Interim Reports on Steward Health Care System

Pursuant to 2010 and 2011 Assessment & Monitoring Agreements

January 30, 2013

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To Interested Parties:

The Office of the Attorney General ("AGO") is pleased to issue two Interim Reports concerning its five-year monitoring of Steward Health Care System LLC ("Steward") following Steward's acquisition of the assets of the Caritas Christi, Morton, and Quincy health systems (the "Transactions"):

- The Compliance Monitoring Report assesses Steward's compliance with certain provisions of the Asset Purchase Agreements for the Transactions; and

- The Impact Monitoring Report evaluates the overall impact of the Transactions on the provision of health care services to the communities served by Steward.

Both Reports are issued pursuant to the Assessment and Monitoring Agreements executed between the AGO and Steward at the time of the Transactions. This letter provides a brief overview of the Transactions and the origin of the AGO's monitoring role.

In 2010 and 2011, Steward acquired substantially all of the assets of the non-profit Caritas Christi, Morton, and Quincy health systems. In connection with its review of each of the three Transactions under the charities law G.L. c. 180, § 8A(d), the AGO entered into an Assessment and Monitoring Agreement with Steward.[1] These agreements allow the AGO to monitor and increase the transparency of the Steward system in two respects. First, the agreements authorize the AGO to collect information and report on Steward's compliance with specific provisions of the Asset Purchase Agreement ("APA") in each acquisition ("Compliance Monitoring"). This includes monitoring Steward's compliance with APA provisions regarding employee retention, capital expenditures, community benefits, indigent and low income care, and restrictions on sale or closure.

Second, the Assessment and Monitoring Agreements authorize the AGO to report on the overall "impact of the Transaction[s] on the provision of health care services to the Communities" served by Steward ("Impact Monitoring").[2] In committing to monitor Steward's impact, the AGO recognized that the Transactions represent a significant increase in for-profit health systems in the Commonwealth, and that Steward's stated business strategy of developing

[1] *E.g.*, Att'y Gen. of the Comm. of Mass., Caritas Christi & Steward Health Care Sys. LLC, Assessment & Monitoring Agreement ¶ 1 (Oct. 20, 2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-p.pdf.
[2] *Id.*

a lower-cost option that keeps more care in the community will have broader implications for the health care market, including competitor providers, insurers, consumers, and other stakeholders. In approving the Caritas acquisition, the AGO stated that its monitoring would allow the AGO to "document and understand" Steward's performance in meeting its stated objectives.[3] The attached Interim Reports fulfill that commitment.

In developing and conducting our review of Steward's impact, we have considered Steward's stated objective in acquiring the Caritas, Morton, and Quincy health systems:

> [T]o improve and further develop a community-hospital based health care system capable of (i) managing risk, (ii) providing high quality, local, and accessible care, and (iii) reducing out-migration of patients who now obtain services, otherwise available at a Caritas Hospital, at higher cost, less accessible settings. By keeping significantly more of that patient care, and the associated revenues, within the Steward system, Steward states it will provide an appