward Home Care Fall River
	Joint Commission : Accreditation Certificate	Steward Home Care Methuen
	Joint Commission : Accreditation Certificate	Steward Home Care Westwood
	Joint Commission : Accreditation Certificate	Steward Home Care Waltham
Steward Norwood Hospital, Inc. DBA Norwood Hospital	AABB: Accreditation for Transfusion Activities	
	American College of Radiology Commission on Quality and Safety: CT	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: MRI	
	American College of Radiology Commission on Quality and Safety: Stereotactic Breast Biopsy	
	American College of Radiology Commission on Quality and Safety: Ultrasound	
	American College of Surgeons: Bariatric Center Certificate of Accreditation	
	College of American Pathologists: Accredited Lab Certificate	
	Commission on Cancer: Certificate of Accreditation	
	Community Health Accreditation Program: DME	
	Joint Commission : Accreditation Certificate	
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Steward PET Imaging, LLC	Intersocietal Commission for the Accreditation of Nuclear Laboratories: Certificate of Accreditation	
Steward Medical Group, Inc.	Intersocietal Commission for the Accreditation of Nuclear Laboratories: Certificate of Accreditation	
	Intersocietal Commission for the Accreditation of Echocardiography: Certificate of Accreditation	
Steward St. Anne's Hospital Corporation DBA Saint Anne's Hospital	AABB: Accreditation for Transfusion Activities	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: Stereotactic Breast Biopsy	
	American Diabetes Association : Certificate of Recognition	
	Commission on Cancer: Certificate of Accreditation	
	Community Health Accreditation Program: DME	
	Joint Commission : Accreditation Certificate	

Issued To	Issued from	Notes
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Steward St. Elizabeth's Medical Center of Boston, Inc DBA St Elizabeth's Medical Center	AABB: Accreditation for Transfusion Activities	
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Cardiovascular Disease
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Clinical Cardiac Electrophysiology
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Hematology/Oncology
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Institutional Review Committee
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Internal Medicine
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Inventional Cardiology
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Psychiatry
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Pulmonary Disease/ Critical Care Medicine
	Accreditation Council for Graduate Medical Education: Accredited Program*	St Elizabeth's Medical Center Surgery
	American College of Radiology Commission on Quality and Safety: CT	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: MRI	
	American College of Radiology Commission on Quality and Safety: Stereotactic Breast Biopsy	
	American College of Surgeons: Bariatric Center Certificate of Accreditation	
	American Diabetes Association : Certificate of Recognition	
	College of American Pathologists: Accredited Lab Certificate	
	Commission on Cancer: Certificate of Accreditation	
	Community Health Accreditation Program: DME	
	Joint Commission : Accreditation Certificate	
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Laboure College, Inc	Commission on Accreditation for Dietetics Education	
	Commission on Accreditation for Health Informatics and Information Management Education	
	Commission on Accreditation of allied Health Education Programs	
	Joint Review Committee on Education in Radiologic Technology	
	National League for Nursing Accreditation	
	New England Association of Schools and Colleges: Certificate of Accreditation	
Morton Hospital, A Steward Family Hospital, Inc. DBA Morton Hospital	AABB: Accreditation for Transfusion Activities	
	Commission on Cancer: Certificate of Accreditation	
	AABB: Certificate of Accreditation	

Issued To	Issued From	Notes
	College of American Pathologists: Accredited Lab Certificate	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: Stereotactic Breast Biopsy	
	American College of Radiology Commission on Quality and Safety: Ultrasound	
	Joint Commission : Accreditation Certificate	
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Quincy Medical Center, A Steward Family Hospital, Inc. DBA Quincy Medical Center	Joint Commission : Accreditation Certificate	
	Commission on Cancer: Certificate of Accreditation	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: Nuclear Medicine	
	American College of Radiology Commission on Quality and Safety: CT	
	American College of Radiology Commission on Quality and Safety: MRI	
	American College of Radiology Commission on Quality and Safety: Ultrasound	
	AABB: Accreditation for Transfusion Activities	
	College of American Pathologists: Accredited Lab Certificate	
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Nashoba Valley Medical Center, A Steward Family Hospital, Inc. DBA Nashoba Valley Medical Center	American Diabetes Association : Certificate of Recognition	
	Joint Commission : Accreditation Certificate	
	AABB: Accreditation for Transfusion Activities	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: Ultrasound	
	American College of Radiology Commission on Quality and Safety: Breast Ultrasound	
	American College of Radiology Commission on Quality and Safety: Nuclear Medicine	
	American College of Radiology Commission on Quality and Safety: Stereotactic Breast Biopsy	
	American College of Radiology Commission on Quality and Safety: MRI	
	College of American Pathologists: Accredited Lab Certificate	
	US Department of Health and Human Services FDA: Certified Mammography Facility	
Merrimack Valley Hospital, A Steward Family Hospital, Inc. DBA Merrimack Valley Hospital	Joint Commission : Accreditation Certificate	
	American College of Radiology Commission on Quality and Safety: Mammography	
	American College of Radiology Commission on Quality and Safety: Ultrasound	
	College of American Pathologists: Accredited Lab Certificate	

Issued To	Issued From	Notes
	US Department of Health and Human Services FDA: Certified Mammography Facility	

ATTACHMENT G.5

Appendix G
Question 5

Facility	License Type	Address	License #	Medicare #	Professional Accreditation
Landmark Medical Center	Hospital Premise	115 Cass Avenue Woonsocket, RI 02895	HOS00117	1699752923	JCAHO
Rehabilitation Hospital of Rhode Island	Rehab Hospital Center	116 Eddie Dowling Highway North Smithfield, RI 02896	RHC02102	1902883275	JCAHO
Southern New England Regional Cancer Center	Organized Ambulatory Care Facility	115 Cass Avenue Woonsocket, RI 02895	ACF01594		

EXHIBIT 1(a)

Organizational Summary of LHS, LMC, NRIMRA and Their Affiliates		
Landmark Health Systems,Inc	Landmark Health Systems, Inc. ("LHS"), a tax exempt organization, is the parent corporation and the sole Corporate Member of Landmark Medical Center. LHS is a general partner with LMC in Northern Rhode Island Rehab Management Associates, LP, a Delaware limited partnership.	Active
Landmark Medical Center, LMC	Landmark Medical Center ("LMC") is a tax exempt, acute care hospital, located in Woonsocket, Rhode Island, that provides secondary and select tertiary care services at its Woonsocket campus and ancillary diagnostic services at its North Smithfield campus. LMC is a general partner with LHS in Northern Rhode Island Rehab Management Associates, LP, (d/b/a Rehabilitation Hospital of Rhode Island ("RHRI"), a Delaware limited partnership. LMC is also a 38% JV partner in Southern New England Regional Cancer Center, a for profit joint venture OACF for radiation therapy services with RTSI, Inc.	Active
Landmark Health Foundation	Landmark Health Foundation, a 501 (c) 3 tax-exempt organization, is a wholly owned subsidiary of LMC, and was created in July 2005 to handle all fundraising activities. It is currently inactive.	Inactive
Landmark PHO	Landmark PHO is a Physician Hospital Organization was formed as a Joint Venture between LMC (50%) and a Physicians Organization formed by LMC's affiliated physicians.	Inactive
LHS Properties	LHS Properties, a wholly owned subsidiary of LHS, formerly owned a medical office building in Cumberland. The medical building was sold in 2006 and the company is currently inactive.	Inactive
LHS Investment Co.	LHS Investment Company, a wholly owned subsidiary of LHS is an inactive holding company.	Inactive
LHS Management Co.	LHS Management Company , a wholly owned subsidiary of LHS formerly provided staffing and management services to physician practices. Company has been inactive since 2004.	Inactive
Landmark Occupational Medicine	Landmark Occupational Medicine, a wholly owned subsidiary of LHS formerly provided outpatient rehabilitation services and is presently inactive.	Inactive
Landmark Physician Office Services ("LPOS")	Landmark Physician Office Services ("LPOS") , a wholly owned subsidiary of LMC, employs physicians who practice in the area and provides practice management and staffing services.	Active
Northern Rhode Island Rehab Management Association (NRIRMA) d/b/a "RHRI"	Northern Rhode Island Rehab Management Associates, LP, a for –profit Delaware limited partnership d/b/a Rehabilitation Hospital of Rhode Island, provides acute inpatient and outpatient rehabilitation services at 116 Eddie Dowling Highway, North Smithfield, RI and outpatient rehabilitation services at Atwood Therapy Services, in Johnston, RI. It leases its main campus facilities from Medistar, LLC.	Active

EXHIBIT 1(b)

STATE OF RHODE ISLAND
PROVIDENCE, S.C.

SUPERIOR COURT

Gary J. Gaube, Chief Executive Officer and Trustee, Plaintiff	:	
vs.	:	**P.B. No: 08-4371**
Landmark Medical Center, Defendant	:	
Richard R. Charest, Chief Executive Officer, Plaintiff	:	
V.	:	**P.B. No. 08-7186**
Northern Rhode Island Rehab Management Associates, L.P., Defendant	:	

SCHEDULING ORDER

This matter came on for hearing on the Providence County Business Calendar on February 9, 2011 on the Collective Motion of Rhode Island Department of Health, Rhode Island Office of the Attorney General and the Special Master (i) to Confirm Extinguishment of Management Services Agreements and Prior "Exclusivity Order," (ii) to Issue a Scheduling Order Setting Dates for Bidders to Submit Bids to Purchase Assets of Landmark Medical Center and Northern Rhode Island Rehab Management Associates, L.P., and (iii) to Issue a Scheduling Order to the Special Master to Submit Seller's Portion of Hospital Conversion Act Application to Regulators. Due and proper notice of said motion was provided by Jonathan N. Savage (the "Special Master"), Special Master in Landmark Medical Center ("LMC") and Northern Rhode Island Rehab Management Associates, L.P. ("NRIRMA") to all creditors and other parties in interest known to the Special Master. Good

cause appearing, and the consent of Rhode Island Department of Health ("DOH"), Rhode Island Office of the Attorney General ("DAG") and the Special Master appearing below, it is hereby

ORDERED, ADJUDGED and DECREED as follows:

1. All prior orders of this Court directing the Special Master to negotiate exclusively with Caritas Christi Health Care ("Caritas Christi") for the sale of the assets and businesses of LMC and NRIRMA are hereby confirmed to have been terminated and to have been rendered null and void and to be of no further force and effect. Similarly, Section 3.4 of the Management Advisory Agreement between Caritas Christi and Jonathan N. Savage as Court-Appointed Special Master of Landmark Health Center, and Section 3.4 of the Management Advisory Agreement between Caritas Christi and Jonathan N. Savage as Court-Appointed Special Master of Northern Rhode Island Rehab Management Associates, L.P., each requiring the Special Master to negotiate exclusively with Caritas Christi for the sale of the assets and businesses of LMC and NRIRMA are hereby confirmed to have been terminated and to have been rendered null and void and to be of no further force and effect. Accordingly, the Special Master is hereby authorized and directed to market and sell the assets and businesses of LMC and NRIRMA according to the provisions of the within scheduling order.

2. When a potential purchaser and the Special Master execute a Confidentiality and Non-Disclosure Agreement and a HIPPA Agreement, on forms supplied by the Special Master, that potential purchaser shall thereinafter be deemed to be a "Qualified Purchaser." The Special Master shall provide each such Qualified Purchaser, DOH and DAG with a "Due Diligence Package," in the form of a formatted and prepared USB "stick"/thumb drive

containing any and all reasonable and appropriate due diligence materials. In the event that a Qualified Purchaser reasonably requests and/or the Special Master identifies additional due diligence documentation/information for review, the Special Master shall immediately provide physical or digital copies of such information to all Qualified Purchasers and copies of the same to DOH and DAG. Notwithstanding anything set forth herein to the contrary, the Special Master shall not disclose to Qualified Purchasers Blue Cross & Blue Shield of Rhode Island's ("Blue Cross") reimbursement rates and/or information from which such reimbursement rates can be derived unless (i) the Special Master discloses their identities to Blue Cross, (ii) the Special Master confirms that they are Qualified Purchasers and that they are deemed qualified by his consultant, Joshua Nemzoff, and (iii) the Qualified Purchasers sign confidentiality and non-disclosure agreements acceptable to the Special Master and Blue Cross.

3. By no later than March 25, 2011, Qualified Purchasers of the assets and businesses of LMC and/or NRIRMA may submit bids to the Special Master to purchase the assets (exclusive of cash and accounts receivable) and businesses of LMC and/or NRIRMA. All such bids shall be without condition except for Court approval and any and all required regulatory approvals. Each such bid shall contain, at a minimum, the following terms and information:

i. The purchase price;

ii. The experience of the Qualified Purchaser in running healthcare facilities, and, if appropriate, financially-distressed healthcare facilities;

iii. The capitalization or access to capital of the Qualified Purchaser;

iv. The minimum amount of capital that the Qualified Purchaser is willing to contractually commit to the successor LMC and/or NRIRMA entity(ies) (exclusive of capital dedicated to the purchase price);

v. A five-year pro forma cash flow projection of the successor LMC and/or NRIRMA entity(ies);

vi. The period of time that the Qualified Purchaser is willing to contractually commit not to sell the assets and business or equity interest in LMC if it becomes the successful purchaser; and

vii. How the Qualified Purchaser intends to meet the healthcare needs of the community currently serviced by LMC including, without limitation, (i) any services that the Qualified Purchaser anticipates terminating, and (ii) the approximate number of employees that the Qualified Purchaser anticipates retaining.

4. On or prior to April 1, 2011, the Special Master shall file with the Court a "Recommendation" disclosing which bid he recommends that the Court approve. In making this Recommendation, the Special Master may consider any and all factors that he deems appropriate, including, without limitation the purchase price. In the Recommendation, the Special Master shall set forth, with specificity, along with a detailed analysis, the reason(s) why he has recommended the bid and Qualified Purchaser being presented to the Court for approval. In addition, the Special Master shall also set forth with specificity, along with a detailed analysis, the reason(s) why all other bids from all other Qualified Purchasers were not recommended for approval. All bids, recommended or not, shall be filed with the Recommendation. Notwithstanding anything set forth in this Order to the contrary, the

Special Master shall not be prohibited from recommending a bid which does not perfectly conform to the requirements of this Order provided that the Special Master demonstrates to the Court's satisfaction that "good cause" exists for accepting a "non-conforming bid." The issue of whether or not "good cause" exists for accepting a "non-conforming bid" shall rest in the sole discretion of the Court; provided however a condition precedent to a Qualified Purchaser's obligation to perform that the Qualified Purchase have additional time to conduct due diligence shall not constitute "good cause."

5. On April 6, 2011 at 9:30 a.m., the Court shall hold a hearing on the Special Master's Recommendation.

6. Within fourteen (14) days from the date upon which the Court approves the Special Master's Recommendation or chooses another winning bidder (i) the Special Master and the winning bidder shall negotiate and execute an asset purchase agreement, and (ii) the Special Master shall file a motion to approve the sale to the winning bidder.

7. Within fourteen (14) days from the date upon which the Special Master files his motion to approve the sale to the winning bidder, the Court shall hold a hearing on said motion.

8. The Special Master shall provide the Court, DOH and DAG status reports on the progress of the bid process at the Court's regularly scheduled bi-weekly public status conferences or at such other dates and times as directed by the Court.

9. The Special Master is hereby authorized and directed to submit the seller's portion of the Hospital Conversion Act application (except those portions which require knowledge as to the identity of the purchaser) to DOH and DAG by no later than March 17, 2011.

10. Any party-in-interest, including without limitation, Blue Cross, may, from time to time, request informal status updates or other information regarding the bid process from the Special Master. In the event that the Special Master refuses to provide such updates or information, that party may seek this Court's approval to obtain the same.

Entered in Providence County on the 14 day of February, 2011.

ENTER:

Associate Justice Silverstein
Dated: 2/14/2011

Clerk, Superior Court
2-14-2011

Agreed and consented to by:

RHODE ISLAND DEPARTMENT OF HEALTH
By its attorney,

Theodore Orson, Esq., No. 3871
Orson and Brusini Ltd.
325 Angell Street
Providence, RI 02906
(401) 223-2100
Date: February 14, 2011

STATE OF RHODE ISLAND

PETER F. KILMARTIN,
ATTORNEY GENERAL

Peter F. Kilmartin, # 6023
Attorney General
Genevieve M. Martin #3918
Assistant Attorney General
150 South Main Street
Providence, RI 02903
Date: February _, 2011

JONATHAN N. SAVAGE, AS AND ONLY AS SPECIAL MASTER OF LANDMARK MEDICAL CENTER AND NORTHERN RHODE ISLAND REHAB MANAGEMENT ASSOCIATES, L.P.

By his attorneys,
Shechtman Halperin Savage LLP

/s/ Stephen F. DelSesto (T.D.)

Stephen F. Del Sesto, Esq. (#6336)
1080 Main Street
Pawtucket, RI 02860
(401) 272-1400
Date: February 4 2011

EXHIBIT 11(a)

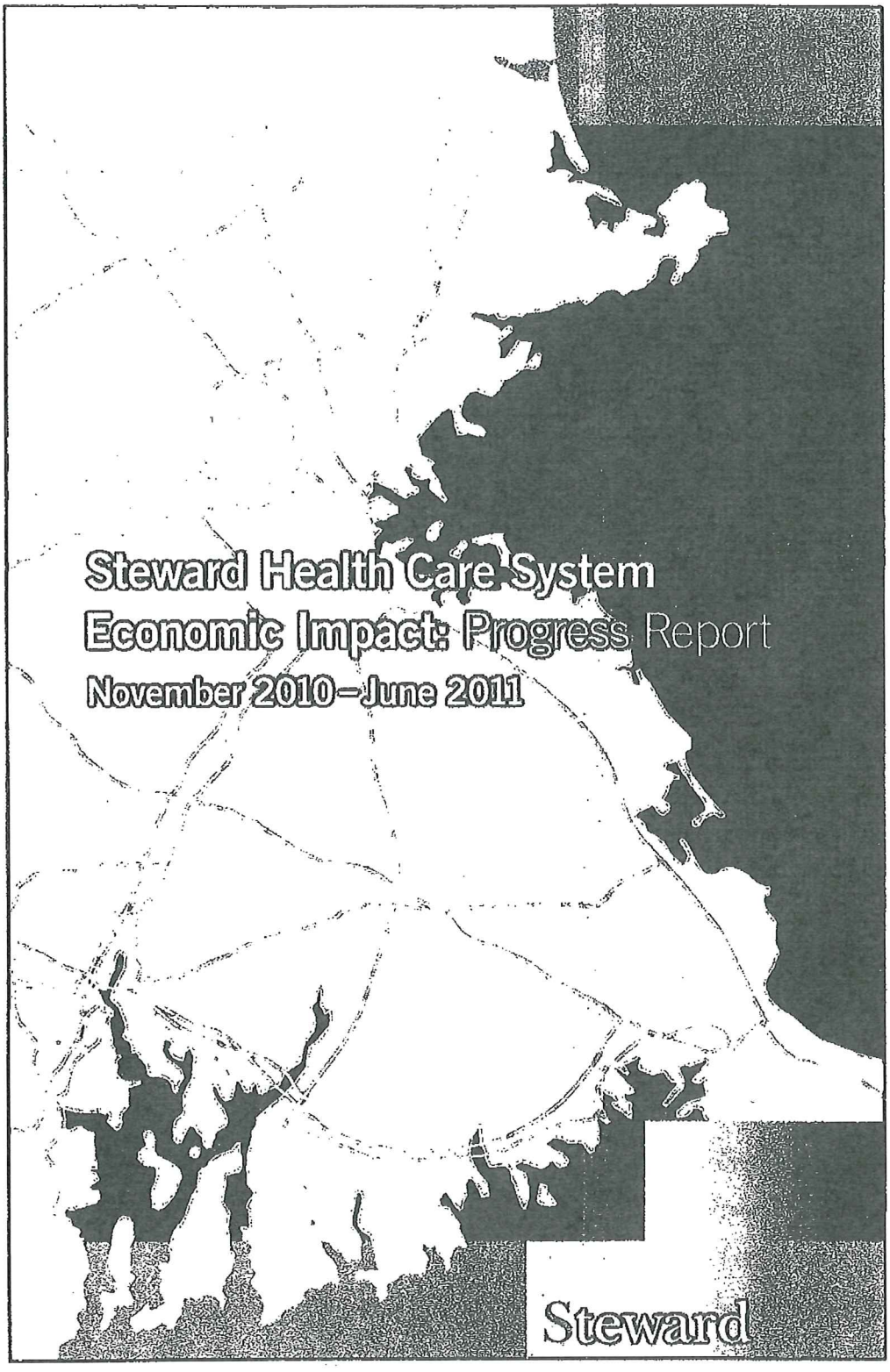
1 Schedule of Clinical and Administrative Services that are Currently Maintained at LHS, LMC, NRIRMA and their Affiliates

LMC:

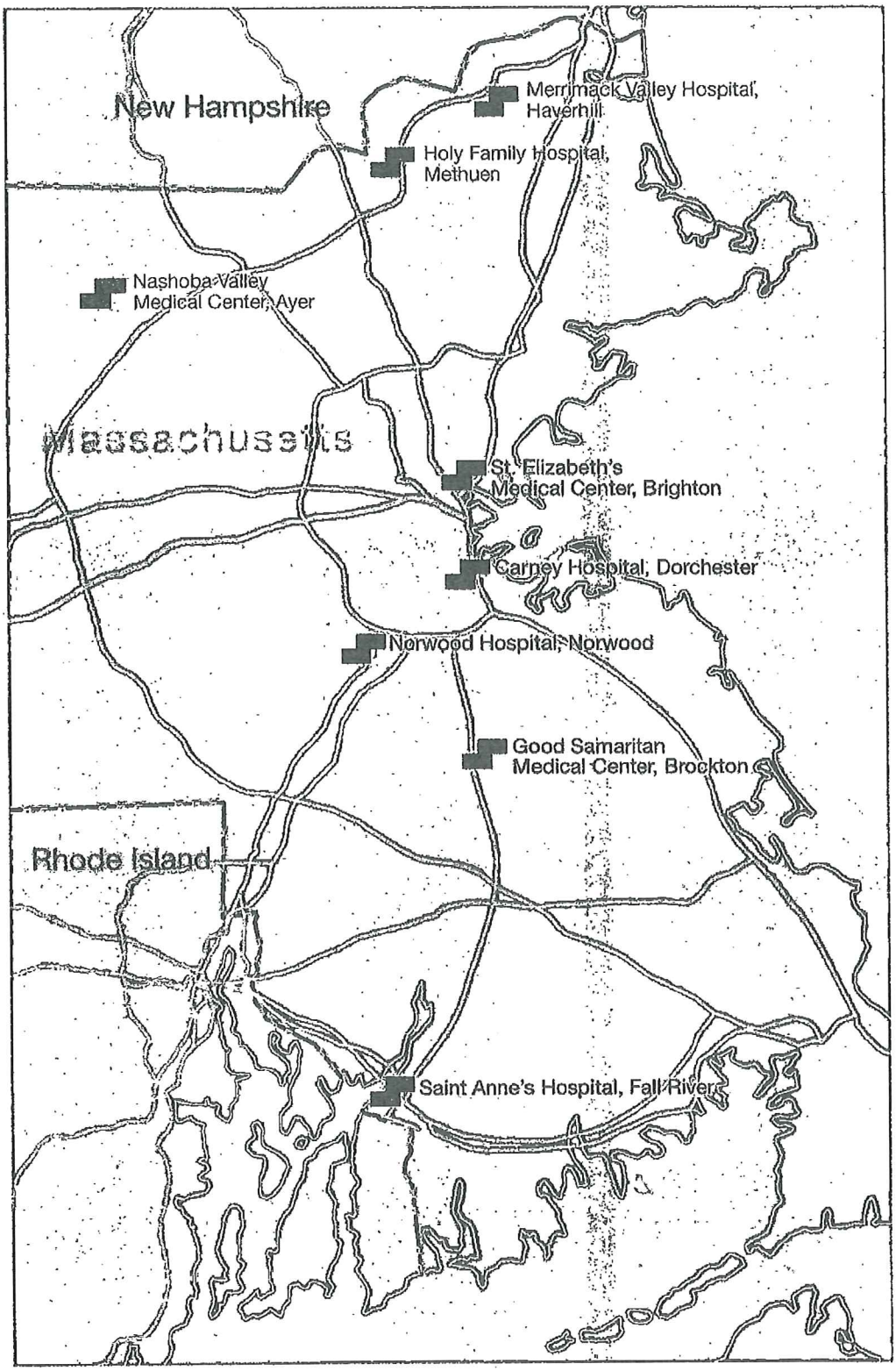
- Emergency Department including InstaCare
- Diagnostic services – full array of diagnostic services including pulmonary function, diagnostic cardiology services (Echo, EKG, Holter), Neurology (EEG)
- Inpatient medical services including step-down progressive care unit
- Inpatient surgical services (operating rooms and recovery)
- Inpatient adult psychiatry
- Cancer services – includes surgical oncology, hematology/medical oncology and radiation therapy (in partnership with 21st Century Oncology).
- Inpatient and Outpatient medical services in all major Disease Groups
- Inpatient and Outpatient surgical care in the areas of General Surgery, Orthopedics, Thoracic Surgery, Vascular Surgery, Otolaryngology, Urology and others
- Cardiac services – diagnostic and medical therapies and interventional catheterization laboratories.
- Cardiac rehabilitation
- Senior care
- Obstetrics
- Critical care (cardiovascular ICU and medical/surgical ICU).
- Laboratory and blood bank services
- Radiology services – including general radiology, mammography, ultrasound, C.T. scan, MRI, nuclear medicine and PET scanning
- Ambulatory surgery including endoscopy services
- Occupational medicine
- Health screening/preventative medicine
- Travel clinic
- Pain clinic
- Hospitalist services
- Social work and care planning services
- Chaplaincy services
- Interpreter services
- Patient education and screening services
- Physician referral services

9-1 Schedule of Clinical and Administrative Services that are Currently Maintained at LHS, LMC, NRIRMA and their Affiliates
NRIRMA
• Inpatient acute rehabilitation services including speech, occupational and physical therapies, ventillator weaning services
• Outpatient rehabilitation services including occupational, physical and speech therapies and workers' rehabilitation services
Administrative
•Housekeeping and Maintenance
•Food Service
•Transportation
•Materials Management
•Financial Services
•Communications
•General Administrative Services

EXHIBIT 11(b)


Steward Health Care System
Economic Impact: Progress Report
November 2010–June 2011
Steward

LMC 3203


New Hampshire
Merrimack Valley Hospital, Haverhill
Holy Family Hospital, Methuen
Nashoba Valley Medical Center, Ayer
Massachusetts
St. Elizabeth's Medical Center, Brighton
Carney Hospital, Dorchester
Norwood Hospital, Norwood
Good Samaritan Medical Center, Brockton
Rhode Island
Saint Anne's Hospital, Fall River

LMC 3204

Believe.

Steward Health Care System LLC (Steward), the largest fully integrated community care organization in New England and the seventh largest employer in Massachusetts, was created in November of 2010. At its inception, Steward consisted of six hospitals with 1,359 inpatient beds and approximately 13,000 employees.

In the following eight months, Steward experienced a period of dramatic growth.

This growth is fueled by out-of-state investment dollars and has had a profound impact on the Massachusetts economy. This impact falls into a number of categories: expansion, construction, job creation and tax generation.

LMC 3205

Expansion.

In the past eight months Steward has acquired **two additional hospitals:**

- **Merrimack Valley Hospital** (Haverhill, MA)
  107-bed acute care hospital with 550 employees
- **Nashoba Valley Medical Center** (Ayer, MA)
  57-bed acute care hospital with 530 employees

Steward has also signed and executed asset purchase agreements for **five more hospitals:**

- **Morton Hospital and Medical Center** (Taunton, MA)
  154-bed acute care hospital with 1,100 employees
- **Landmark Medical Center** (Woonsocket, RI)
  214-bed acute care hospital with 750 employees
- **Rehabilitation Hospital of Rhode Island** (North Smithfield, RI)
  70-bed rehabilitation hospital with 150 employees
- **Quincy Medical Center** (Quincy, MA)
  196-bed acute care hospital with 1,100 employees
- **Saints Medical Center** (Lowell, MA)
  157-bed acute care hospital with 1,300 employees

STEWARD HEALTH CARE SYSTEM LLC

LMC 3206

Each of these acquisitions comes with a capital commitment to upgrade existing facilities over the course of the next few years. For the existing eight Steward hospitals, plus the five upcoming acquisitions,

Steward will have spent a **total of $260 million** for facility renovations, upgrades and expansion by the end of 2011.

This **includes:**

- **$10 million** for a new radiation therapy center at St. Elizabeth's Medical Center in Brighton, MA
- **$30 million** for a new emergency department at Good Samaritan Medical Center in Brockton, MA
- **$10 million** for a renovated and expanded operating room suite at Carney Hospital in Dorchester, MA
- **$7 million** for a renovated and expanded cardiac catheterization lab at Norwood Hospital in Norwood, MA

Steward

LMC 3207

Construction.

At the time of its creation, Steward's facilities totaled more than 3.5 million square feet in Massachusetts. Since November 2010,

Steward has expanded its physical presence in Massachusetts by more than **770,000 square feet** of new or renovated space. This includes newly acquired office and physician space, as well as new construction at existing Steward facilities. This dramatic expansion required more than $122 million in capital to complete. Moving forward, Steward has committed to spend approximately

$270 million on new construction projects over the next five years.

STEWARD HEALTH CARE SYSTEM LLC

LMC 3208

System growth to date **in Massachusetts:**

- More than **56,000 sq. ft.** in **Methuen**
- More than **109,000 sq. ft.** in **Fall River**
- More than **48,000 sq. ft.** in **Dorchester**
- More than **60,000 sq. ft.** in **Norwood**
- Approx. **100,000 sq. ft.** in **Westwood**
- More than **58,000 sq. ft.** in **Brockton**
- Approx. **2,000 sq. ft.** in **Stoughton**
- More than **20,000 sq. ft.** in **Brighton**
- More than **38,000 sq. ft.** in **Boston**
- More than **158,000 sq. ft.** in **Ayer**
- More than **137,000 sq. ft.** in **Haverhill**

Steward

LMC 3209

Job Creation.

Steward has 14,000 employees and is the seventh largest employer in Massachusetts.

Since November, the existing system has grown by more than **300 new full-time jobs.**

More than half of this job growth consists of new doctors and nurses. In addition to this growth, Steward's construction activity has generated approximately

500 new construction jobs throughout the state.

Steward's upcoming activity is expected to add an additional 500–800 construction jobs in Massachusetts within the next year.

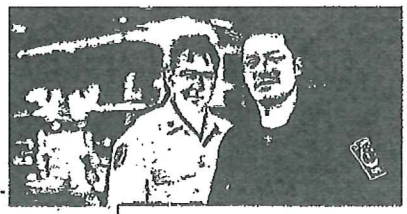
STEWARD HEALTH CARE SYSTEM LLC

LMC 3210

According to a housing and urban development formula, the economic stimulus Steward is creating with these construction projects

has resulted in almost
4,000 new jobs in these communities.

This job creation projection will increase significantly as Steward moves forward with additional expansion and renovation projects.



Steward

LMC 3211

Tax Generation.

Unlike all but two hospitals in Massachusetts, Steward is a taxable entity. Steward facilities will pay approximately

$9 million annually in property taxes

to local Massachusetts communities for the eight current Steward hospitals.

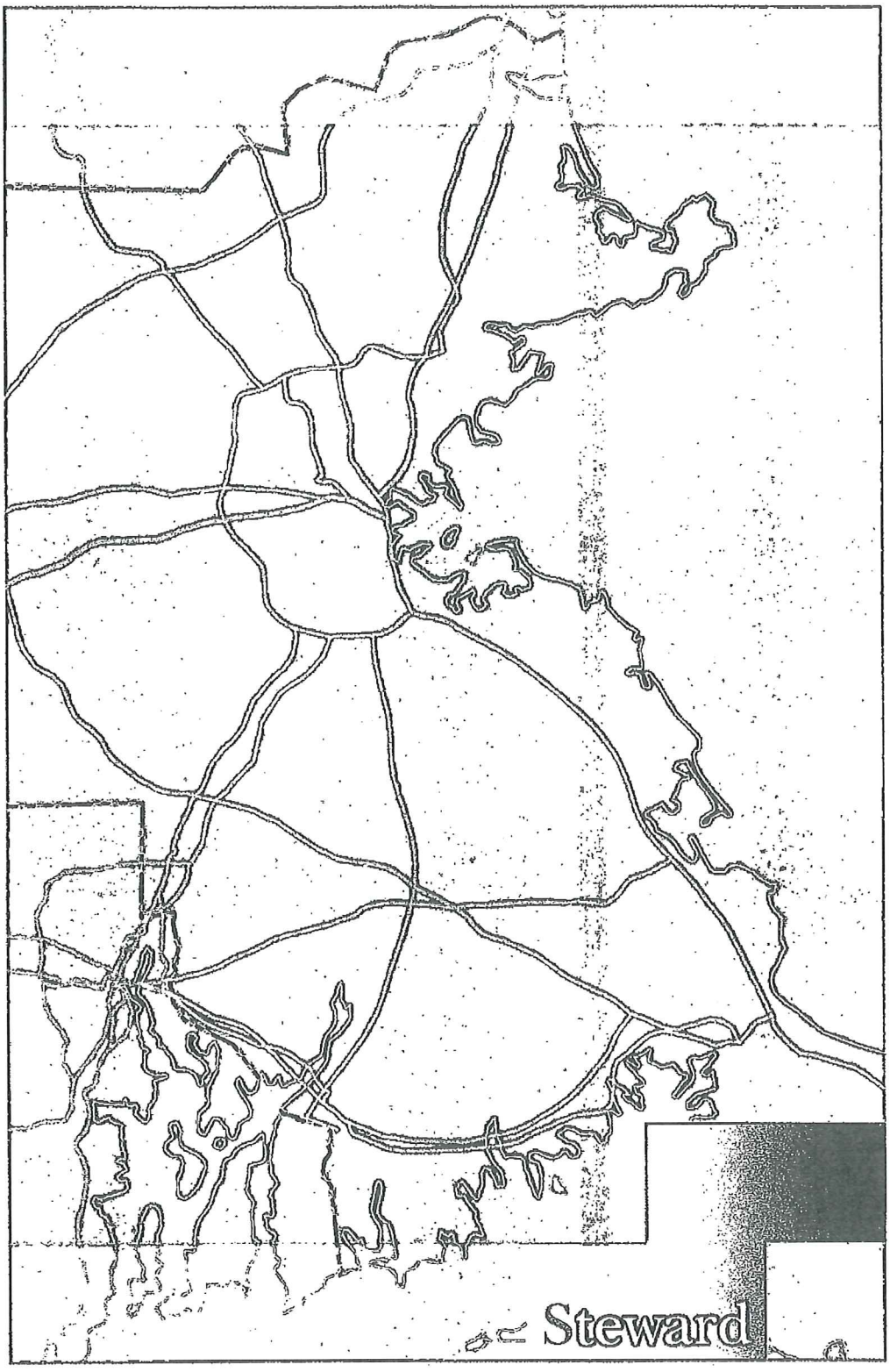
In 2012, Steward Health Care System will pay a total of approximately

$80 million in state and local taxes

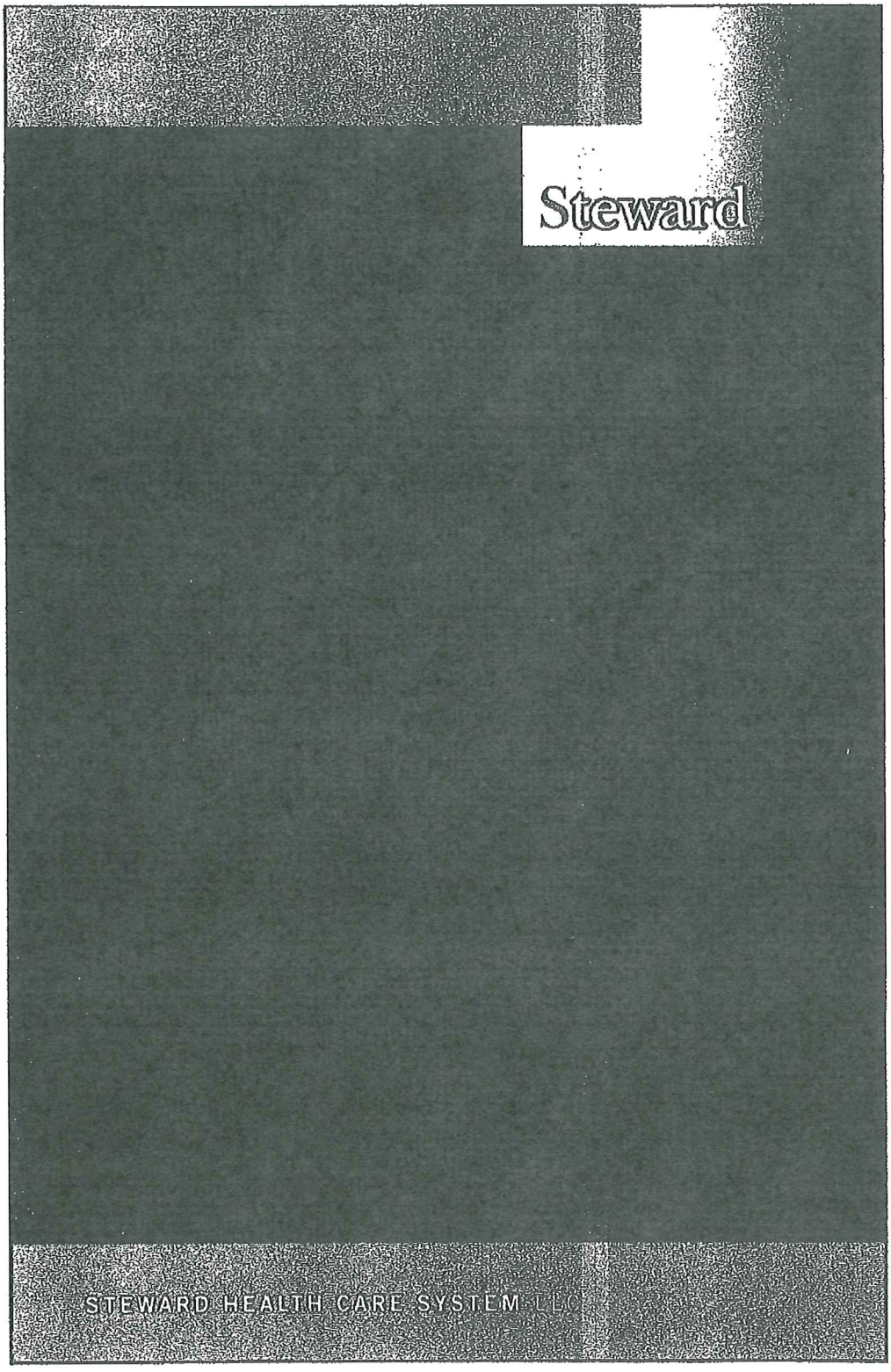
to the communities where we live.

STEWARD HEALTH CARE SYSTEM LLC

LMC 3212



LMC 3213

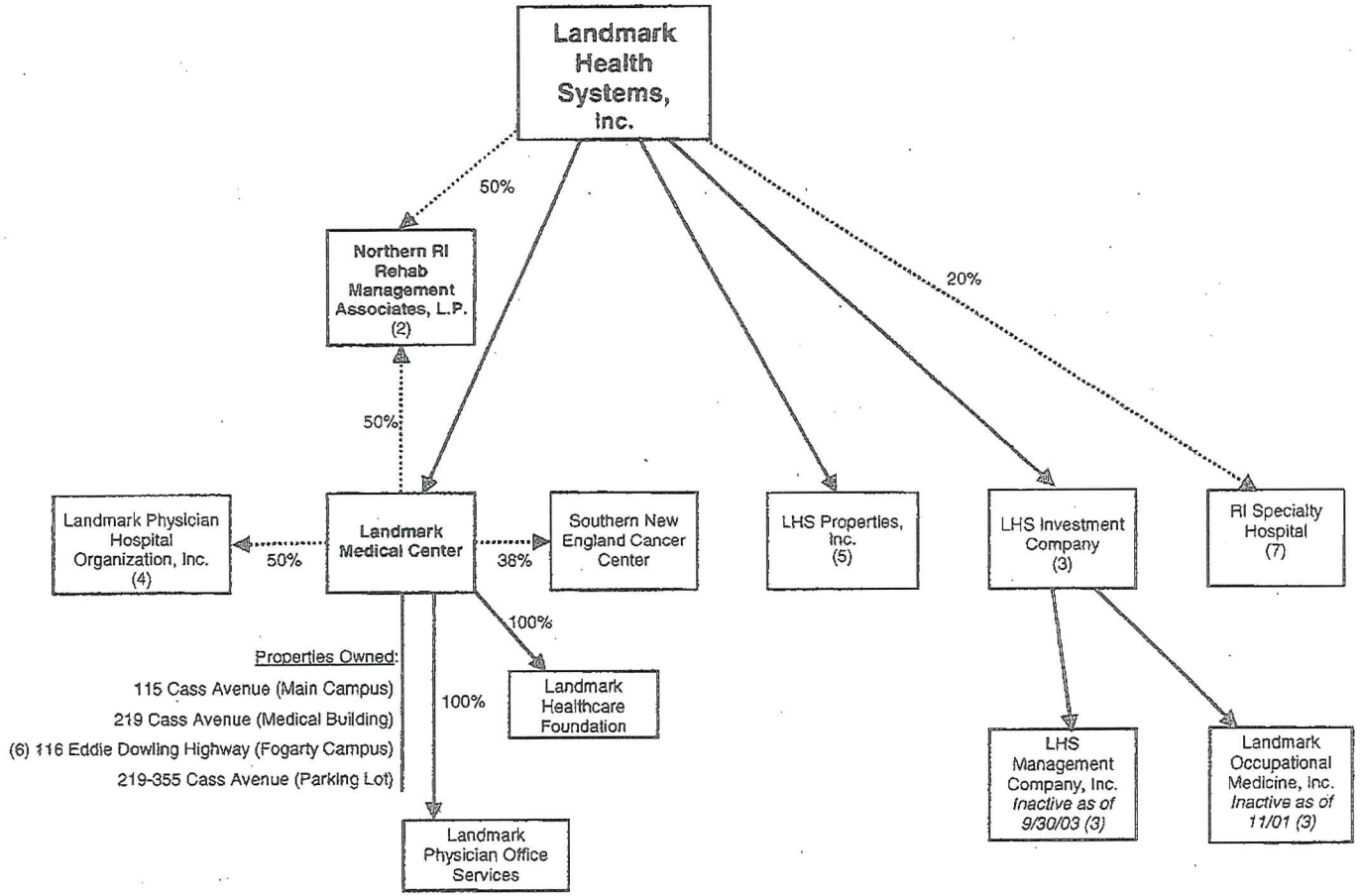


LMC 3214

EXHIBIT 15

LANDMARK HEALTH SYSTEMS ORGANIZATIONAL STRUCTURE

Revised 7-11



LMC 00461

(1) n/a.

(2) DBA Rehabilitation Hospital of Rhode Island (RHRI).

(3) Currently inactive.

(4) Currently inactive.

(5) Currently inactive.

(6) Sold to Medistar.

(7) JV Partner with RehabCare.

Dissolved as of 9/30/02 -- Hospital Plaza Company, Landmark Medical Laboratory, Inc., Para-Med Ambulance Service, Inc.

DESCRIPTION OF COMPANIES & ACTIVITIES

Landmark Health Systems	No operational activity. Overseen by Special Master.
Landmark Medical Center	115 Cass Avenue, Woonsocket RI. Overseen by Special Master. Acute care hospital with inpatient med/surg, critical care, step down unit, psych, LDRP, surgery, stemi/interventional/diagnostic catheterization. Outpatient services include lab, radiology (ultrasound, CT, general radiology), cardiology, diagnostic services, acute emergency room, express care emergency services, interventional radiology. At Fogarty Site (Eddie Dowling Highway in North Smithfield, RI). Acute outpatient services - laboratory, radiology, MRI, occupational medicine. *Owns:* MOB @ 219 Cass Avenue adjacent to hospital. Leased to independent & employed MDs. Houses several LMC Administrative Services departments. *Rents:* Space at 20 Cumberland Hill MOB in Woonsocket for LMC phlebotomy drawing station. CVS Plaza building across from main hospital housing LMC Heart Center - Cardiac Rehab Program, LMC Billing/Business Office, LMC Finance Office, MD Offices. Sold 9-03 to Wellington. Space at Park Square MOB in North Smithfield for OB/GYN Practice.
Southern New England Cancer Center (SNERCC)	Owned jointly by Landmark Medical Center (38%) and Radiation Therapy Services Inc./21st Century Oncology (62%). *Rents:* Space to Landmark for Physician-Based Infusion/Chemotherapy Center.
Landmark Healthcare Foundation	Wholly-owned subsidiary of LMC created 7-1-05 to handle all fundraising activities of LMC. 501 (c) 3 tax-exempt organization.
Northern RI Rehab Partnership	At Fogarty Site (Eddie Dowling Highway in North Smithfield, RI) "Rehabilitation Hospital of RI" acute inpatient rehabilitation services, outpatient therapy services including physical therapy, occupational therapy, pulmonary rehab, stroke rehabilitation. Leases space from Medistar and purchases services from LMC. Managed by Special Master. *Note*: Rick Charest, President of LMC & President & CEO of RHRI. *Rents:* Atwood Therapy @ 1526 Atwood Avenue, Johnston
Landmark PHO	50% JV between LMC & LMC-affiliated primary & specialty MDs. Held risk contracts with Tufts (small # lives) and Blue Cross/Blue Shield of RI BlueChip. Currently inactive.
LHS Properties	Formerly owned MOB @ 106 Nate Whipple Highway, Cumberland RI. Sold late in FY 06. Inactive.
LHS Investment Company	Holding company. Inactive.
LHS Management Company	Formerly employed small # of staff deployed out to MD practices, grants & LMC house officer program. Inactive as of 10/1/04.
Landmark Occup. Medicine.	Inactive. Small amount of remaining A/R being collected so corporation cannot be closed out. Will be dissolved.
Landmark Physician Office Services (LPOS)	Employs small # of MDs + staff deployed to MD practice.

EXHIBIT 17(a)

PRICEWATERHOUSECOOPERS

Landmark Medical Center Community Benefit Analysis

December 2009

Table of Contents

Executive Summary

Landmark Medical Center (LMC, Landmark, or the hospital) is an independent, non-profit 214-bed Medicare certified acute care hospital in the State of Rhode Island. LMC, in conjunction with the Rehabilitation Hospital of Rhode Island (RHRI), where LMC has 50 percent interest, comprise Landmark Health Systems, Inc. (LHS). A general overview of the hospital based on FY09 and recently available market data is a follows:

- Operates 123 acute care and 18 psychiatric beds.
- The Hospital employs over 1,000 individuals.
- Provided care for 7,000 inpatient cases, including newborns, and nearly 75,000 outpatient visits.
- Provided emergency room care to nearly 40,000 patients including approximately 11,000 arriving via ambulance.
- Approximately 88% of its inpatient volume comes from six towns in Rhode Island and three towns in Massachusetts, considered its primary service area (PSA).
- It served nearly 33% of the patients admitted for inpatient acute care in its PSA and a significantly higher percentage for the City of Woonsocket.
- Approximately 100 physicians admit patients to LMC.

In June 2008, LHS was placed under mastership and a Special Master was appointed to oversee the hospital's operations. LMC has faced financial distress over the past few years and as a result has been evaluating what direction the hospital should take to continue to serve its constituents in Woonsocket and surrounding towns as a viable, operating acute care hospital. The most likely scenario was to pursue an affiliation, and after evaluating in-state options, the hospital is currently pursuing an out-of-state affiliation. LMC is looking to satisfy the potential affiliate's request for interim relief of approximately $7 million annually for three years. The relief could take on many forms but has been delineated from the estimated impact of two proposed regulatory payment conditions:

- Maintain current payment levels from Medicaid for three years in comparison to payments under the implementation of the Global Medicaid Waiver, estimated by LMC to be $2 million annually, requiring approval from the Department of Health and Human Services.

- Waive the Hospital License Fee payments for three years, estimated by LMC to be $5 million annually, while still receiving the Disproportionate Share (DSH) payments, requiring legislative approval.

In order to assess an aspect of the business rationale for consideration of these terms, PricewaterhouseCoopers was asked to evaluate and provide a summary of the following:

- Model estimates of the direct, indirect and induced impacts of revenue, employment (jobs and income) and business taxes (primarily sales tax) of LMC on the local region (the six LMC PSA towns in Rhode Island) and on Providence County, using the IMPLAN economic model.

- Commentary on the impact to ambulance services.

The discussion of the analyses that follows provide support that if the state agrees to proposed regulatory payment conditions to solidify the affiliate transaction, those conditions could potentially be less costly to the community and to the state than the impact of LMC closing. It appears that the enclosed analysis demonstrates a potential annual impact of $11M through the loss of business and employee paid taxes, unemployment compensation and increased Medicaid costs.

Our Services were performed and this Report was developed in accordance with our engagement letter dated October 26, 2009 and is subject to the terms and conditions included therein. Our Services were performed in accordance with Standards for Consulting Services established by the American Institute of

Certified Public Accountants ("AICPA"). Accordingly, we are providing no opinion, attestation or other form of assurance with respect to our work and we did not verify or audit any information provided to us.

Our work was limited to the specific procedures and analysis described herein and was based only on the information made available through November 20, 2009. Accordingly, changes in circumstances after this date could affect the findings outlined in this Report. This information has been prepared solely for the use and benefit of, and pursuant to a client relationship exclusively with, the Special Master for Landmark Medical Center. PwC disclaims any contractual or other responsibility to others based on its use and, accordingly, this information may not be relied upon by anyone other than the Special Master for Landmark Medical Center.

Economic Impact Assessment

The health care sector plays a major role in the economy of local communities. It does this by keeping local dollars in the community, attracting some external dollars into the community, attracting other business into the community and providing a key component to promoting a healthy workforce in the community. The "industry tested" economic impact model, IMPLAN, was use to estimate the economic impact of Landmark Medical Center on its community, taking into account all these factors.

The IMPLAN model was developed to help estimate the level at which an activity creates "recycled dollars" for a community, using LMC specific input data and economic statistics from the local region and county. For this exercise, the model generated factors, called "multipliers," using 2007 economic data to quantify the economic impact based on 2008 LMC data, which created output of direct, indirect and induced impacts of a hypothetical LMC closure on the community.

- A *direct* impact results from an increase or decrease in demand for goods and services based directly on the activity modeled (in this case, a hypothetical LMC closure).
- *Indirect* impacts occur when the activity creates (or reduces) secondary demand for goods and services from businesses in the local community (related to the hospital industry, this could be medical supplies vendors).
- *Induced* impacts are proportional to employee household income, where goods and services are consumed in the region where the income is generated, in the form of spending, which in turn stimulates other industries through revenue generation and thereby creates jobs in those industries. Reduction in income (i.e. job loss) could result in reduction of consumption of goods and services in those other industries.

The remainder of this assessment will provide additional detail on the following components of estimated economic impact:

- Landmark Medical Center generates a potential total impact of nearly $189 million in output, or sales and spending.
- This sales and spending activity generates an estimated indirect and induced impact of $4.0 million in indirect business taxes (primarily sales taxes).
- Landmark Medical Center directly employs over 1,000 individuals - 750 of those in Providence County alone and those 750 potentially creates nearly 540 more indirect and induced jobs for a total of nearly 1,300.
- Landmark Medical Center's employment base represents an estimated potential direct labor impact of over $44 million and a combined potential direct, indirect and induced labor income impact of approximately $64 million.

Overall, the results of the IMPLAN analysis estimate that Landmark Medical Center's business and its employees annually create:

- Nearly 1,300 jobs, equating to nearly $64 million in labor income,
- Generate nearly $189 million in revenues and
- Nearly $4.0 million in business taxes to Providence County.
- LMC employees pay nearly $1.8 million in state taxes, approximately $1.3 million from employees in Providence County.
- Additionally, the closure of LMC would likely impact the state as unemployment compensation and the level of Medicaid beneficiaries increase.

Two scenarios were modeled, the impact of LMC on:

- Providence County, and
- The six Rhode Island towns in LMC's PSA.

Each scenario factors in the percentage of LMC employees that reside in either area. The table below highlights the economic impacts of each modeled scenario.

Table 1: Economic Model Impacts

	Impact of LMC on Providence County			
Impact	Direct	Indirect	Induced	Total
Revenue (000s)	$118,600	$37,300	$32,600	$188,500
Employment	750	260	280	1,290
Employee Compensation (000s)	$ 44,900	$ 9,200	$ 9,400	$ 63,500
Indirect Business Taxes (000s)	$ -	$ 1,970	$ 2,010	$ 3,980

	Impact of LMC on 6 RI PSA Towns			
	Direct	Indirect	Induced	Total
Revenue (000s)	$118,600	$ 33,700	$ 22,300	$174,600
Employment	600	230	180	1,010
Employee Compensation (000s)	$ 35,500	$ 8,200	$ 6,000	$ 49,700
Indirect Business Taxes (000s)	$ -	$ 1,510	$ 1,410	$ 2,920

Definition
Direct Impact - impact in demand for goods and services in that industry based directly on the activity modeled.
Indirect Impact - the impacts caused by changes in inter-industry activities.
Induced Impact - the change in household consumption demand generated by the direct and indirect impact.

Source: IMPLAN model.

While unemployment reached close to 12% in the state, Providence County was close to 13% and Woonsocket reached close to 14% (based on nine months of data for 2009). However, the Health Care & Social Assistance sector comprised 19% of the private sector employment in Rhode Island, which was the largest employment sector in the state. It was only one of two sectors to grow in 2008, with hospitals growing 1.8% and LMC ranking 31st of the largest state employers. Closing LMC could impact these growth trends and contribute further to the unemployment statistics. Given the economic condition of the service area and the state, it may be unlikely that all LMC's employees would find re-employment within the healthcare sector, much less other industry sectors, within the region or potentially even within the state.

Furthermore, the Woonsocket population is estimated to remain stable (slight decline of 0.1% overall by 2014), with the largest decline estimated in the 18-44 age cohort. The overall primary service area is expected to grow by 2.0%, and the secondary service area is expected to grow by 1.8%, indicating that overall demand for healthcare services will continue to exist in the service area. The service area also has a high population of uninsured residents (10% in the PSA) - many of those in Woonsocket (19%).

With the hypothetical closing of LMC, these rates could rise as unemployment increases, which could contribute to increased unemployment compensation (on average, unemployment compensation could approximate upwards of $13,000 if an employee receives the benefit for the maximum duration) and the cost of uncompensated care and Medicaid to the state (according to Hospital officials, paid claims for LMC employees and their families exceeded $6.5 million each of the last two years). For every 250 employees that reach full unemployment compensation, the impact would equate to approximately $3.2

million. The level of uninsured will impact the hospitals, while the increase in Medicaid beneficiaries would impact the state's Medicaid budget. Although there is no definitive way to estimate which individuals and respective families would qualify and enroll in Medicaid, if one third of the LMC Providence County employees were not re-employed, the potential impact to Medicaid could be upwards of $2 million cost to the state.

Impact on Ambulance Services

Close to 11,000 rescues were sent to LMC in FY09, with nearly 5,000 serviced by Woonsocket rescue itself (comprised of 17 employees in the Woonsocket Fire Department according to the latest city budget). The current level of staffing and operations of service area rescue departments assumed that LMC would be fully operational and accepting emergency patients. If LMC closes, operational adjustments would likely need to take place to support a shift in transportation routes to other hospitals, which depending on drive times and distances, are further away than LMC is.

Hypothetically, staffing or overtime hours would need to increase to accommodate the change in service area coverage, or, in a worst case situation, rescue staffing or operations would also be cut due to budgetary constraints (which may have already been impacted by the downturn in the economy). However, ambulance services would still need to be covered for LMC's service area. The Woonsocket Fire Chief estimated that the additional operating costs to the Woonsocket's Fire Department alone would be an increase of 33% in fuel costs ($32,000 annually) and a $175,000 replacement cost per vehicle every two years instead of six to seven years, due to the increased depreciation from more "wear and tear."

The following table highlights the driving distances to the nearest hospitals from the six Rhode Island PSA towns.

Table 2: Driving Distances in Miles from Primary Service Area Towns to Area RI Hospitals

PSA RI Towns	Landmark	Rhode Island Hospital	Women & Infants	Miriam	Saint Joseph	Memorial Hospital	Roger Williams	Butler	Kent County Memorial
Woonsocket	1.0	14.3	14.4	12.0	12.6	11.7	12.2	14.8	24.5
Burrillville	10.1	22.3	18.6	17.5	15.2	18.0	16.6	22.5	27.1
Cumberland	4.2	10.7	10.9	8.1	10.4	6.9	9.0	11.2	24.2
Glocester	12.2	18.3	15.8	15.5	12.0	16.4	14.0	18.5	23.1
Lincoln	7.1	8.4	7.2	4.7	6.6	4.5	5.2	7.5	18.2
North Smithfield	3.8	16.4	13.0	11.1	10.5	11.2	10.8	16.1	21.6

Source: googlemaps.com

Summary

LMC is looking to satisfy the potential affiliate's request for interim relief of $7 million annually for three years which could amount to the state granting two regulatory payment conditions:

- Maintain current payment levels from Medicaid for three years in comparison to payments under the implementation of the Global Medicaid Waiver, estimated by LMC to be $2 million annually, requiring approval from the Department of Health and Human Services.

- Waive the Hospital License Fee payments for three years, estimated by LMC to be $5 million annually, while still receiving the Disproportionate Share (DSH) payments, requiring legislative approval.

To assess an aspect of the business rationale for consideration of these conditions, PricewaterhouseCoopers was asked to evaluate and provide a summary of the following:

- Model estimates of the direct, indirect and induced impacts of revenue, employment (jobs and income) and business taxes (primarily sales tax) of LMC on the local region (the six LMC PSA towns in Rhode Island) and on Providence County, using the IMPLAN economic model.

- Commentary on the impact to ambulance services.

What is the hypothetical economic impact of an LMC closure to the state and local community? The output of the IMPLAN economic model indicated that a hypothetical LMC closure could cost the local region. Ranges reflect the six Rhode Island towns in the PSA versus Providence County.

- Nearly 1,000 and 1,300 jobs, respectively,
- Generate $175 million and $189 million, respectively, in direct, indirect and imputed revenue,
- Amounting to approximately $50 million and $64 million in compensation, respectively,
- Approximately $2.9 million and $4.0 million, respectively, in indirect business taxes.
- LMC employees pay nearly $1.8 million in state taxes, approximately $1.3 million from employees in Providence County.
- Additionally, the closure of LMC would likely impact the state as unemployment compensation and the level of Medicaid beneficiaries increase.

The analyses provide support that if the state agrees to proposed regulatory payment conditions to solidify the affiliate transaction; those conditions could potentially be less costly to the community and to the state than the impact of LMC closing. Furthermore, it is also uncertain what the impact would be on the overall healthcare system, where LMC provides acute care, psychiatric, rehabilitation and emergency services, and including impact to ambulance services, other hospitals and the health of the service area.

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Introduction

Landmark Medical Center (LMC, Landmark or the hospital) is an independent, non-profit 214-bed Medicare certified acute care hospital in the State of Rhode Island. LMC, in conjunction with the Rehabilitation Hospital of Rhode Island (RHRI), where LMC has 50 percent interest, comprise Landmark Health Systems, Inc. (LHS). A general overview of the hospital based on FY09 and recently available market data is a follows:

- Operates 123 acute care and 18 psychiatric beds.
- The Hospital employs over 1,000 individuals.
- Provided care for 7,000 inpatient cases, including newborns, and nearly 75,000 outpatient visits.
- Provided emergency room care to nearly 40,000 patients including approximately 11,000 arriving via ambulance.
- Approximately 88% of its inpatient volume comes from six towns in Rhode Island and three towns in Massachusetts, considered its primary service area (PSA).
- It served nearly 33% of the patients admitted for inpatient acute care in its PSA and a significantly higher percentage for the City of Woonsocket.
- Approximately 100 physicians admit patients to LMC.

In July 2008, LHS was placed under mastership and a Special Master was appointed to oversee the hospital's operations.

The purpose of this document is to assess the value proposition outlining the potential benefits to the State of Rhode Island, its health insurers and LMC's employees and local community of remaining a viable, operational hospital. Community demographic, hospital and state economic profiles were prepared in this paper as part of a foundation to qualitatively define the hypothetical impact of closing LMC. An "industry tested" economic model was used to help quantitatively define the hypothetical economic impact of an LMC closure.

Given the financial condition of LMC, various affiliate options were explored, leading to pursuit of the latest option. The paper will address the community profile of LMC's service area, summarize LMC's current financial and operational situation and highlight the healthcare environment in the state to help answer the question: What is the hypothetical economic impact of an LMC closure to the state and local community?

Affiliate Pursuits

Given LMC's operating and financial situation and the healthcare climate in Rhode Island, LMC has encountered difficulties in finding an affiliate solution within the state. Even before LMC entered into mastership, hospital leadership had been involved in various pursuits to create an affiliation that would maintain LMC as a viable and operational hospital. LMC had explored the option of keeping cardiac surgery services as an incentive for an affiliate, but financially, leadership determined that volumes were not sufficient to warrant continuation of the cardiac surgery program, which ended in May 2008. LMC had also felt strongly, and vetted the concept with key constituents, that the community needed an acute care hospital in the service area. Therefore an "emergency room only" or "outpatient only" facility was not pursued as a viable alternative. LMC then explored options to change its Medicare hospital designation for the purposes of changes in reimbursement associated with operating at lower bed capacity. After review of criteria for designation as a Critical Access Hospital, a Sole Community Hospital or a Medicare Dependent Hospital, LMC did not appear eligible and no longer pursued those designations.

LMC was unable to find an in-state partner who was fiscally sound, who was interested in an affiliation and who would provide a strategic complement to LMC's services as an acute care hospital. Therefore, LMC is currently pursing an out of state affiliate that appears to align with its mission and strategy. As part of the due diligence process, the potential affiliate is seeking $7 million annually in relief for three years. The relief could take on many forms but has been delineated from the estimated impact of two proposed regulatory payment conditions:

- Maintain current payment levels from Medicaid for three years in comparison to payments under the implementation of the Global Medicaid Waiver, estimated by LMC to be $2 million annually (Table 4 shows a calculated $2.2 million impact to LMC), requiring approval from the Department of Health and Human Services.
- Allow LMC to forgo Hospital License Fee payments, estimated by LMC to be $5 million annually, for three years, but still receive Disproportionate Share (DSH) payments (Table 5 shows an estimated FY10 License Fee of $5.4 million), requiring legislative approval.

The community profile of LMC's service area, coupled with direct, indirect and induced contributions that LMC continues to make, indicate that the community could be negatively impacted by LMC's closure. The quantitative benefits of LMC are modeled using a recognized modeling methodology called IMPLAN, which provides output estimating the economic impact of an entity on the community. The impact to ambulance services are also discussed, along with potential changes to other hospitals' capacities.

The analyses provide support that even if the state agrees to regulatory payment conditions to solidify the affiliate transaction; those conditions could potentially be less costly to the community and to the state than the impact of LMC closing. Furthermore, it is also uncertain what the impacts would be on the overall healthcare system, where LMC provides acute care, psychiatric, rehabilitation and emergency services, and including impact to ambulance services, other hospitals and the health of the service area.

Impact of Global Medicaid Waiver

Faced with budget deficits, in January 2009 the State of Rhode Island submitted a proposal to CMS (Centers for Medicare & Medicaid Services) to operate its Medicaid program under a "global cap" for five years through a demonstration project called the Global Medicaid Waiver (CMS approved as Global Section 1115 Waiver). The state will receive $12.1 billion from the federal government in the form of an annual block grant to operate Medicaid, instead of receiving a traditional federal match (federal matching assistance percentage - FMAP) for dollars spent by the state. In return, while the state assumes the costs that exceed the federal funds, Rhode Island has the flexibility to design benefits and manage the program outside of traditional regulations. The changes are expected to save the state $67 million. [1] The goals of the Waiver are to "rebalance the long-term care system by replacing institutional level of care criteria with needs-based level of care criteria; better manage care by mandating enrollment in a managed care plan and establishing Healthy Choice Accounts to encourage wellness and prevention behavior; and completing the transition from payor to purchaser through reimbursement changes and enhancing competition for services." [2] [3] According to an external study prepared by the Center on Budget and Policy Priorities, the Medicaid Waiver would "end the federal funding guarantee, restrict state funding and eliminate federal protections for beneficiaries." The study estimated that based on the state's submitted budget, the federal government would end up spending 64% of Rhode Island's Medicaid costs, higher than the existing federal match of 52.5%. The state's Medicaid spending is further capped to a percentage of the state's budget, which could imply that if expenses grow higher than projected, the state would reduce benefits. [4]

The Rhode Island Department of Health provided estimates of the Waiver reimbursement changes by hospital. Inpatient reimbursement changes were modeled to be "breakeven" for the state based on moving reimbursement to All Patient Refined Diagnosis Related Groups (APR-DRGs), and outpatient services were modeled to be reimbursed based on the Ambulatory Payment Classifications (APC) Fee Schedule at 100% of Medicare rates. Based on the simulated inpatient analysis, only seven hospitals (Butler, Kent, Miriam, Rhode Island, Roger Williams, South County and Westerly) will receive an estimated increase in Medicaid inpatient payments, at the "expense" of the other hospitals (resulting in the overall "breakeven" impact). Based on the six-month simulated outpatient analysis, all but two hospitals (Miriam and Roger Williams) are expected to be impacted negatively by the outpatient changes, resulting in an overall decline of 14% in estimated Medicaid outpatient payments. [5] [6]

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[1] "Providence Market Overview", March 2009: HealthLeaders-InterStudy
[2] "Rhode Island Medicaid Reform", Joint House & Senate Finance Committee Meeting document, August 5, 2008. RI Executive Office of Health and Human Services
[3] "Global Waiver Implementation Update to External Task Force", July 14, 2009. RI Executive Office of Health and Human Services
[4] "Rhode Island's Medicaid Proposal Would Put Beneficiaries at Risk and Undermine the Federal-State Partnership", September 4, 2008. Judith Solomon, Center on Budget and Policy Priorities
[5] Inpatient calculations based on figures prepared by Affiliated Computer Services, Inc (ACS) on behalf of the RI Dept of Health
[6] "An APC Fee Schedule for Medicaid - Presentation to Rhode Island Hospitals", September 9, 2009. Affiliated Computer Services, Inc. (ACS)

The following table shows the calculated reimbursement impact of the Waiver on LMC for Medicaid inpatient and outpatient services, estimated to be an overall reduction of 22%, or $2.2 million annually, in Medicaid payments.

Table 4: Calculated Impact of Global Medicaid Waiver

	Inpatient				Outpatient*		Total Impact	
Facility	Baseline Pay to Cost	Simulated Pay to Cost	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Landmark	153%	135%	(738,000)	-12%	(1,450,000)	-39%	(2,188,000)	-22%

Sources:

Inpatient: based on figures prepared by Affiliated Computer Services, Inc (ACS) on behalf of the RI Dept of Health; FY08 data.
Outpatient: "An APC Fee Schedule for Medicaid Presentation to Rhode Island Hospitals September 9, 2009." Affiliated Computer Services, Inc. (ACS); April - Sept 08 data.
** Outpatient estimates were provided for half the year and therefore annualized.*

Disproportionate Share Discussion

Recognizing the declining financial health of the state's hospitals, amended FY09 and FY10 budgets were passed with increased disproportionate share (DSH) and Medicaid upper limit (UPL) funding to hospitals. All hospitals in Rhode Island are required to pay into the DSH fund in the form of a Hospital License Fee, calculated as a percentage of net patient service revenue, and in return those funds are distributed to hospitals based on eligible reimbursable DSH costs. According to calculations provided by the Hospital Association of Rhode Island (HARI), the estimated budget amendments will result in the following payments to LMC:

Table 5: FY09 and FY10 LMC DSH Payments (Dollars in Thousands - 000s)

	House Approved Model	
	FY09	FY10
License Fee *	$ (5,700)	$ (5,400)
Reimbursable DSH Costs	6,900	6,500
Net DSH Payment	**$ 1,200**	**$ 1,100**

Source: Edward Quinlan, HARI, June 25, 2009.
** Estimated. FY09 rate = 5.473% and FY10 rate = 5.237% of NPSR.*

Economic Impact Analysis

The hospital industry is part of the largest sector of employment for the State of Rhode Island. There have been numerous analyses of the economic impact of hospitals on the community; some of the methodology will be incorporated in this paper to help quantify LMC's contribution to its service area and the state.

Economic Impact Model

An "industry tested" model was used to quantify the economic impact of LMC on the community, based on LMC specific input data and economic statistics from the local region. The specific model used for this study, developed by the Minnesota IMPLAN Group, Inc., is used nationwide for economic impact studies. IMPLAN, which refers to IMpact analysis for PLANning, utilizes a computer program to adapt national input-output tables to county and state tables, thereby allowing for impact estimates to be generated at the local level. The data comes from the system of national accounts for the United States based on data collected by the U.S. Department of Commerce, the U.S. Bureau of Labor Statistics, and other federal and state government agencies. "The IMPLAN database contains county, state, zip code, and federal economic statistics which are specialized by region, not estimated from national averages and can be used to measure the effect on a regional or local economy of a given change or event in the economy's activity." [7] [8]

The IMPLAN model was developed to help estimate the level at which an activity creates "recycled dollars" for a community. For this exercise, the model generated factors, called "multipliers," that created output of direct, indirect and induced impacts of a hypothetical LMC closure on the community.

- A *direct* impact results from an increase or decrease in demand for goods and services based directly on the activity modeled (in this case, a hypothetical LMC closure).
- *Indirect* impacts occur when the activity creates (or reduces) secondary demand for goods and services from businesses in the local community (related to the hospital industry, this could be medical supplies vendors).
- *Induced* impacts are proportional to employee household income, where goods and services are consumed in the region where the income is generated, in the form of spending, which in turn stimulates other industries through revenue generation and thereby creates jobs in those industries. Reduction in income (i.e. job loss) could result in reduction of consumption of goods and services in those other industries. [9]

For LMC's economic model, two scenarios were modeled.

- For the first, the local region was defined as the Rhode Island towns in LMC's primary service area (Woonsocket, Burrillville, Cumberland, Glocester, Lincoln and North Smithfield).
- For the second, the economic impact was modeled for Providence County, where all of the Rhode Island LMC service area towns are located.

The economic activities outlined here will affect the economies of other towns and counties in the state and even in other states, but the focus of this analysis is only the hypothetical impact to the six Rhode Island towns and to Providence County. The model helps quantify the potential economic impact as a result of the change in the region's employment using LMC's specific data.

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[7] www.IMPLAN.com
[8] Pearce, David (1989). Modern Economics, Third Edition. pg 189: The Mackmillian Press LTD. (en.wikipedia.org)
[9] "Economic Impact of the New Reid Hospital", a report prepared by Jerry N. Conover, Director and Vincent B. Thompson, Economic Research Analyst, Indiana Business Research Center at the Indiana University Kelley School of Business, February 2006. www.ibrc.indiana.edu

The IMPLAN model creates factors to extrapolate the hypothetical economic impact of an LMC closure. For example, a 1.5 factor, or "multiplier," could indicate that every one dollar lost in the region could result in another .50 dollars lost, and every one job lost could result in another .50 jobs lost. For the Providence County impact, the model suggests that a hypothetical LMC closure could cost the county close to $189 million in revenue and sales, approximately 1,300 jobs worth close to $64 million in compensation and about $4.0 million in indirect business taxes. The model output suggests that a hypothetical LMC closure could cost the local region (six Rhode Island PSA towns) $175 million in sales and revenue, 1,000 jobs worth close to $50 million in compensation, and approximately $2.9 million in indirect business taxes. The table below summarizes the IMPLAN model outputs.

Table 6: Economic Model Impacts

	Impact of LMC on Providence County				Impact of LMC on 6 RI PSA Towns			
Impact	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total
Revenue (000s)	$ 118,600	$ 37,300	$ 32,600	$ 188,500	$ 118,600	$ 33,700	$ 22,300	$ 174,600
Employment	750	260	280	1,290	600	230	180	1,010
Employee Compensation (000s)	$ 44,900	$ 9,200	$ 9,400	$ 63,500	$ 35,500	$ 8,200	$ 6,000	$ 49,700
Indirect Business Taxes (000s)	$ -	$ 1,970	$ 2,010	$ 3,980	$ -	$ 1,510	$ 1,410	$ 2,920

Definition
Direct Impact - impact in demand for goods and services in that industry based directly on the activity modeled.
Indirect Impact - the impacts caused by changes in inter-industry activities.
Induced Impact - the change in household consumption demand generated by the direct and indirect impact.

Source: IMPLAN model.

Assumptions

The most recent data available for IMPLAN is 2007 data. Preset deflators in the model were applied to adjust 2007 data to a 2008 dollar value. The FY08 LMC financial data was used as the model base, shown in the next table, and adjusted for region specific and county modeling. Approximately 58% of LMC's employees, or 600 employees, reside within the six Rhode Island towns, and the remainder was not incorporated, considered "leakage" in terms of household spending within the local community (the induced impact) for the first scenario. About 73% of LMC's employees, or 750 employees, reside within Providence County, and the remainder was considered leakage for the second scenario. The IMPLAN data has built in economic factors specific to the region and county that are correlations between "industry output" generated in the region (defined in this case as patient care revenue) and supplier demand for goods and services (which is the indirect impact). Therefore, all of patient care revenue was modeled to let the dollars flow using the region's specific economic statistics. For the purposes of this exercise, the impacts of two scenarios were evaluated:

1. All LMC employees will leave the county or no longer be employed, i.e. a 100% employment decrease to Providence County
2. All LMC employees will leave the region or no longer be employed, i.e. a 100% employment decrease to the six Rhode Island PSA towns

Table 7: IMPLAN Input Assumptions and Scenarios (Dollars in Thousands - 000s)

		Scenarios	
Assumptions/Inputs	Base Data	County *	6 RI PSA **
Employee Compensation (Salary + Benefits)	$ 61,200	$ 44,900	$ 35,500
Employment (head count)	1,025	750	600
Industry Output (Patient Care Revenue)	$ 118,600	$ 118,600	$ 118,600
* *% LMC Employees living in Providence County:*	*73%*		
** *% LMC Employees living in 6 RI PSA Towns:*	*58%*		

Output

The IMPLAN model has four outputs from the assumptions: direct, indirect and induced impact on the region, quantified in revenue, employment, employee compensation and indirect business taxes. The results of the model are discussed below.

Impact on the economy in dollars

Scenario 1 models the hypothetical impact of all 750 LMC employees who live in Providence County leave, either through finding jobs outside the county or not being re-employed at all. In addition to the direct economic impact of the county potentially losing all the hospital's patient care revenue of approximately $119 million, LMC's closure could also cause indirect and induced impacts on the local economy. Indirect impact, which represents the impact caused by the changes in inter-industry activities, could be approximately $37 million. The direct and indirect impacts could create changes in household consumption demand, i.e. induced impacts, which could result in a negative impact of $33 million. Therefore, the total economic impact of 100% LMC employee loss to the county could reach $189 million, as projected by the IMPLAN model.

Scenario 2 models the hypothetical impact of all 600 LMC employees who live in the six Rhode Island PSA towns, leaving the region, either through finding jobs outside the region or not being re-employed at all. In addition to the direct economic impact of the region potentially losing all the hospital's patient care revenue of approximately $119 million, LMC's potential closure could also create an indirect impact of approximately $34 million. The induced effect could result in a negative impact of $22 million. Therefore, the total economic impact of 100% LMC employee loss to the region could reach $175 million in revenue and sales, as projected by the IMPLAN model.

Some industries will be affected more than others, according to the IMPLAN output. For instance, the economic impact on the real estate industry could be close to $12 million if all 750 jobs in the county are lost. The table below lists the industries which could experience the largest negative economic impact.

Table 8: LMC Impact by Scenario in Revenue and Sales (Dollars in Thousands - 000s)

Industry	Impact of LMC on Providence County					Impact of LMC on 6 RI PSA Towns				
	Direct	Indirect	Induced	Multiplier	Total	Direct	Indirect	Induced	Multiplier	Total
Doctor hospitals	$ 118,600	$ -	$ 800		$ 119,400	$ 118,600	$ 100	$ 1,000		$ 119,700
Real estate	-	9,900	1,900		11,800	-	6,600	900		7,500
Pharmaceutical preparation manufacturing	-	-	-		-	-	3,600	400		4,000
Imputed rental value for owner-occupied dwellings	-	-	4,900		4,900	-	-	3,900		3,900
Insurance carriers	-	1,800	1,200		3,000	-	1,700	900		2,600
Medical and diagnostic labs and outpatient and other ambulatory care services	-	2,100	600		2,700	-	2,100	400		2,500
Food services and drinking places	-	800	2,000		2,800	-	900	1,500		2,400
Wholesale trade	-	1,200	1,300		2,500	-	1,300	1,000		2,300
Offices of physicians, dentists, and other health practitioners	-	-	2,300		2,300	-	-	1,800		1,800
Veterinary services	-	2,000	-		2,000	-	2,000	-		2,000
Other Industries	-	16,700	18,100		37,800	-	16,600	10,800		26,400
Total	$ 118,600	$ 37,300	$ 32,600	1.59	$ 188,500	$ 118,600	$ 33,700	$ 22,300	1.47	$ 174,600

Definitions

Direct Impact - Impact in demand for goods and services in that industry based directly on the activity modeled.

Indirect Impact - the impacts caused by changes in inter-industry activities.

Induced Impact - the change in household consumption demand generated by the direct and indirect impact.

Source: IMPLAN model.

Impact on employment and payroll income

For Scenario 1 where there could be 750 LMC employees leaving the county, the indirect impact to other industries could cost approximately 260 jobs, and the induced impact could be a reduction of approximately 280 jobs. Therefore, the total economic impact to the region could be close to 1,300 jobs lost, as projected by the IMPLAN model. This equated to approximately $64 million in compensation.

For Scenario 2, if LMC's 600 employee workforce leaves the region, the total impact could be approximately 1,010 jobs, of which, the impacts could be 230 indirect jobs and 180 induced jobs. This equated to $50 million in compensation.

The next two tables list the industries that would hypothetically face the most negative economic impact in terms of jobs lost and in terms of employee compensation lost.

Table 9: LMC Impact by Scenario in Employment

Industry	Impact of LMC on Providence County					Impact of LMC on 5 RI PSA Towns				
	Direct	Indirect	Induced	Multiplier	Total	Direct	Indirect	Induced	Multiplier	Total
Private hospitals	750	-	-		750	600	-	10		610
Real estate	-	70	10		80	-	50	10		60
Food services and drinking places	-	10	40		50	-	10	30		40
Veterinary services	-	30	-		30	-	30	-		30
Offices of physicians, dentists, and other health practitioners	-	-	20		20	-	-	10		10
Medical and diagnostic labs and outpatient and other ambulatory care services	-	20	-		20	-	20	-		20
Environmental services	-	20	-		20	-	10	-		10
Wholesale trade	-	10	10		20	-	10	10		20
Retail - Food and beverage	-	-	10		10	-	-	10		10
Other Industries	-	100	190		290	-	100	100		200
Total	750	260	280	1.72	1,290	600	230	180	1.68	1,010

Definitions

Direct Impact - Impact in demand for goods and services in that industry based directly on the activity modeled.

Indirect Impact - the impacts caused by changes in inter-industry activities.

Induced Impact - the change in household consumption demand generated by the direct and indirect impact.

Source: IMPLAN model.

Table 10: LMC Impact by Scenario in Employee Compensation (Dollars in Thousands - 000s)

Industry	Impact of LMC on Providence County					Impact of LMC on 6 RI PSA Towns				
	Direct	Indirect	Induced	Multiplier	Total	Direct	Indirect	Induced	Multiplier	Total
Private hospitals	$ 44,900	$ -	$ 100		$ 45,000	$ 35,500	$ -	$ -		$ 35,500
Offices of physicians, dentists, and other health practitioners	-	-	1,200		1,200	-	-	-		-
Real estate	-	600	200		1,100	-	600	600		1,200
Medical and diagnostic labs and outpatient and other ambulatory care services	-	700	200		900	-	700	700		1,400
Food services and drinking places	-	200	700		900	-	200	200		400
Wholesale trade	-	400	400		800	-	400	400		800
Securities, commodity contracts, investments, and related activities	-	400	400		800	-	200	200		400
Insurance carriers	-	400	300		700	-	400	400		800
Management of companies and enterprises	-	600	100		700	-	600	600		1,200
Other Industries	-	5,600	5,800		11,400	-	5,100	2,900		8,000
Total	$ 44,900	$ 9,200	$ 9,400	1.41	$ 63,500	$ 35,500	$ 8,200	$ 6,000	1.40	$ 49,700

Definitions

Direct Impact - Impact in demand for goods and services in that industry based directly on the activity modeled.

Indirect Impact - the impacts caused by changes in inter-industry activities.

Induced Impact - the change in household consumption demand generated by the direct and indirect impact.

Source: IMPLAN model.

Impact on indirect business taxes

The IMPLAN model measures the change in sales taxes, excise taxes, property taxes, etc., paid by businesses. For Scenario 1, the county could potentially lose $4.0 million in indirect business taxes. If LMC loses all the jobs in the PSA Rhode Island towns, the indirect business tax implication could be approximately $2.9 million. The next table lists by industry the potential direct, indirect and induced indirect business taxes impact of a hypothetical LMC closure on the county or the region.

Table 11: LMC Impact by Scenario in Indirect Business Taxes (Dollars in Thousands - 000s)

Industry	Impact of LMC on Providence County				Impact of LMC on 6 RI PSA Towns			
	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total
Real estate	$ -	$ (1,230)	$ (240)	$ (1,470)	$ -	$ (800)	$ (100)	$ (900)
Imputed rental value for owner-occupied dwellings	-	-	540	540	-	-	400	400
Wholesale trade		(60)	(60)	(360)		(200)	(100)	(300)
Electric power generation, transmission, and distribution	-	90	50	140	-	100	-	100
Food services and drinking places		30	(110)	(140)		-	(100)	(100)
Insurance carriers	-	70	50	120	-	100	-	100
Retail - Food and beverage		10	(130)	(120)		-	(60)	(60)
Telecommunications	-	50	50	100	-	-	-	-
Retail - Motor vehicle and parts		10	(90)	(100)		-	(100)	(100)
Other Industries	-	300	590	890	-	310	510	820
Total	$ -	$ 1,970	$ 2,010	$ 3,980	$ -	$ 1,610	$ 1,410	$ 2,920

Definitions

Direct Impact - Impact in demand for goods and services in that industry based directly on the activity modeled.
Indirect Impact - the impacts caused by changes in inter-industry activities.
Induced Impact - the change in household consumption demand generated by the direct and indirect impact.

Source: IMPLAN model.

Ambulance Impact

For LMC, most ambulance rescues arriving to the hospital are handled by town fire departments' rescue groups. Over 11,000 rescues went to LMC in FY09 and the number of rescues increased annually from FY06 and FY09. Forty-seven percent (47%) of the rescues were serviced by Woonsocket Rescue; this volume represented an increase of over 900 people between FY06 and FY09. Thirty-three percent (33%) of rescues were handled by the rescue departments in the surrounding PSA towns.

Table 12: LMC Rescue Arrivals

Rescue Method	Number of Transports FY06	FY07	FY08	FY09	Average	Percent Total	FY06-FY09 Change
Woonsocket Rescue	4,617	4,710	5,152	5,555	5,009	47%	938
PSA Rescue	3,638	3,523	3,442	3,564	3,542	33%	(74)
SSA Rescue	51	51	52	39	48	0%	(12)
Other Rescue	220	216	277	310	256	2%	90
Police Dept	238	245	224	235	236	2%	(3)
Private	1,658	1,864	1,610	1,545	1,669	16%	(113)
Total	**10,422**	**10,609**	**10,757**	**11,248**	**10,759**	**100%**	**826**

Source: LMC Physician Hospital Organization internal Rescue Arrival Reports, 2005-2009.

According to the Woonsocket Fire Chief, 96% of their total FY09 rescues went to LMC. Woonsocket Rescue is comprised of 17 employees in the Woonsocket Fire Department, according to Woonsocket's proposed budget for FY10. These employees represent approximately $900,000 in salaries (not including extra compensation or benefits), or approximately $53,000 per employee.

Table 13: Woonsocket Rescue Staffing Budget

Fire Dept Rescue	# People	Salary *	$ Per Person *
EMS Coordinator	1	$ 58,252	$ 58,252
Rescue Drivers	8	406,030	50,754
Rescue Captains	2	116,504	58,252
Rescue Lieutenants	6	323,729	53,955
Total	**17**	**$ 904,515**	**$ 53,207**

Source: "Forward Woonsocket: 'A City on the Move.' Proposed Municipal Budget Plan 2009-2010," submitted May 27, 2009 by Mayor Menard.

** Does not include Extra Compensation (e.g. overtime, holiday, sick leave) or Benefits*

The current level of staffing for Woonsocket Rescue assumed that LMC would be fully operational and accepting emergency patients. While it is unclear what the minimum staffing model is required to service rescues in the area, operational adjustments will need to take place for both Woonsocket Rescue and rescue squads in surrounding towns to support a shift in transportation routes to other hospitals if LMC closes. Hypothetically, staffing or overtime hours would need to increase to accommodate coverage, increasing costs to Woonsocket and neighboring towns and increasing the transportation time to the emergency room if the LMC option was not available. Additionally, it is unclear whether other hospital emergency rooms could accommodate the increased volume from LMC.

Driving distances to the next nearest hospital for the PSA towns in Rhode Island are as follows:

Table 14: Driving Distances in Miles from Primary Service Area Towns to Area RI Hospitals

PSA RI Towns	Landmark	Rhode Island Hospital	Women & Infants	Miriam	Saint Joseph	Memorial Hospital	Roger Williams	Butler	Kent County Memorial
Woonsocket	1.0	14.3	14.4	12.0	12.6	11.7	12.2	14.8	24.5
Burrillville	10.1	22.3	18.6	17.5	15.2	18.0	16.6	22.5	27.1
Cumberland	4.2	10.7	10.9	8.1	10.4	6.9	9.0	11.2	24.2
Glocester	12.2	18.3	15.8	15.5	12.0	16.4	14.0	18.5	23.1
Lincoln	7.1	8.4	7.2	4.7	6.6	4.5	5.2	7.5	18.2
North Smithfield	3.8	16.4	13.0	11.1	10.5	11.2	10.8	16.1	21.6

Source: googlemaps.com

When asked to comment on a hypothetical LMC closure, the Woonsocket Fire Chief stated: "The alternative to a local facility is Providence based, and that would result in significantly extended transport distances and out of service times. These factors would increase the response burden to the surrounding communities to provide mutual aid EMS responses into Woonsocket which would eliminate all EMS coverage in those communities. This situation would create a domino effect, our community would have a delayed response from surrounding units and those communities would need to extend into there mutual aid communities, there by delaying their EMS response. Emergency Medical Service would become Delayed Medical Service; not the model of efficiency for our profession or the needs of the communities involved." He estimated that the additional operating costs to the Woonsocket's Fire Department alone would be an increase of 33% in fuel costs ($32,000 annually) and a $175,000 replacement cost per vehicle every two years instead of six to seven years, due to the increased depreciation from more "wear and tear." [10]

[10] Letter to Richard Charest, President, LMC, from Chief Gary Lataille, Woonsocket Fire Department, November 3, 2009

Discussion of Acute Care Hospital Activity in Rhode Island

Hypothetically, if LMC does close, a concern is whether the nearest hospitals in Rhode Island even have existing capacity to absorb LMC's volume. Rhode Island Hospital, the hospital with the second largest service area market share (after LMC), had a calculated 82% bed occupancy percentage in FY08. Miriam Hospital, who has seen the largest market share growth in the service area between FY06 and FY08, had a calculated occupancy percentage of 83%. This is based on staffed, operating and available beds, which is less than the number of Medicare certified beds. Putting more beds in operation could require hospitals to ramp up staffing levels. The New York Department of Health estimated that the ideal occupancy levels for hospitals were "80-85% for acute care medical/surgical beds and 65-70% for acute care pediatric beds, according to its report, 'Acute Care Bed Need Methodology Background for the Derivation of 1996 Adult and Pediatric Bed Need'". [11] [12] The table shows the calculated occupancy percentage for each of the area hospitals compared to the state, New England and national rates.

Table 15: FY08 Calculated Hospital Occupancy Percentages

						Emergency Visits	
Hospital	Patient Days *	Operating Beds **	ADC	Occ %	Medicare Certified Beds	Admitted	Released
Landmark	37,016	141	101	72%	214	14,400	7,900
Rhode Island Hospital	180,258	605	494	82%	719	40,500	29,600
Women & Infants ***	73,438	197	201	102%	137	6,800	4,500
Miriam	74,879	247	205	83%	247	18,900	14,500
Saint Joseph (Fatima)	76,876	386	211	55%	359	15,000	7,200
Memorial Hospital	37,515	167	103	62%	294	8,400	5,900
Roger Williams	41,410	171	113	66%	220	11,300	7,500
Butler	39,981	117	110	94%	117	-	-
Kent County Memorial	85,371	291	234	80%	359	30,600	16,200
Rhode Island				76%			
Connecticut				79%			
Maine				66%			
Massachusetts				74%			
New Hampshire				67%			
Vermont				68%			
National				67%			

Average Daily Census (ADC) = patient days / 365 days
Occupancy % = ADC / operating beds
Source: Thompson Reuters The Market Planner Plus & American Hospital Directory (ahd.com).
** Inpatient days do not include Newborns.*
*** Total "Complex" beds as reported in ahd.com; includes subprovider units.*
**** Additional operating beds over certified beds are 60 Neonatal ICU beds.*

[11] "The Facts About...New York State Hospital Capacity", New York State Conference of Blue Cross and Blue Shield Plans. www.nysblues.org
[12] "A Plan to Stabilize and Strengthen New York's Health Care System", Commission on Health Care Facilities in the 21st Century. Page 49, December 2006. www.nyhealthcarecommission.org

Discussion of Healthcare Insurer Perspectives

Another consideration in analyzing the impact on the community and the state is whether costs to insurers, and consequently residents, could increase as the result of volume going to other hospitals, particularly those in higher wage areas or where costs include expenses associated with training medical residents. The estimated cost per day for general medical and surgical inpatient stays at LMC was $815, based on the most recent Medicare Cost Report (FY08). On average, the other area hospitals have a cost per day 14% higher than LMC. The overall ratio of cost to charges for the other area hospitals is higher by 24%, and the average hourly wage for the top two competitors is also higher than LMC's by 2% to 3%. The following table shows cost per day, cost to charge ratios and average hourly wage comparisons for area hospitals.

Table 16: FY08 Cost Comparisons of Area Hospitals

	Cost/Day		Overall Cost to Charge Ratio					Salaries and Other Costs	
Hospital	General Med/Surg	% Compared to LMC	Inpatient Routine Services	Ancillary Service Cost Centers	Outpatient Service Cost Centers	Overall Cost Centers	% Compared to LMC (Overall)	Employee Benefits - AHW	% Compared to LMC
Landmark	$ 815		0.50	0.26	0.18	0.29		$ 36.95	
Rhode Island Hospital	$ 1,391	71%	0.61	0.21	0.40	0.31	6%	$ 37.71	2%
Saint Joseph (Fatima)	$ 791	-3%	0.47	0.27	0.30	0.33	14%	$ 38.15	3%
Miriam	$ 808	-1%	0.79	0.21	0.25	0.27	-8%	$ 31.08	-16%
Women & Infants ***	$ 937	15%	0.37	0.38	1.02	0.41	41%	$ 37.54	2%
Roger Williams	$ 966	19%	0.75	0.33	0.25	0.39	35%	$ 27.07	-27%
Memorial Hospital	$ 942	16%	0.85	0.31	0.75	0.42	46%	$ 29.81	-19%
Butler	$ 727	-11%	0.42	0.59	0.42	0.44	53%	N/A	
Kent County Memorial	$ 856	5%	0.42	0.27	0.30	0.32	9%	$ 30.96	-16%
Competitor Average	$ 927	14%	0.58	0.32	0.46	0.36	24%	$ 33.19	-10%

Source: American Hospital Directory (ahd.com) based on Medicare Cost Reports.
Ratio of cost to charges = costs / (IP + OP charges)

While it is unknown what the payor contracts are for the other hospitals, if negotiated rates at those hospitals are higher than LMC's, the overall costs to the healthcare system in the service area could also be higher with the volume shift. It is also unclear what the shift would mean for LMC's Medicare and Medicaid population, given MS-DRG and APC mixes between hospitals with Medicare and changes to the Medicaid payment methodology in Rhode Island. The payor mix for LMC for fiscal year to date June 2009, based on gross charges, was as follows:

Table 17: LMC Payor Mix - FYTD June 2009

Payor	IP	OP	Total
Medicare	40%	20%	30%
Medicaid	4%	6%	5%
Medicare - Managed	23%	16%	19%
Medicaid - Managed *	8%	14%	11%
Blue Cross	8%	18%	13%
Blue Chip-Commercial	2%	4%	3%
UHPNE-Commercial	3%	7%	5%
Comm & Champus	4%	4%	4%
Other Payor	3%	4%	3%
Self Pay	3%	7%	5%
Other	1%	2%	2%
Total	**100%**	**100%**	**100%**

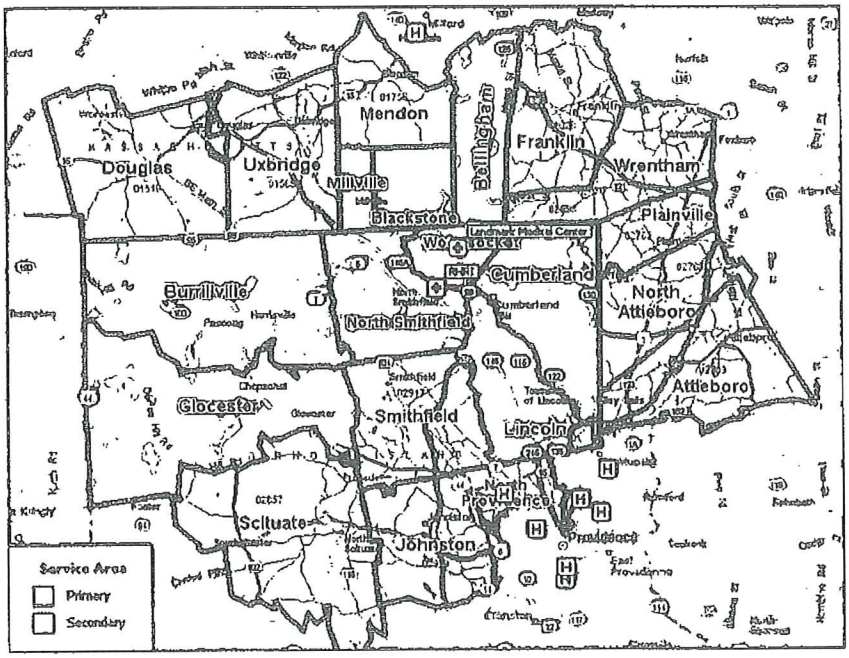
Source: LMC internal financial reports, FYTD June 2009.
** Includes Rite Care*

Hospital Profile

Service Area

Landmark's service area is defined as the Primary Service Area (PSA) and Secondary Service Area (SSA) towns where the hospital draws approximately 90% of its inpatient discharges. The PSA is defined as Woonsocket, Burrillville, Cumberland, Glocester, Lincoln and North Smithfield in Rhode Island and Bellingham, Blackstone and Millville in Massachusetts. The SSA is defined as Central Falls, Johnston, North Providence, Scituate and Smithfield in Rhode Island and eight towns along the border in Massachusetts (Attleboro, North Attleboro, Franklin, Plainville, Wrentham, Douglas, Mendon and Uxbridge). A map of the service area is depicted below.

Figure 1: Service Area Map



The following tables show trends in LMC's inpatient volume by service area town between FY06 and FY08 and internal LMC inpatient and outpatient volume trends for FY06 to FY09. (Note that inpatient volumes between the tables do not tie due to the different data sources used and the potential different classification of discharges and cases between the sources.)

Table 18: LMC Trends in Inpatient Volume by Service Area

		FY06		FY07		FY08		FY06-FY08 Change	
Service Area/Town	County	Disch	% Total	Disch	% Total	Disch	% Total	Disch	% Total
Primary Service Area									
Woonsocket	Providence, RI	4,035	52.4%	3,747	51.7%	3,648	52.0%	(387)	-0.4%
Burrillville	Providence, RI	626	8.1%	664	9.2%	575	8.2%	(51)	0.1%
Cumberland	Providence, RI	866	11.2%	744	10.3%	767	10.9%	(99)	-0.3%
Glocester	Providence, RI	71	0.9%	55	0.8%	49	0.7%	(22)	-0.2%
Lincoln	Providence, RI	424	5.5%	359	4.9%	382	5.4%	(42)	-0.1%
North Smithfield	Providence, RI	641	8.3%	655	9.0%	584	8.3%	(57)	0.0%
Bellingham	Norfolk, MA	148	1.9%	125	1.7%	135	1.9%	(13)	0.0%
Blackstone	Worcester, MA	247	3.2%	239	3.3%	189	2.7%	(58)	-0.5%
Millville	Worcester, MA	40	0.5%	40	0.6%	22	0.3%	(18)	-0.2%
Subtotal - PSA		7,098	88.8%	6,628	88.2%	6,351	87.7%	(747)	-1.1%
Secondary Service Area									
Central Falls	Providence, RI	17	0.2%	22	0.3%	23	0.3%	6	0.1%
Johnston	Providence, RI	29	0.4%	28	0.4%	24	0.3%	(5)	-0.1%
North Providence	Providence, RI	26	0.3%	45	0.6%	43	0.6%	17	0.3%
Scituate	Providence, RI	14	0.2%	4	0.1%	7	0.1%	(7)	-0.1%
Smithfield	Providence, RI	49	0.6%	58	0.8%	56	0.8%	7	0.2%
Attleboro	Bristol, MA	22	0.3%	12	0.2%	14	0.2%	(8)	-0.1%
North Attleboro	Bristol, MA	18	0.2%	13	0.2%	15	0.2%	(3)	0.0%
Franklin	Norfolk, MA	23	0.3%	21	0.3%	9	0.1%	(14)	-0.2%
Plainville	Norfolk, MA	3	0.0%	1	0.0%	3	0.0%	-	0.0%
Wrentham	Norfolk, MA	4	0.1%	8	0.1%	10	0.1%	6	0.0%
Douglas	Worcester, MA	6	0.1%	1	0.0%	1	0.0%	(5)	-0.1%
Mendon	Worcester, MA	6	0.1%	2	0.0%	1	0.0%	(5)	-0.1%
Uxbridge	Worcester, MA	18	0.2%	16	0.2%	21	0.3%	3	0.1%
Subtotal - SSA		235	3.0%	231	3.2%	227	3.0%	(8)	0.0%
Other Discharges		371	8.2%	394	8.6%	438	9.3%	67	1.1%
Total 2006 - 2008		7,704	100.0%	7,263	100.0%	7,016	100.0%	(688)	0.0%

Sources: Thompson Reuters The Market Planner Plus for non-MA providers; WebMD for MA providers.
Does not include Normal Newborns.
Fiscal Years Ending September 30.

Table 19: LMC Trends in Volume by Service Category

					FY06-FY08 Change		FY08-FY09 Change	
Volume	FY06	FY07	FY08	FY09	Cases	Percent	Cases	Percent
Inpatient								
Medicine	4,469	4,184	4,183	4,115	(286)	-6%	(68)	-2%
Surgery	1,289	1,253	1,112	1,000	(177)	-14%	(112)	-10%
Cardiac	660	648	418	246	(242)	-37%	(172)	-41%
Obstetrics	582	525	513	490	(69)	-12%	(23)	-4%
Newborn	556	484	476	465	(80)	-14%	(11)	-2%
Psychiatry	721	659	761	770	40	6%	9	1%
Pediatrics	9	11	13	7	4	44%	(6)	-46%
Total Inpatient	8,286	7,764	7,476	7,093	(810)	-10%	(383)	-5%
Outpatient								
Outpatient	108,258	102,953	82,792	74,730	(25,466)	-24%	(8,062)	-10%
Emergency Room	44,769	41,352	41,170	40,065	(3,599)	-8%	(1,105)	-3%
Total Outpatient	153,027	144,305	123,962	114,795	(29,065)	-19%	(9,167)	-7%

Source: Internal LMC Actual to Budget Reports FY07-FY09.

Market Share

Landmark's service area volume has shifted primarily to other Rhode Island hospitals. LMC's PSA market share, while declining 3.7%, still remains high at 33.3%. Between FY06 and FY08, while LMC lost over 750 discharges in the service area (1.5% decline), the other Rhode Island hospitals collectively increased their inpatient discharges by over 1,300, or 2.8%, the bulk of which went to Miriam Hospital. Table 20 depicts FY08 market share by provider, and Table 21 shows the market share changes from FY06 to FY08 by provider.

Table 20: FY08 Service Area Market Share by Provider

	Primary Service Area		Secondary Service Area		Total Service Area	
Hospital Name	Disch	Market Share	Disch	Market Share	Disch	Market Share
Rhode Island Hospitals						
Landmark Medical Center - Woonsocket	6,351	33.3%	227	0.7%	6,578	13.2%
Rehabilitation Hospital Of Rhode Island	325	1.7%	121	0.4%	446	0.9%
Rhode Island Hospital	2,383	12.5%	3,964	12.8%	6,347	12.7%
Saint Joseph Health Services Of Rhode Island	1,132	5.9%	4,555	14.7%	5,687	11.4%
Miriam Hospital	2,000	10.5%	3,206	10.4%	5,206	10.4%
Women And Infants Hospital Of Rhode Island	1,248	6.5%	1,970	6.4%	3,218	6.4%
Roger Williams Medical Center	657	3.4%	1,867	6.0%	2,524	5.1%
Memorial Hospital Of Rhode Island	880	4.6%	1,259	4.1%	2,139	4.3%
Other Rhode Island Hospitals	868	4.6%	1,279	4.1%	2,147	4.3%
Subtotal - Rhode Island Hospitals	**15,844**	**83.0%**	**18,448**	**59.6%**	**34,292**	**68.7%**
Massachusetts Hospitals						
Caritas Christi Health Care	147	0.8%	1,826	5.9%	1,973	3.9%
Partners HealthCare	373	2.0%	1,132	3.7%	1,505	3.0%
UMass Memorial Health Care	285	1.5%	655	2.1%	940	1.9%
Metrowest Medical Center	213	1.1%	264	0.9%	477	1.0%
Southcoast	7	0.0%	49	0.2%	56	0.1%
Baystate Health	9	0.0%	6	0.0%	15	0.0%
Other MA Hospitals	2,097	11.0%	8,361	27.0%	10,458	20.9%
Subtotal - Massachusetts Hospitals	**3,131**	**16.4%**	**12,293**	**39.8%**	**15,424**	**30.8%**
Other State Hospitals	86	0.6%	175	0.6%	261	0.5%
Total 2008	**19,061**	**100.0%**	**30,916**	**100.0%**	**49,977**	**100.0%**

Sources: Thompson Reuters The Market Planner Plus for non-MA providers; WebMD for MA providers.
Does not include Normal Newborns.
Fiscal Year Ending September 30, 2008

Table 21: Service Area Market Share Changes - FY06 to FY08

	Primary Service Area		Secondary Service Area		Total Service Area	
Hospital Name	Disch	Market Share	Disch	Market Share	Disch	Market Share
Rhode Island Hospitals						
Landmark Medical Center - Woonsocket	(747)	-3.7%	(8)	-0.1%	(755)	-1.5%
Rehabilitation Hospital Of Rhode Island	(35)	-0.2%	(29)	-0.1%	(64)	-0.1%
Rhode Island Hospital	165	0.9%	132	0.3%	297	0.6%
Saint Joseph Health Services Of Rhode Island	35	0.2%	(124)	-0.6%	(89)	-0.2%
Miriam Hospital	287	1.6%	586	1.9%	873	1.7%
Women And Infants Hospital Of Rhode Island	(31)	-0.2%	46	0.1%	15	0.0%
Roger Williams Medical Center	165	0.8%	(57)	-0.3%	108	0.3%
Memorial Hospital Of Rhode Island	(89)	-0.4%	(27)	-0.1%	(116)	-0.2%
Other Rhode Island Hospitals	148	0.9%	215	0.6%	363	0.7%
Subtotal - Rhode Island Hospitals	**(102)**	**-0.1%**	**734**	**1.7%**	**632**	**1.3%**
Massachusetts Hospitals						
Caritas Christi Health Care	(2)	0.0%	(268)	-0.9%	(270)	-0.6%
Partners HealthCare	49	0.3%	83	0.3%	132	0.2%
UMass Memorial Health Care	(2)	0.0%	(34)	-0.1%	(36)	-0.1%
Metrowest Medical Center	1	0.0%	(68)	-0.2%	(67)	-0.1%
Southcoast	(7)	-0.1%	5	0.1%	(2)	0.0%
Baystate Health	7	0.0%	2	0.0%	9	0.0%
Other MA Hospitals	(73)	-0.3%	(197)	-0.9%	(270)	-0.6%
Subtotal - Massachusetts Hospitals	**(27)**	-0.1%	**(477)**	-1.7%	**(504)**	-1.2%
Other State Hospitals	(12)	0.2%	(19)	0.0%	(31)	-0.1%
Total 2006 - 2008	**(141)**	**0.0%**	**238**	**0.0%**	**97**	**0.0%**

Sources: Thompson Reuters The Market Planner Plus for non-MA providers; WebMD for MA providers.
Does not include Normal Newborns.
Fiscal Year Ending September 30, 2006 - 2008

Physician Profile

In FY08, nearly 40% of LMC's physician staff was between the ages of 46 to 55 and also accounted for 35% of total admissions. The large prevalence of pulmonary admissions was a function of activity by the hospitalist group comprising of pulmonary/critical care physicians. The table below shows the distribution of FY08 inpatient admissions by specialty and age range.

Table 22: LMC Admissions by Physician Specialty and Age

SPECIALTY	Number of Admitting Physicians	Number of Board Certified Physicians	Total FY08 Admissions	Ages 25-35		Ages 36-45		Ages 46-55		Ages 56-65		Ages 66 & Over	
				PHYS	ADM	PHYS	ADM	PHYS	ADM	PHYS	ADM	PHYS	ADM
Anesthesiology	1	1	1	-	-	1	1	-	-	-	-	-	-
Cardiology	14	14	688	1	40	6	265	2	125	4	169	1	89
Family Medicine	4	3	197	-	-	-	-	2	2	1	22	1	173
Gastroenterology	4	3	187	-	-	1	15	1	10	1	47	1	115
General Surgery	7	5	331	-	-	1	30	2	180	-	-	4	121
Geriatrics	3	3	359	-	-	1	197	1	16	1	146	-	-
Hematology/Oncology	2	2	8	-	-	-	-	1	2	1	6	-	-
Internal Medicine	12	6	1,614	-	-	2	504	7	776	1	155	2	179
Neurology	1	-	3	-	-	-	-	1	3	-	-	-	-
Neurological Surgery	2	2	18	-	-	-	-	2	18	-	-	-	-
OB/GYN	6	5	613	1	281	-	-	2	84	2	230	1	18
Oral & Maxillofacial Surgery	1	-	1	1	1	-	-	-	-	-	-	-	-
Orthopedics	8	7	141	-	-	1	6	6	67	1	68	-	-
Otolaryngology	1	1	14	-	-	-	-	-	-	-	-	1	14
Pediatrics	13	9	480	-	-	5	332	6	82	2	66	-	-
Psychiatry	4	2	770	-	-	1	368	1	1	2	401	-	-
Pulmonary Medicine (incl Hospitalists)	8	5	1,842	-	-	3	378	2	1,195	1	269	-	-
Cardiovascular & Thoracic Surgery	5	4	164	-	-	1	25	1	23	2	60	1	56
Urology	7	6	63	1	19	2	17	2	15	2	12	-	-
Total Staff with Admissions	**101**	**78**	**7,494**	**4**	**341**	**25**	**2,139**	**39**	**2,599**	**21**	**1,651**	**12**	**765**
Distribution of Age of Admitting Staff				**4.0%**		**24.8%**		**38.6%**		**20.8%**		**11.8%**	
Distribution of Total Admissions					**4.6%**		**28.5%**		**34.7%**		**22.0%**		**10.2%**
Average age of Total Admitting Staff	**51.7**												

Source: Landmark Medical Center Finance Department. Includes Newborns.

Legend: Distribution of Age of Admitting Staff (calculated by active number of admitting staff for each age range divided by total FY 2008 Admitting Staff)
Admissions: (calculated by admissions for each age range divided by Total Admissions for FY08)

Financial Snapshot

LMC has experienced deteriorating financial performance over the past few years. As mentioned earlier, LMC petitioned for mastership in July 2008 and a Special Master has been appointed to oversee its operations. In May 2008, faced with declining volumes, LMC ended its cardiac surgery program. The emergency department is affiliated with Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center in Massachusetts.

The latest audited financials (FY07) indicated that LMC "will continue as a going concern", and LMC was ranked the "weakest hospital in overall financial performance" for FY08 in a report issued by the Rhode Island Department of Health. The report indicated that LMC's net worth declined 120% in FY08, and the hospital was "technically insolvent (where its liabilities exceeded its assets)" every year between FY04 and FY08.[13]

[13] "The Health of Rhode Island's Hospitals (2008)", July 2009. Bruce Cryan, MBA, MS, Rhode Island Department of Health, Center for Health Data & Analysis

The following table shows LMC's financial performance over the past three years.

Table 23: LMC Operating Margin FY07 - FY09

Dollars in Thousands (000s)	FY07 AFS	FY08 Prelim	FY09 Ann'l**
Revenue			
Net patient service revenue	$ 115,700	$ 112,600	$ 111,600
Disproportionate share	4,100	6,000	6,900
Other	4,900	3,900	3,300
Total unrestricted revenue	**124,700**	**122,500**	**121,800**
Expenses			
Salaries and benefits	62,700	61,200	60,800
Medical/surgical supplies and drugs	19,100	18,400	17,800
Provision for uncollectible patient accounts	12,300	13,300	13,900
Hospital license fee ***	2,900	3,500	5,700
Other	37,800	32,500	29,100
Total expenses	**134,800**	**128,900**	**127,300**
Operating loss	**$ (10,100)**	**$ (6,400)**	**$ (5,500)**
Operating margin	**-8%**	**-5%**	**-5%**

Sources: LMC FY07 audited financials, preliminary unaudited FY08 and internal August 2009 financials.
** Annualized based on August 2009 internal financials
*** Fee is calculated as a percentage of net patient service revenue

LMC currently operates approximately 123 acute and 18 psychiatric beds, with an overall occupancy percentage of 70%.

Table 24: LMC Beds Occupancy Rates - FY09

Bed Type	Patient Days	Operating Beds	ADC	Occ %
Acute	30,734	123	84	68%
Psych	5,365	18	15	82%
Total	**36,099**	**141**	**99**	**70%**

Average Daily Census = patient days / 365 days
Occupancy % = ADC / operating beds
Source: Internal LMC Actual to Budget Reports FY09.
Inpatient cases do not include Newborns.

LMC and its employees have paid approximately $16 million in federal and state taxes in 2008, as summarized in the next table.

Table 25: LMC Tax Payments - 2007 and 2008

Dollars in Thousands (000s)

	LMC	
	2007	**2008**
Employer Portion of TDI	$ 470	$ 480
Employee Portion of TDI	470	480
State Withholding	1,810	1,830
FICA	5,350	5,510
Medicare	1,310	1,330
Federal withholding	6,500	6,490
Total	**$ 15,910**	**$ 16,120**

Source: LMC Finance.
TDI = Temporary Disability Insurance
FICA = Federal Insurance Contributions Act

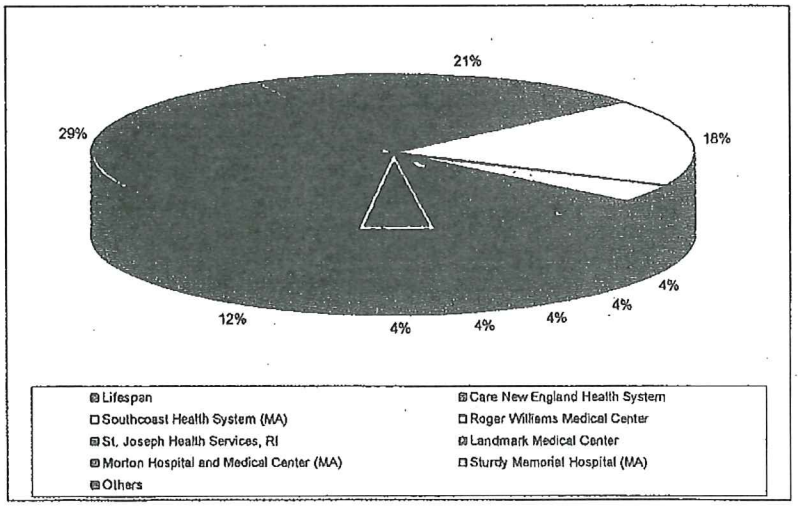
State Profile

Landscape

Rhode Island was recently the second highest state in the nation for unemployment rates, behind Michigan. "Rhode Island ranks No. 9 in terms of economic distress because of the increase in unemployment, its foreclosure rate and increase in food-stamp participation, according to a national analysis by the Kaiser Family Foundation." [14] According to a report by the Rhode Island Department of Labor and Training, the majority of the state's employment was in the private sector (approximately 87% in 2008) with the Health Care & Social Assistance sector employing the largest portion of private sector workers (19%). Since the end of 2007, when the recession began, only two sectors, private Educational Services and Health Care & Social Assistance, grew jobs; ambulatory and health care services grew .6% and hospitals grew 1.8%. The report projected that Health Care would be one of the first sectors to "rebound" when the recession ends. [15]

Not uncommon for other states, in FY08 Rhode Island's 13 non-profit hospitals suffered a decrease in profitability and net worth, primarily due to investment losses in the financial market. These hospitals experienced increased bad debt and uncompensated care and limited access to credit. Hospitals that are part of the two large state healthcare networks (Care New England Health System and Lifespan, which are seeking approval to merge) "fared better" than the independent ones. Care New England is comprised of Butler, Kent and Women & Infants Hospitals, while Lifespan is comprised of Bradley, Miriam, Newport and Rhode Island Hospitals. [16] [17] Market share for the Providence area market, defined as the counties of Bristol, Kent, Newport, Providence and Washington in Rhode Island and Bristol in Massachusetts, is depicted below by key provider.

Figure 26: Providence MSA Inpatient Market Share - 2008



Source: HealthLeaders-Interstudy, 2009; Billian's HealthDATA, 2008.

[14] "Providence Market Overview", March 2009. HealthLeaders-InterStudy
[15] "Rhode Island Employment Trends and Workforce Issues 2009", September 2009. Labor Market Information Unit, Rhode Island Department of Labor & Training.
[16] "Providence Market Overview", March 2009. HealthLeaders-InterStudy
[17] "The Health of Rhode Island's Hospitals (2008)", July 2009. Bruce Cryan, MBA, MS, Rhode Island Department of Health, Center for Health Data & Analysis

Competitor Profile

Based on service area market share, LMC's Rhode Island competitors are defined as the following: [18]

Lifespan Health System:

Rhode Island Hospital is the largest inpatient facility in Providence, with 576 beds. It includes the Hasbro Children's Hospital and is the main teaching hospital for Medical School of Brown University. Rhode Island Hospital is the Level 1 trauma center for southeastern New England and operates the largest kidney transplant program in New England.

The Miriam Hospital of Rhode Island is a 247 bed acute care hospital affiliated with Brown Medical School. It is recognized as a leader in cardiovascular care and operates the Women's Cardiac Center as well as a tuberculosis clinic. It is a Center for AIDS Research.

Bradley Hospital is a 60 bed psychiatric hospital for children.

Care New England Health System:

Women & Infants Hospital of Rhode Island operates 197 beds in an acute care setting. It is the primary teaching affiliate in obstetrics, gynecology and newborn pediatrics for Brown Medical School and has been expanding with state-of-the-art facilities for obstetrical patients and neonatal patients. It is also the first hospital-based, all digital facility in the region.

Kent Hospital is a 271 bed acute care hospital affiliated with the University of New England College of Osteopathic Medicine. It provides comprehensive inpatient and outpatient services. It operates a Women's Diagnostic Imaging Center and a Wound Recovery Center as well as provides laboratory and primary-care services at community clinics. Kent Hospital was recently given permission to perform emergency angioplasties to treat heart attacks - only three other Rhode Island hospitals perform this procedure. Kent Hospital is also a part of the Kent PHO with is a non-profit joint venture of Kent Hospital and more than 200 physicians on the hospital's medical staff.

Butler Hospital is a 117 bed psychiatric hospital is a teaching facility for Brown University's department of psychiatry.

Of note - the merger of Lifespan and Care New England is pending regulatory approval.

Independent Hospitals:

Memorial Hospital of Rhode Island is a non-profit community hospital and teaching affiliate of Brown Medical School. It is also affiliated with Dana-Farber/Partners Cancer Center in Boston. In December 2008, Memorial Hospital opened its new state-of-the-art emergency room equipped with a communications system that allows electronic transmission of electrocardiogram data to the department prior to patient arrival. Memorial is also affiliated with about 200 physicians.

Roger Williams Medical Center is a non-profit, community owned teaching hospital for Boston University School of Medicine. It houses a bone-marrow transplant unit and the Center for Stem Cell Biology. It is a 159 bed acute care hospital, which in October 2009, officially received approval to merge with Saint Joseph Health Services of Rhode Island (see below).

Saint Joseph Health Services of Rhode Island is a Catholic-sponsored, non-profit health system comprised of Our Lady of Fatima Hospital and St. Joseph Hospital for Specialty Care. Rehab and

[18] "Providence Market Overview", March 2009. HealthLeaders-InterStudy

psychiatric programs from Saint Joseph already moved into rented space at Roger Williams and the remaining hospital of 250 beds will be sold. Roger Williams expanded its existing cancer center to include a Chemotherapy Infusion Center, BMT Clinic, Multi-Disciplinary Clinic and Hematology-Oncology Clinic.

Community Profile

Population Trends

Historical and projected population estimates were obtained from Thomson Reuters. The summary for the town of Woonsocket, as well as both the primary and secondary service areas for LMC, is presented in the table below.

Table 27: Service Area Population

Woonsocket	Historical 2000		Estimated 2009		Percent Change	Projected 2014		Percent Change
	Population	Percent of Total	Population	Percent of Total	2000-2009	Population	Percent of Total	2009-2014
Age Category								
Age 0-17	11,182	25.8%	11,247	25.9%	0.6%	11,341	26.1%	0.8%
Age 18-44	17,010	39.3%	16,242	37.4%	-4.5%	15,483	35.7%	-4.7%
Age 45-64	8,528	19.7%	10,006	23.0%	17.3%	10,386	23.9%	3.8%
Age 65-84	5,621	13.0%	4,701	10.8%	-16.4%	4,855	11.2%	3.3%
Age 85+	985	2.2%	1,240	2.9%	25.9%	1,325	3.1%	6.9%
Total Service Area	43,326	100.0%	43,436	100.0%	0.3%	43,390	100.0%	-0.1%
Females Age 15-44 [1]	9,529	22.0%	9,146	21.1%	-4.0%	8,758	20.2%	-4.2%
Primary Service Area	**Historical 2000**		**Estimated 2009**		**Percent Change**	**Projected 2014**		**Percent Change**
	Population	Percent of Total	Population	Percent of Total	2000-2009	Population	Percent of Total	2009-2014
Age Category								
Age 0-17	39,804	25.4%	38,671	23.6%	-2.8%	38,303	23.0%	-1.0%
Age 18-44	59,180	37.8%	56,877	34.8%	-3.9%	55,269	33.1%	-2.8%
Age 45-64	35,438	22.6%	45,880	28.0%	29.5%	48,595	29.1%	5.9%
Age 65-84	19,211	12.3%	18,294	11.2%	-4.8%	20,363	12.2%	11.3%
Age 85+	2,890	1.9%	3,861	2.4%	33.6%	4,304	2.6%	11.5%
Total Service Area	156,523	100.0%	163,583	100.0%	4.5%	166,834	100.0%	2.0%
Females Age 15-44 [1]	33,526	21.4%	32,589	19.9%	-2.8%	31,246	18.7%	-4.1%
Secondary Service Area	**Historical 2000**		**Estimated 2009**		**Percent Change**	**Projected 2014**		**Percent Change**
	Population	Percent of Total	Population	Percent of Total	2000-2009	Population	Percent of Total	2009-2014
Age Category								
Age 0-17	64,871	24.9%	63,894	23.6%	-1.5%	62,813	22.8%	-1.7%
Age 18-44	103,501	39.7%	96,477	35.7%	-6.8%	92,233	33.5%	-4.4%
Age 45-64	57,003	21.9%	74,825	27.6%	31.3%	80,414	29.2%	7.5%
Age 65-84	30,202	11.6%	29,060	10.7%	-3.8%	33,127	12.0%	14.0%
Age 85+	5,200	1.9%	6,364	2.4%	22.4%	6,840	2.5%	7.5%
Total Service Area	260,777	100.0%	270,620	100.0%	3.8%	275,427	100.0%	1.8%
Females Age 15-44 [1]	57,009	21.9%	53,840	19.9%	-5.6%	51,289	18.6%	-4.7%

Source: Thomson Reuters The Market Planner Plus.
Notes: (1) These numbers are included in the total age cohort 15-44.

Population in Woonsocket (which is part of LMC's PSA) was estimated to have a modest increase of 0.3% between 2000 and 2009 and is projected to lose 0.1% between 2009 and 2014. For the primary and secondary service areas, a larger increase was estimated between 2000 and 2009, 4.5% and 3.8%, respectively. The projections between 2009 and 2014 suggest the populations will continue to increase in

both the primary and secondary service areas by 2.0% and 1.8%, respectively. The female population of childbearing age (15 to 44) are estimated to decrease between 2009 and 2014 for the total service area.

The 2009 uninsured population in the service area is estimated to be nine percent of the total population, which is lower than the state and national uninsured percentages (12% and 16%, respectively). The lower percentages are due in part to towns in Massachusetts being in the service area, a state where there is mandated health insurance coverage. However, the city of Woonsocket has an estimated 19% uninsured rate, driven largely by the 18 to 44 age group (30% uninsured). These figures could be exacerbated with an LMC closure, should it occur, given the displacement of employees and the economic conditions in the community and state. The next two tables show estimated uninsured rates by service area town and by age group.

Table 28: Estimated 2009 Uninsured Rates by Service Area Town

Service Area/Town	County	Total Lives	% Unins
Primary Service Area			
Woonsocket	Providence, RI	43,436	19%
Burrillville	Providence, RI	16,469	7%
Cumberland	Providence, RI	34,418	7%
Glocester	Providence, RI	8,107	5%
Lincoln	Providence, RI	22,039	9%
North Smithfield	Providence, RI	11,267	6%
Bellingham	Norfolk, MA	15,987	3%
Blackstone	Worcester, MA	8,931	4%
Millville	Worcester, MA	2,929	3%
Total PSA		**163,583**	**10%**
Secondary Service Area			
Central Falls	Providence, RI	18,707	25%
Johnston	Providence, RI	28,510	12%
North Providence	Providence, RI	43,940	15%
Scituate	Providence, RI	9,022	4%
Smithfield	Providence, RI	21,288	7%
Attleboro	Bristol, MA	43,125	4%
North Attleboro	Bristol, MA	27,939	3%
Franklin	Norfolk, MA	31,759	2%
Plainville	Norfolk, MA	8,502	3%
Wrentham	Norfolk, MA	11,137	2%
Douglas	Worcester, MA	8,024	3%
Mendon	Worcester, MA	5,807	3%
Uxbridge	Worcester, MA	12,860	4%
Total SSA		**270,620**	**8%**
Total Service Area		**434,203**	**9%**
State of Rhode Island			**12%**
United States			**16%**

Source: Thomson Reuters The Market Planner Plus - Insurance Estimates.

Table 29: Estimated 2009 Uninsured Rates by Age Group

	Woonsocket			Total Service Area		
Age Group	Uninsured	Total Lives	% Unins	Uninsured	Total Lives	% Unins
00-17	1,146	11,248	10%	4,900	102,571	5%
18-44	4,938	16,241	30%	22,766	153,371	15%
45-64	1,942	10,006	19%	9,308	120,724	8%
65+	78	5,941	1%	368	57,537	1%
Total	**8,104**	**43,436**	**19%**	**37,342**	**434,203**	**9%**

Source: Thomson Reuters The Market Planner Plus - Insurance Estimates.

Labor Data

In the city of Woonsocket, the healthcare and social assistance sector employed approximately 3,600 employees in 2008, which represented over 23% of the city's total workforce. Within this sector, LMC employed over a quarter of the employees.

Table 30: Woonsocket Employment by Industry

Woonsocket Industry Title	2006 Average Employment	2006 Percent	2007 Average Employment	2007 Percent	2008 Average Employment	2008 Percent	Change 2006-2008 Average Employment	Change 2006-2008 Percent
Total Private & Government	**15,201**		**15,472**		**15,324**		**123**	**0.8%**
Total Private Only	**13,561**	**89.2%**	**13,765**	**89.0%**	**13,630**	**88.9%**	**69**	**0.5%**
Health Care & Social Assistance	3,506	23.1%	3,600	23.3%	3,588	23.4%	82	2.3%
Retail Trade	2,016	13.3%	1,975	12.8%	1,958	12.8%	(58)	-2.9%
Management of Companies & Enterprises	1,697	11.2%	1,728	11.2%	1,927	12.6%	230	13.6%
Government	1,640	10.8%	1,708	11.0%	1,695	11.1%	55	3.4%
Manufacturing	1,338	8.8%	1,325	8.6%	1,233	8.0%	(105)	-7.8%
Accommodation & Food Services	1,132	7.4%	1,178	7.6%	1,150	7.5%	18	1.6%
Transportation & Warehousing	775	5.1%	838	5.4%	810	5.3%	35	4.5%
Administrative Support & Waste Mngmnt.	589	3.9%	516	3.3%	506	3.3%	(83)	-14.1%
Other services, (except Public Administration)	531	3.5%	544	3.5%	534	3.5%	3	0.6%
Professional & Technical Services	404	2.7%	399	2.6%	394	2.6%	(10)	-2.5%
Educational Services	382	2.5%	355	2.3%	305	2.0%	(77)	-20.2%
Wholesale Trade	375	2.5%	387	2.5%	371	2.4%	(4)	-1.1%
Construction	312	2.1%	315	2.0%	289	1.9%	(23)	-7.4%
Finance & Insurance	253	1.7%	222	1.4%	191	1.2%	(62)	-24.5%
Real Estate & Rental & Leasing	139	0.9%	149	1.0%	141	0.9%	2	1.4%
Arts, Entertainment, & Recreation	68	0.4%	92	0.6%	103	0.7%	35	51.5%
Information	45	0.3%	143	0.9%	131	0.9%	86	191.1%
Unclassified Establishments	1	0.0%	1	0.0%	*	*	*	*
Agriculture, Forestry, Fishing & Hunting	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Mining	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Utilities	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Source: Rhode Island Department of Labor and Training

** Some data are not shown due to the possibility of identifying data of a specific employer.*

Based on data released by Rhode Island Economic Development Corporation in December 2008, LMC ranked 31st among the top employers in the state. Much of the state's employer community is comprised of small employers (90% of all private sector employers have less than 20 employees). The city of Woonsocket was home to over 5,700 of the 6,000 employees of the CVS Corporation and 650 of the 2,800 Rhode Island ARC employees, as shown in the next table.

Table 31: Rhode Island Employers

Rank	Employer	Industry	Employee Size State of RI	Employee Size Woonsocket
1	Rhode Island State Government	Government	15,978	
2	Lifespan	Hospital	11,772	
3	US Government (in RI)	Government	9,700	
4	Roman Catholic Diocese of Providence	Church	6,200	
5	Care New England	Hospital	6,193	
6	CVS Corp	Drug Store	5,951	5,730
7	Citizens Financial Group, Inc.	Bank	5,500	
8	Brown University	Education	4,877	
9	Stop & Shop Supermarket Co., Inc	Grocery Store	4,385	
10	Bank of America (Statewide)	Bank	4,000	
11	Rhode Island ARC	Hospital	2,851	650
12	University of Rhode Island	Education	2,545	
13	Fidelity Investments	Finance	2,300	
14	General Dynamics Corp.	Ship and Boat Builder	2,143	
15	Wal-Mart	Department Store	2,084	
16	St Joseph Health Services of RI	Hospital	2,079	
17	MetLife Insurance Co.	Insurance	2,056	
18	The Jan Companies	Restaurants	2,050	
19	Shaw's Supermarkets	Grocery Store	1,920	
20	The Home Depot, Inc.	Building Material Supply Store	1,780	
21	Raytheon	Instruments Manufacturing	1,672	
22	Memorial Hospital of Rhode Island	Hospital	1,488	
23	Roger Williams Medical Center	Hospital	1,470	
24	Roger Williams University	Education	1,452	
25	Amica Life Insurance	Insurance	1,282	
26	Johnson & Wales University	Education	1,270	
27	Cox Communications, Inc.	Telecommunications	1,260	
28	Rite Aid/Brooks Pharmacy Store	Drug Store	1,228	
29	Verizon Communications	Communications	1,205	
30	Amgen Inc.	Pharmaceutical Manufacturing	1,200	
31	Landmark Health Systems	Hospital	1,190	1045
32	Securitas AB	Security Services	1,167	
33	American Power Conversion Corporation	Manufacturing	1,144	
34	Blue Cross & Blue Shield of RI	Insurance	1,143	
35	US Security Associates, Inc.	Security Services	1,100	
36	McDonald's	Restaurants	1,089	
37	AAA Southern New England	Travel Services	1,080	
38	GTECH Corporation	Computer Business Service	1,074	
39	National Grid USA	Utilities	1,050	
40	South County Hospital	Hospital	1,015	

Source: Rhode Island Economic Development Corporation

Since 2006, the unemployment rates in the City of Woonsocket, Providence County and State of Rhode Island have been on the rise. Based on the 9 months' average for 2009, the unemployment rates were 13.9% for Woonsocket, 12.9% for Providence County and 11.8% for Rhode Island, all higher than the national average of 9.0%. These figures could also be exacerbated by an LMC closure, should it occur.

Table 32: Unemployment Rates

Unemployment Rates				
Year	Woonsocket	Providence County	Rhode Island	United States
2009 [1]	13.9%	12.9%	11.8%	9.0%
2008	9.1%	8.4%	7.8%	5.8%
2007	5.9%	5.6%	5.2%	4.6%
2006	5.5%	5.4%	5.0%	4.6%

Data Source: Rhode Island Department of Labor and Training, Bureau of Labor Statistics
Notes: [1] 2009 data is based on average of 9 months unemployment rate

The average annual wages of the state's total private sector and the Health Care and Social Assistance industry sector were below the 2008 national average and below most of the other New England states. The state's average private sector wages was also lower than the average wages of the public sector ($41,099 compared to $55,838).

Table 33: Average Annual Wages - 2008

Industry Sector	US	RI	CT	ME	MA	NH	VT
Total Private	$45,368	$41,099	$59,305	$35,624	$57,272	$45,274	$37,567
Agriculture, Forestry, Fishing & Hunting	$25,982	$26,129	$28,409	**	$45,743	$29,313	$26,958
Mining, Quarrying, & Oil & Gas Extraction	$87,211	$44,617	$63,920	**	$51,897	$50,835	$53,737
Construction	$49,014	$50,699	$57,895	$40,250	$62,170	$49,946	$41,300
Utilities	$84,191	$78,823	$109,502	$63,977	$99,447	$91,141	$89,953
Manufacturing	$54,392	$46,491	$70,566	$46,148	$69,014	$58,599	$50,653
Wholesale Trade	$61,847	$60,207	$79,653	$50,129	$76,961	$72,248	$50,381
Retail Trade	$26,181	$26,493	$30,289	$23,258	$27,709	$26,457	$25,264
Transportation & Warehousing	$42,969	$34,759	$46,014	$34,880	$41,295	$35,750	$36,437
Information	$70,780	$57,412	$69,421	$44,185	$86,360	$71,392	$44,277
Finance & Insurance	$85,274	$67,767	$141,194	$54,068	$118,985	$73,965	$64,793
Real Estate & Rental & Leasing	$43,239	$36,639	$52,861	$31,541	$56,490	$43,716	$31,948
Professional & Technical Services	$74,354	$61,681	$85,540	$54,214	$96,802	$73,377	$59,612
Management of Companies & Enterprises	$94,842	$104,254	$136,573	$71,534	$100,428	$77,941	$58,600
Administrative & Waste Services	$32,078	$29,459	$37,925	$28,787	$38,646	$38,656	$30,365
Educational Services	$40,832	$43,632	$50,576	$36,152	$52,484	$44,846	$39,037
Health Care & Social Assistance	$42,150	$39,333	$46,106	$38,250	$49,401	$44,858	$37,141
Arts, Entertainment, & Recreation	$31,935	$23,198	$28,977	$21,224	$34,695	$19,635	$20,255
Accommodation & Food Services	$16,694	$15,734	$17,943	$15,284	$19,295	$16,413	$17,580
Other Services	$28,776	$26,140	$29,969	$25,846	$28,185	$31,110	$27,631

Source: Bureau of Labor Statistics for US and other New England states. Wages are preliminary and subject to change.
***Wages are confidential.*
Taken from Rhode Island Employment Trends and Workforce Issues 2009", September 2009.
Labor Market Information Unit, Rhode Island Department of Labor & Training.

EXHIBIT 17(b)

Report:

The Economic Impact Of Landmark Health Systems On The Rhode Island Economy

March, 2010

Vector Group, LLC
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Contents

1. Executive Summary

This report evaluates the statewide consequences of closing Landmark Medical Center (LMC) and The Rehabilitation Hospital of Rhode Island (RHRI). These facilities are owned by Landmark Health Systems (LHS). This report refers to these facilities collectively as "the LHS facilities." or simply "LHS."

In recent years, LHS has operated under significant financial stress despite praise from various sectors for its efficient operations.[1] This has largely been the result of inadequate reimbursement rates from government and commercial payers. In the latter case, significant payment disparities have been especially unfavorable for Rhode Island's independent hospitals such as LMC as opposed to hospitals that are members of large hospital groups. (See Section 4 below.) According to Rhode Island's Health Insurance Commissioner, in 2008 LMC was paid at a rate 22% below the state average even when providing the same services to similarly ill patients.[2]

If LMC was paid at the average statewide rate in 2008 on a service by service basis, its net operating results would have reflected earnings rather than losses. This longstanding payment disparity has resulted in the complete depletion of the hospital's capital base. -- See Section 4. below

This pattern of payment disparity has consistently drained LHS of its capital reserves throughout most of the current decade. This is demonstrated in a recent report issued by the Rhode Island Department of Public Health.[3] This report shows that LMC -- which enjoys a capital productivity rate more than twice any other Rhode Island hospital-- has nevertheless suffered the largest capital decline of any hospital in the current decade.

In June 2008, LMC was placed under the protection of the Superior Court of Providence County and a Special Master was appointed to oversee daily

1 LMC has been audited twice in the past several years by BCBSRI, with positive findings, and has been identified by the RI Department of Health as effectively using limited resources.

2 Variations in Hospital Payment Rates Among Commercial Insurers in RI; Office of the Health Insurance Commissioner; Providence , RI; 2010

3 Hospital Capital 2008.; RI Department of Health; Providence, RI; 2010

management and assess the feasibility of continued operations. The purview of the Special Master was extended to RHRI in November of that year.

While options exist for maintaining these facilities, limited government aid is required to assure success. This aid would constitute one part of a broader, multi-part recovery plan that would ensure the continued operation of LHS.

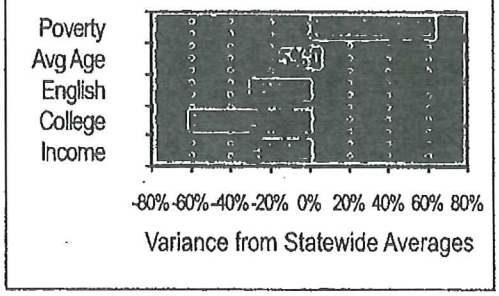
Such assistance would clearly be in the public interest considering the impact of closing LHS upon the state's health care system and its general economy.

LMC and RHRI provide services that could not readily be replaced or safely absorbed by other area providers without expansion of their facilities and services. Expansion, however, would require time, investment and planning. While awaiting this expansion virtually all patients and physicians across the state would be "competing" for fewer hospital beds. The net result would be overcrowding, treatment delays and care shortages.

At most, only a third of LMC patients could be safely accommodated at Providence area hospitals without impairing access for other patients. Other hospitals would have to be expanded to reduce overcrowding and allow for more patients. -- See Section 2. below.

Even with expansion of other facilities, access to care would be impaired for the large population of low income and elderly residents of the LHS service area. Many area residents lack ready transportation. The need to travel greater distances for routine and even emergency care would impose additional costs and complexities upon this population. Industry studies have consistently shown the close relationship between proximity and access to care -- especially among lower income persons.[4] In the event that LHS facilities were closed, new investments in local services would be required to maintain the health status of

Figure 1: Woonsocket Population



4 Examples: 1. Lee., Ward et al; Impact of Geographic Distance on the Use of the Emergency Room; Health Care Management Review: January/March 2007 - Volume 32 - Issue 1; 2. Schroen, Brenin, Kelly, Knaus, Slingluff; Impact of Patient Distance to Radiation Therapy on Mastectomy Use in Early-Stage Breast Cancer; Journal of Clinical Oncology; Vol 23, No 28 (October 1), 2005: pp. 7074-7080

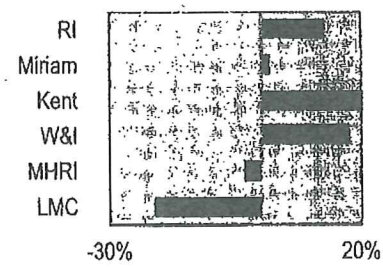
these special populations.

Finally, there would be inevitable consequences for the rescue services provided by local cities and towns. A recent letter from the Woonsocket Fire Chief points out that closure of LMC would more than triple the annual mileage for emergency runs of his department. This, in turn, would raise annual fuel and equipment costs by more than $160,000 per year. Loss of LMC would, in fact, undermine the entire local network of cities and towns which provide mutual back-up when one member is engaged in a rescue. According to Chief Lataille, the impact of closing LMC would "be incalculable."[5]

Closure of LHS would pose significant consequences for the broader economic health of Rhode Island as well.

Given LHS' low payment rates (Figure 2), treatment costs for its former patient group would be higher at those (larger facilities) most likely to serve as alternate sources of care. Despite higher costs, patients would receive precisely the same services and treatments they would have received at LMC - no different, no more or no less. Payments for these patients would simply increase raising the financial burden on insurers and subscribers without providing any additional benefits in return.

Figure 2: Rate Differentials '08



CMI Adj. Commercial Rates
Source: RI Office of health Insurance Commissioner (2010)

As the state's 31st largest employer, LHS' closure would further challenge the state's already troubled economy. The current record levels of unemployment (the nation's

> Health care is one of the few industry sectors in RI that has consistently expanded in recent decades. Health care is expected to supply approximately 25% of the new jobs needed to relieve the recession by 2013. Closure of LHS will significantly limit this expected growth.

third highest) will rise even further. Additional job losses would increase outlays for government programs while further reducing government tax revenues. These

5 Gary Lataille; Chief, Fire Division; City of Woonsocket; Correspondence to R. Charest; 11/03/09

impacts would have a significant net effect. (See table below.) The critical task of balancing the state budget would clearly become more difficult at precisely the time when consumer and business confidence is most needed. The closure of LHS would result in an even longer period of sluggish growth and economic instability in Rhode Island than is already anticipated.[6]

Table 1: Budget Deficit Implications	
Item	Estimate
Increased Spending	
Increased Unemployment Benefits	**$25.3 M**
Increased Medicaid Enrollment	**$5.02 M**
Increased Uncompensated Care	**$5.52 M**
Total Increased Spending	**$35.84 M**
Revenue Reductions	
Decreased Personal Income Taxes	**$3.98 M**
Decreased Sales Tax Collections	**$2.80 M**
Decreased TDI Payments	**$1.22 M**
Decreased Hospital Licensing Fees	**$5.33 M**
Total Revenue Reductions	**$13.33 M**
Grand Total	**$49.17 M**

The purpose of this report is to detail the specific consequences of closing LHS and the implications for the government and people of the state. In the sections that follow, we review the contributions of LHS to both the healthcare system and the general economy. We summarize the reasons for its present difficulties and the options for avoiding closure. We also estimate the impact of these closures on the state's budget and financial well being of Rhode Islanders. We demonstrate, as

6 Note: The longer the duration of a recessionary period, the greater is its long term damage on an economy. One key measure of duration is the number of months or years required for employment to return to pre-recession levels. In Rhode Island this would be the point at which 2006 employment levels were reestablished. As shown in Section 7 below, present projections indicate the recession will lift by the end of 2013. With the loss of jobs associated with the closure of LMC the duration of the recession will be extended for a year or more.

well, how the closure of these facilities would diminish access to health services and how this would lead to more overcrowding in emergency rooms and significant delays in hospital care - not simply in northern Rhode Island but throughout the state. In summarizing our findings we conclude that the difficulties and costs associated with the closure of LHS would far outweigh the comparatively small but necessary government assistance needed to insure their future operation.

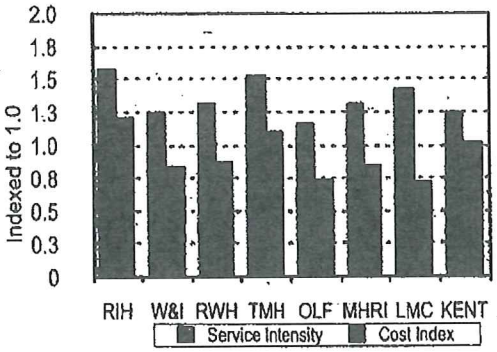
2. The Role of LHS in Providing Health Services

LMC and RHRI are each unique to the markets that they serve.

LMC is the dominant provider of short term acute hospital care in northern Rhode Island. At more than 40,000 emergency visits per year, it operates one of the state's busiest emergency services. More than 25% of LMC emergency room patients arrive by ambulance suffering from life threatening conditions such as acute cardiac disease or stroke. In some instances the care they require is not uniformly available at other area facilities. LMC is, for example, one of only three hospitals in Rhode Island qualified to provide emergency interventional care to patients suffering heart attacks.

In comparison with the seven other hospitals in the Providence vicinity, LMC ranks third in the complexity[7] of the care it provides. (See Figure 3.) LMC delivers more intensive and clinically complex care than is frequently provided at many other area hospitals. Nevertheless, LMC provides care at a lower cost than other facilities when compared on a patient-to-patient, service-to-service basis. This rare combination of complex care and low cost is important in restraining the growth of health costs in the area.

Figure 3: Case Mix Index Vs. Average Case Mix



Index level 1.0 equals payment received if all hospitals were reimbursed the same amount for like services.

Sources: The American Hospital Directory & The RI Office of the Health Insurance Commissioner. Cost Index includes Inpatient and Outpatient '08

RHRI, the second of the two LHS facilities, provides post acute rehabilitation services to patients who would otherwise require extended hospital stays because of difficulties in achieving full recovery. RHRI is the only freestanding hospital in Rhode Island approved by Medicare which is exclusively dedicated to providing rehabilitation care to such patients. This rigorous focus, once again, reduces patient lengths of stay in more costly acute settings and improves patient outcomes.

7 The blue bar in Figure 3 represents each hospital's case mix index. The red bar represents its average case mix adjusted costs. Case mix adjustment is a process developed by Medicare to measure the relative amount of care provided to different patients in order to determine reimbursement based on the relative value of services provided.

Finally, RHRI is the primary if not the only local program that can provide acute or post-acute rehabilitation to patients who must be weaned from ventilators. Without the availability of these services, the majority of such patients would remain hospitalized at an acute level of care incurring both higher costs and delays in their rehabilitation and recovery.

Like LMC, many of the services provided by RHRI are unique and would be costly to duplicate. Many patients typically served by this facility could not be accommodated by other area providers. Closure of RHRI would require out-of-state placement for a substantial portion of RHRI patients while others would simply remain in suboptimal settings at much higher costs.

Limited Capacity at Most RI Hospitals

Other area acute care hospitals have only limited ability to absorb the current patient load of LMC. This is largely due to the high average operating efficiency of Rhode Island facilities compared to those in other parts of the country. As a result, local hospitals require a lower than average supply of beds despite the fact that state residents (given mean age and other demographic characteristics) have greater than average need for hospitalization. This is demonstrated at right.

Table 2: Hospital Facts RI vs. US 07 *(per 1,000)*

Measure	RI	US Average
Hospital Beds	23	27
Hospital Admissions	121	117
Hospital Patient Days	636	645

Source: Kaiser Foundation, Fast Health Facts 2010

Current occupancy levels in Rhode Island are in fact approaching maximum functional capacity --particularly after considering the need to maintain reserve capacity for emergencies.

Emergency hospital admissions must be accommodated on an "on demand" basis. At the same time they are very frequent and occur unpredictably. For this reason, hospitals must routinely operate at average census levels well below their maximum capacities. This is an industry practice that ensures ready availability of emergency care.

Studies show that access to hospital care typically becomes compromised when average daily occupancies exceed eighty percent. At this level patients begin to back up in emergency rooms and the frequency of day-to-day bed shortages increases.[8]

The problem of high utilization is further compounded by differences in the types of care provided by area hospitals. As mentioned above, many of the particular services required by LMC patients are not uniformly available at other area hospitals (e.g., emergency angioplasty or radiation therapy.) LMC treats a relatively high proportion of adult medical surgical patients[9] compared to many other area facilities. These patients cannot be routinely served on hospital units designed to treat psychiatric, maternity or even pediatric patients. To the extent that an empty bed may be available elsewhere, it may not be the type of bed or service needed.

Table 3 below provides the current operating capacities for those hospitals that represent the closest sources of alternative care for LMC patients. Columns (f) and (g) indicate the current availability of adult medical surgical (AMS) beds only. These figures show that the number of AMS beds routinely available across the region is insufficient on any given day to accommodate the majority of LMC patients *without compromising the ability to care for area emergencies.*

While additional beds and services could be created at other hospitals, this process would require capital investment, planning and time. Area hospitals, moreover, may not be eager to undertake such investments in the face of uncertainty about which facilities would be the most likely to attract LMC patients. A "wait and see" attitude will likely prevail at area facilities in the event that LHS closes. In the meantime most hospitals will experience treatment and capacity shortages as more patients seek access to fewer available beds.

8 Giller et al; The Effect of Hospital Average Occupancy on Access to Care; Journal of Health Care Management, 2001

9 As opposed to patients requiring psychiatric or maternity services or pediatric care.

Table 3: Area Availability of Adult Medical Surgical (AMS) Bed for LMC Patients

(a)	(b)	(c)	(d)	(e)	(f)	(g)
Hospital	Patient Days	Total Staffed Capacity	Avg. Daily Census	Total Occupancy	Total AMS Capacity*	AMS Capacity @ 80%
Kent	85,371	291	234	80%	270	0
MHRI	37,515	167	103	62%	144	26
Fatima	76,876	295	211	72%	212	18
RIH	180,258	605	494	82%	514	-8
RWMC	41,410	171	113	66%	139	19
TMH	74,879	247	205	83%	247	-7
W&I	73,438	197	201	102%	51	-11
					Beds Available:	37
					Beds Needed:**	112
					Bed Deficit:	75
					Percent Deficit:	67%

Source: Price, Waterhouse, Coopers, 2010 - based upon FY 08 Statistics

* AMS = Adult Medical Surgical Beds; Calculation: Total beds minus dedicated beds for maternity, psychiatry, rehabilitation & pediatrics (Source: RI Dept. of Health, Annual Hospital Staffing Plans

** Beds needed are the number of beds required by LMC to maintain its average daily census of AMS patients at 80% occupancy.

3. The Role of LHS in the Rhode Island Economy

In addition to its importance to the state's system of health services, LHS is also a vital component of the state's economy. This section examines some of the key economic contributions made by these facilities.

- LHS is Rhode Island's 31st largest employer
- LMC & RHRI directly employ more than 1,300 persons annually
- LHS generates almost $190M in annual economic activity in addition to the salaries it pays. This activity supports a variety of business and other state institutions.
- The economic activity created by LHS supports an additional 1,500 "downstream" jobs within the state. (See Section 6 and Attachment 1.)
- LHS supports the activities of more than 100 physicians and their staffs throughout the state.
- LHS generates more than $13M in annual state tax revenues. (See Section 8.)

Closure of LHS would impose significant consequences upon the Rhode Island economy. At the current time of increasing unemployment and recession, these effects would be especially burdensome. These consequences are summarized in the list below and further discussed in subsequent sections.

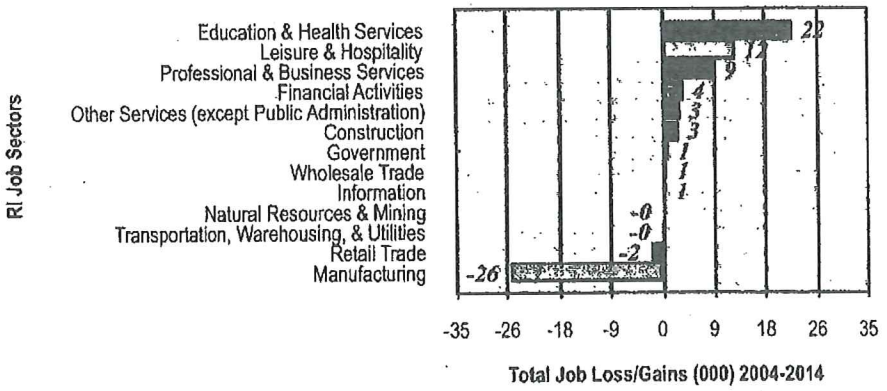
Yet another factor suggests that loss of jobs at LHS will have an exaggerated impact on the RI economy. This is because the health care sector is one of the most important sectors for future job growth.

Closure of LHS would result in:

- Loss of more than 2, 800 jobs
- A rise in the current unemployment rate to more than 14%
- Increased government borrowing to pay additional unemployment benefits
- An increase in the state's budget imbalance by almost $50 M (See Section 9.)
- An increase in Medicaid enrollment and uncompensated care costs
- Further jeopardy for the state's credit rating and possible increase in debt service costs

While Rhode Island has experienced a net loss of more than 30,000 jobs since the beginning of the recession (end of 2006), health care has actually continued to experience growth -- adding approximately 2,000 new jobs during that same period. In fact health services have been one of the state's most dependable growth sectors for more than a decade. Current projections indicate that health services will create more than 25% of the new jobs needed to relieve the current recession.[10] The fact that job losses at LHS would disturb the continued growth in a sector of the economy which is so critical to growth suggests that the closure of LHS would have a disproportionately large impact on the depth and duration of the current recession.

Figure 4:
Historical & Projected Change in Employment (000) by Sector 2004-2014



Source: Moody's Job Growth, RI 2000-2020, 2009

10 Statistics on growth and contraction in employment are based on Moody's "Historical and Projected Job Growth in Rhode Island"; 2010.

4. Causes of Financial Difficulties

Like many U.S. Hospitals, LMC and RHRI have been caught in the cross currents of diminishing reimbursement and increasing costs. LHS has been especially vulnerable to negative pricing pressures and has had little opportunity to supplement declining reimbursement in other ways.

One key element of this dilemma is well documented in the recent report on hospital payments issued by the Office of Rhode Island's Health Insurance Commissioner (OHIC).[11] This report identifies a statewide pattern of substantially lower reimbursement for independent hospitals (such as LMC) for any given service they might provide. That is, certain hospitals in Rhode Island are paid considerably less than certain other hospitals even when both groups of facilities provide the exact same set of services to similarly ill patients. This differential in payment is, moreover, not fully explained by other issues such as teaching costs, location or charity care.[12] According to the OHIC report, a significant portion of these differences are explained instead by preferential treatment garnered through bargaining power:

> "Hospitals affiliated with either of the two systems in Rhode Island are compensated on a case mix adjusted basis at 149 percent of Medicare for Care New England hospitals and 117 percent of Medicare for Lifespan hospitals. In comparison, while unaffiliated hospitals are paid at an average of 97 percent of Medicare.....There is considerable evidence that the hospital systems - particularly Care New England - possess power in particular service markets that gives them negotiating leverage."[13]

These disparities in payments have been a major factor in undermining the financial foundation of LMC in recent years. In reviewing payments for 2008, for example, the RI Insurance Commissioner concluded that LMC was reimbursed at only 78% of the statewide average for commercially insured patients (on a "service -to-service", case-mix adjusted basis.) This 22% "penalty" is highly significant. If LMC had been

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11 Office of the Rhode Island Health Insurance Commissioner; Variations in Hospital Payments by Insurers in Rhode Island; Providence , RI; 2010

12 Ibid, See Page #4, Paragraph 4

13 Ibid

paid at 100% of average in 2008 (rather than at 78%) the resulting increasing in revenues would have resulted in an annual positive net income for the year instead of the losses that were experienced.[14]

The size of this underpayment has serious implications. This is especially true after noting that these payment disparities have spanned several years (and continue today.) [15]

In February of this year, The Rhode Island Department of Health published an analysis of changes in capital reserves at Rhode Island Hospital's between 2003 and 2008.[16] As was the case with the OHIC report, The DOH found that, capital reserves at independent hospitals suffered far more in general in recent years than those at hospitals belonging to larger systems. In stating this finding DOH noted that these hospitals were literally facing a "capital crisis."

The inability to accumulate capital impairs a hospital's ability to operate during financially stressful periods and to maintain its plant and facilities on a regular basis. The relationship between the capital depletion of independent hospitals and the pattern of underpayment to these same facilities suggests at least a partial link between the two. It suggests as well that the inequitable bargaining power of the large systems is at least one key factor undermining the stability of the system as a whole.

The financial stability of LMC has been especially impaired by these dynamics. The hospital has seen its net assets drained away by almost $20 M since 2003. Having been forced into a negative reserve position, LHS has no more reserve capital to sustain itself in the face of inadequate commercial reimbursement and the other challenges it faces.

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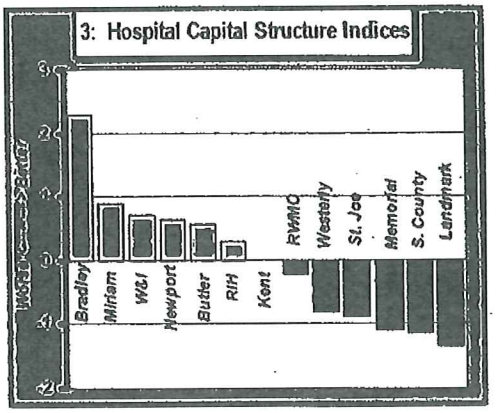
14 While the OHIC report examines only certain product lines (i.e., just a portion of total payments from BCBSRI and UHPNE,) the process for negotiating rates for these lines is similar or the same as that for all other contractual arrangements with these payers. This estimate above reasonably assumes that similar pricing differentials exist across all products with these insurers.

15 This issue is not new. From 2004-06, LMC continually raised this issue with the major payers and government officials. At the request of Blue Cross Blue Shield of RI, LMC submitted to an operations and financial audit by an outside auditor chosen by Blue Cross. After months of onsite review, this organization found that LMC was efficiently operated and was indeed inadequately reimbursed. Despite these findings little definitive long term action was taken.

16 Hospital Capital Investment; RI Department of Health; Providence R.I., 2010

Figure 5: Capital Assessment RI Hospitals



Source: RI Dept. Of Health 2010

It is important to note that disparities in commercial payments, imbalances in payer mix and other factors described above are not phenomena founded in public policy or the result of efforts designed to achieve any publicly adopted health system goals. They are by-products of the current business environment. The public assistance sought by LHS is, on the other hand, designed to counter balance these effects to a small but sufficient degree in order to maintain quality and accessibility of health care and to restrain rising costs. This assistance will make it possible to repair the damage that has occurred over the past several years to the economic foundation of LHS to and preserve valuable assets for the health care system and economy of the state.

While other area hospitals have been similarly affected by commercial payment discrepancies and other negative influences, they have been able to compensate to a degree by drawing upon local charitable support. This has not been an option for LMC. The core communities LMC serves are among the state's poorest -- suffering high poverty rates and long term endemic unemployment. While highly valuing LHS, little opportunity exists for these communities to generate the charitable support necessary to sustain it.

Despite constant cost cutting and the development of highly efficient operations, LHS facilities have functioned for many years upon a dwindling capital base. By the end of 2008, the organization's capital reserve balance was determined to have fallen to a negative $20M.[17] LHS cannot function indefinitely at this level of reserves.

17 Hospital Capital, Rhode Island Department of Health, Providence, 2010

5. A Viable Alternative

The most promising option for insuring the future of LHS is to join with a larger network of hospitals that could provide recapitalization and create opportunities for expense reduction and long term growth. LHS' negative capital balance however, poses a barrier to this approach. It establishes a formidable threshold beneath which new investment fails to create functional benefits such as facility improvement, program development or future stability.

LHS has explored merging with several possible suitors. In 2009 LHS entered into exclusive court approved negotiations with the Massachusetts based Caritas Christi Network; one of New England's most substantial hospital systems. Caritas Christi is able to invest capital in LHS and could provide other important benefits by incorporating LHS into its existing six hospital network. Accordingly LHS and Caritas have developed a multi-part recovery plan that includes the elements discussed below.

The cornerstone of this plan entails merging with the Caritas Christi Network. Under this arrangement Caritas would invest the $20M in capital for modernization of facilities and equipment and for making other improvements. It would also provide LHS with the value of its multi-million dollar infrastructure of operational support services for member hospitals. Through these mechanisms, Caritas would help LHS expand base of primary care and specialty staff, create cost reductions through economies of scale and otherwise promote future growth.

Another important element of the recovery plan is for LHS and Caritas to pursue certain changes in LHS' provider agreements with the federal Medicare and other government programs. These changes are expected to result in improved levels of reimbursement for the large portion of LHS patients who utilize these programs.

Finally, this plan includes a request for state assistance. This assistance would consist of subsidy payments over a four year period in the amount of approximately $5M per year. Payments would terminate after the fourth year resulting in total assistance equivalent to $20M. Provision of these temporary subsidies would enable LHS to joint with Caritas and begin its recovery as soon as possible. As demonstrated throughout this document, this assistance would be more than justified in light of the value that LHS brings to the health care and economy of Rhode Island.

6. Economic Profile: State of Rhode Island

In order to fully demonstrate the economic consequences of closing LHS, it is necessary to review the local economy and the challenges faced in achieving a speedy recovery from the current recession.

Rhode Island has been especially hard hit by the current nation-wide recession. Since 2007 the state's gross economic output has declined by almost 1% and is estimated to have declined similarly in the past year.[18] As indicated in Table 3, this contraction has affected Rhode Islanders in key ways.

Table 3
RI Key Economic Measures

Measure	2006	2009	% Change
Unemployment	5.2%	13%	+130%
Personal Income Growth*	5.2%	0.8%	- 85%
Bankruptcy Rate*	2.59	4.79	+85%
* Per Capita			

According to Moody's, two factors in particular will determine the depth of the current recession and the ease of recovery. The first is the ultimate severity of unemployment in RI. How high will it rise? How much time will be required to reduce it to normal levels?

The second factor is the speed and effectiveness with which state government will achieve a balanced budget. This factor plays a key role in creating the confidence needed from businesses, the financial community and consumers to rebuild the state's economy.

Unemployment

Unemployment is both a key result and a key cause of recession. Long standing increases in unemployment create self-reinforcing patterns of economic contraction. As these patterns ripple through the economy they become entrenched within it.

18 Precis on the Rhode Island Economy; Moody's; 2010

The longer that high unemployment persists, the greater is its effect and the more difficult it becomes to combat.

As Table 4 indicates, the Rhode Island economy lost approximately 30,000 jobs between 2006 and 2009. Another 6-7,000 are presently expected to be lost the current year.[19] Given the current and projected rates of job creation, pre-recession employment levels will not be reached until 2013 at the earliest.

Closure of LHS facilities would measurably increase the additional number of jobs lost this year. It would furthermore delay re-employment for many persons by increasing competition for the finite number of jobs that are created. With few sectors of the economy growing in the near future, the loss of jobs at LMC could not be readily replaced by growth in other industries. Disruption of expected growth within a primary growth sector at a time of especially high unemployment would slow the speed of recovery just as efforts to spur it are getting underway. Table 4 indicates the difference between current job growth projections (Moody's) and revised projections assuming closure of LHS. (See Attachment 1.) Comparison is made between the key years of 2006 (the last pre-recession year) and 2013 (the year currently projected for completion of the recovery.)[20] The table shows that recovery level employment will be delayed by a year or more by closure of LHS.

Table 4: Impact on Unemployment & Recovery

	2006	2009	2010	2011	2012	2013
Current Projections						
Total employment (000)	493	464	458	464	478	493
Projected employment Change	0.5%	-3.7%	-1.2%	1.2%	3.1%	3.2%
Unemployment rate	5.1%	12.0%	13.4%	11.8%	9.2%	7.7%
With Closure of LHS						
Total employment (000)		464	455	460	475	490
Revised unemployment rate		12.0%	14.5%	12.4%	9.8%	8.3%
Difference						
Total employment (000)			-3.11	-3.19	-3.14	-3.06
Unemployment rate			-1.1%	-0.6%	-0.6%	-0.6%

Sources: Current Projections / Moody's Precis of RI Economy 2010

Revised Projections - See Calculations - Attachment 1

19 Annual Five Year Precis of The RI Economy, Moody's Economy.com, 2009.

20 The impact on unemployment used for this comparison is the loss of 2,800 jobs in 2010. This estimate is further described in Attachment 1. It is based on the loss of all employment at LHS (approximately 1,300 jobs) and the additional downstream or indirect loss of 1,500 jobs in the broader economy. The estimate of indirect job losses is based on employment conversion tables published by the Institute for Economic Development in Washington, DC. These are industry specific indices are further explained in Attachment 1.

Deficits

The second key factor affecting the speed of recovery is the speed with which deficit spending will be eliminated. While substantial efforts have been taken to close this gap, deficits continue to loom in the years ahead.

FY 2011 - FY 2014 Estimated Deficits
$ million

	FY 2011	FY 2012	FY 2013	FY 2014
State Budget Office	($155.7)	($369.9)	($429.9)	($482.3)
Deficit as Percent of Available Revenues	-5.0%	-11.7%	-13.2%	-14.5%

Source: RIPEC Calculations based on State Budget Documents

Deficit spending, like unemployment, is also a driving cause and a significant effect of recession. The longer it continues, the longer is the persistent threat of higher taxes and / or cutbacks in public services. These threats create uncertainty for individuals as well as the business community. They make growth of existing businesses and attraction of new ones (and therefore reduction of unemployment) more difficult. Deficits also create further increases in government costs as both borrowing and the cost of borrowing rise for government and government dependent borrowers (schools, hospitals and public facilities.)

While Rhode Island deserves praise from the financial community for addressing its deficits head-on, it has nevertheless suffered reduced credit ratings and received criticism for failing to address the underlying structural causes of deficit spending. In a recent public comment on the state's credit worthiness, Moody's specifically cited deficit spending as a key reason for the state's continued negative credit outlook:

> " In the past several years, Rhode Island has balanced its budgets with one-time solutions and increased its short-term borrowings for cash flow purposes. This raises concern regarding the state's likelihood of achieving structural budget balance in the near term, especially given the recently identified budget gaps for fiscal 2010 and forecast for fiscal 2011 as the state's economy remains weak. As a result, the outlook on the state's credit is negative. Future credit reviews will consider the state's resolution of its budget shortfalls, with a focus on solutions that move toward balancing recurring revenues with ongoing expenditures; out

year planning for the fall off in federal stimulus funds; liquidity position; and potential for economic resilience."[21]

As indicated, closure of LHS will have a direct impact on both the annual revenues and costs of state government --with the net effect of increasing the budget imbalance by approximately $50M in the next 12 months (see Table 5 below) and affecting future budgets in various ways. The net effect will be an enlargement of the budget gap even as new steps are being taken to reduce it.

21 *"Moody's Also Confirms Negative Outlook on State's Rating", Municipal Bonds News, Municipal Bonds.com 1/19/10*

7. A Longer and Deeper Recession

The current recession, while clearly national in scope, was felt sooner in Rhode Island and is expected to last longer here than across the nation as a whole. The state faces significant challenges in achieving a strong and lasting recovery. To quote Moody's once again:

> " RI's recovery will lag, and employment will not return to its pre-recession level until 2013. Longer term, the state still has significant problems to work through, including weak demographics, high energy costs, and a poor business-competitiveness profile. As a result, employment and income growth in RI will lag behind the U.S. average for the foreseeable future." [22]

The closure of LHS will increase projected unemployment in RI above 14% in the current year based upon recent projections.[23] Given the presently projected balance between annual job creation and job loss, this increase will delay the re-establishment of pre-recession job levels by one year or more. (See above.)

Closure of LHS facilities would clearly present yet further challenges to state recovery efforts both in terms of unemployment as well as fiscal management. It would likely result in a recessionary period that is both longer and deeper than presently projected.

22The Rhode Island Economy Annual 5 Year Precis,, Moody's Economy.com, 2009

23 Ibid.

8. Impact Summary

We have described the various ways in which the closure of LHS will impact the availability of health services and the Rhode Island economy. The ramifications of these impacts have been discussed as well. The following Table provides a summary of specific impacts we have discussed or referenced above as well as a specific estimate for each. The substance of these estimates is provided in greater detail in Attachment 1.

Table 5: Summary of Economic Impacts

Item	Estimate
Increased Spending	
Increased Unemployment Benefits	**$25.3 M**
Increased Medicaid Enrollment	**$5.02 M**
Increased Uncompensated Care	**$5.52 M**
Total Increased Spending	**$35.84 M**
Revenue Reductions	
Decreased Personal Income Taxes	**$3.98 M**
Decreases in Sales Tax	**$2.80 M**
Decreased TDI Payments	**$1.22 M**
Decreased Hospital Licensing Fees	**$5.33 M**
Total Revenue Reductions	**$13.33 M**
Grand Total	**$49.17 M**

9. Conclusion

As this review demonstrates, the closure of LHS would have significant consequences for the availability of health services in most locations in Rhode Island and for the future health of the state's economy as well. Health care would quickly become both less affordable and less accessible while the sluggishness in job growth and economic instability will persist longer than presently expected.

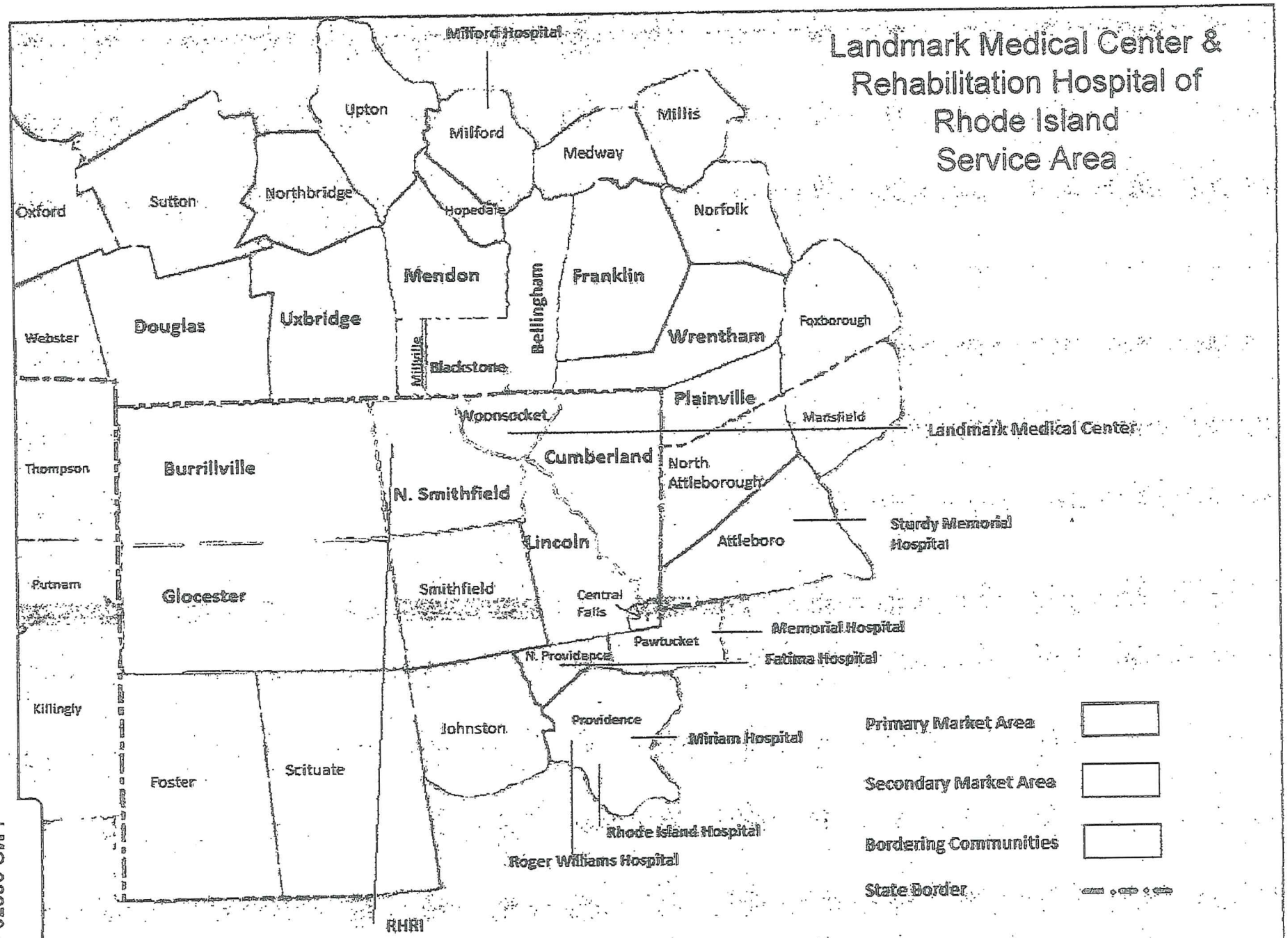
There can be little question that the public would be well served by government measures to facilitate the plan developed by LHS and its prospective partner. **The total amount of assistance required would clearly be far less than the costs and other disruptions that would otherwise result.**

LHS has worked creatively to establish an option that will garner several times again the the value of the public assistance needed to set it in place. This option poses a promising opportunity for LHS and a promising arrangement for the people of Rhode Island.

(End page)

EXHIBIT 17(c)

Landmark Medical Center & Rehabilitation Hospital of Rhode Island Service Area



LMC 02879-1282

EXHIBIT 18

Landmark Medical Center
Patient Financial Services
Patient Accounts

Policy

Charity Care Program

Title of Contact: Director of Patient Accounts

Date Effective	Supercedes	Date Reviewed/Revised	Page 1 of 3
February 1997	March 2008	September 2009	

Purpose:

To ensure every patient regardless of their residence who claims an inability to pay and requests a Charity Care application is treated equally during the process. Documentation of "Family Unit" (related by birth, adoption or by legal means) incomes, assets, is required with the application or appropriate letters showing no income. The Federal Poverty Income Guideline, as published and updated each year, is used to determine the percentage of the reduction.

Policy:

1. **Documentation Requirements**:
    a. Patient/guarantor must provide (4) current pay stubs and/or copy of the most current W-2 and related Income Tax Return
    b. Patients that are un-employed are required to apply for un-employment and to provide letter of proof for unemployment
    c. Patient/guarantor required to provide Family Unit income

2. **Asset Requirements**:
    a. Assets = Cash on hand, savings accounts, checking accounts, CDs, money market accounts, stocks, bonds, mutual funds, IRAs, 401(k), 403(b), personal property, motor vehicles other than for personal use, second homes and rental properties
    b. Assets exclude primary residence and a motor vehicle for personal use
    c. Asset Protection Threshold, which is updated annually (see attached schedule)
    d. Patients with Assets greater than the threshold may not qualify for 100% Charity Care, but may qualify for a lesser discount
    e. Excess of Asset Protection Threshold + Income = Adjusted Income for sliding scale purposes
    f. Sliding Scale criteria is based on current year Federal Poverty Guidelines. This scale is updated annually in March. (see attached schedule)

3. **Discount Schedule**

a.	0 – 200% poverty level	100% discount
b.	201 – 225% poverty level	80% discount
c.	226 – 250 %poverty level	60% discount
d.	251 – 275 %poverty level	40% discount
e.	276 – 300% poverty level	20% discount

4. All patients, family member/legal representative requesting Charity Care must complete an application form. Application forms may be requested by telephone, letter, in person at the Customer Service Department, from a Public Assistance Advocate (PAA), and all registration areas at LMC. Complete applications must be received within 90 days of discharge from the hospital. Incomplete applications will not be considered after 90 days.

5. The approval effective date will be retroactive for dates of service within the last three months for patients with outstanding accounts from prior months. Account balances that are prior to the three month threshold will not be eligible. If no prior accounts, the approval will be effective on the 1st of the month in which the application is received.

6. Applications and all required documentation must be attached and sent to the PAA at the Woonsocket Unit who will date stamp and review the form and the documentation attached for completeness. The PAA will enter a standard account note (991-Charity App. Rec'd.-Pending Review). The PAA has 14 days from receipt of application to review, render a decision, and request additional information, and notify patient/guarantor of the determination.

7. The determination letter will be sent to the patient/guarantor. Approval letters will show the amount of the reduction, listing of eligible account numbers and/or 6-12 month eligible date range. Denial letters will show the reason for denial. The patient/guarantor has the right to appeal the amount of reduction or denial. Additional information/documentation must be provided within 10 days of receipt of the determination letter. Both letters include information regarding setting up a payment plan, if applicable.

8. The PAA enters an account note on all accounts affected by the application period with the approval and the percentage or the denial and the reason.

9. The PAA will forward all the documents pertaining to the application to the File Clerk/Collator, which will be scanned to the patient's account as a global document.

10. The PAA also completes the user defined field in Account Revision in the following format (Financial Class, %, Approval time frame).

11. All existing and any subsequent accounts with balances will appear on a daily SQL report until the user defined field information is deleted after the end date. This report is reviewed daily by the Customer Service Representative and balances are adjusted accordingly

12. The CSR will reduce the account balance by the approved percentage reduction on each account owed by the patient or family member living in the household as indicated on the application. If an application is returned to the patient as "incomplete", this is considered a denial. A zero dollar credit allowance will be posted to track all denials. If a denied application is subsequently approved you must debit the zero denial allowance. Below is a listing of the allowances to be used:

- A0280 Charity Care Approved 0-200% (S)
- A0281 Charity Care Approved >200% (S)
- A0282 Charity Care Denied 0-200% (S)
- A0283 Charity Care Denied >200% (S)
- A0284 Charity Care Approved 0-200% (Y)
- A0285 Charity Care Approved >200% (Y)
- A0286 Charity Care Denied 0-200% (Y)
- A0287 Charity Care Denied >200% (Y)
- A0288 Charity Care Approved 0-200% (Z)
- A0289 Charity Care Approved >200% (Z)
- A0290 Charity Care Denied 0-200% (Z)
- A0291 Charity Care Denied >200% (Z)

Responsibility: Public Assistance Advocate, Customer Service Representative

Landmark Medical Center/RHRI Hospital of Rhode Island
Sliding Fee Scale
Based on 2011 Federal Poverty Guidelines

Family Size	100 % Discount		80 % Discount		60 % Discount		40 % Discount		20 % Discount	
	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below
1	$0	$21,780	$21,781	$24,503	$24,504	$27,225	$27,226	$29,948	$29,949	$32,670
2	$0	$29,420	$29,421	$33,098	$33,099	$36,775	$36,776	$40,453	$40,454	$44,130
3	$0	$37,060	$37,061	$41,693	$41,694	$46,325	$46,326	$50,958	$50,959	$55,590
4	$0	$44,700	$44,701	$50,288	$50,289	$55,875	$55,876	$61,463	$61,464	$67,050
5	$0	$52,340	$52,341	$58,883	$58,884	$65,425	$65,426	$71,968	$71,969	$78,510
6	$0	$59,980	$59,981	$67,478	$67,479	$74,975	$74,976	$82,473	$82,474	$89,970
7	$0	$67,620	$67,621	$76,073	$76,074	$84,525	$84,526	$92,978	$92,979	$101,430
8	$0	$75,260	$75,261	$84,668	$84,669	$94,075	$94,076	$103,483	$103,484	$112,890
% of Poverty	100% -200%		201% - 225%		226% - 250%		251% - 275%		276% - 300%	

For Family Units with more than 8 members, for each additional member add $3,820

Y & Z-Bal After Ins	100%	75%	50%	25%	20%

Assets Protection Thresholds for Charity Care in RI hospitals					
ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt					
		raw		rounded closest 100	
		individual	family	individual	family
	avg-avg increase				
base year 2006		8000	12000		
increase 2006-2007	3.20%				
level for 2007		8256	12384	8300	12400
increase 2007-2008	2.80%				
level for 2008		8487.17	12730.75	8500	12700
increase 2008-2009	3.80%				
level for 2009		8809.68	13214.52	8800	13200
increase 2009-2010	-0.40%				
level for 2010		--------	-------	8800	13200
increase 2010-2011	1.6%*				
level for 2011	1.3% two year*	8924.21	13386.31	8900	13400
increase 2011-2012					
level for 2012***					
*** CPI has risen steadily each month in 2011 so expect increase for 2012					
* raw score 2009 = 215.303					
raw score 2011= 218.056					
net increase 2009-2011= 1.3%					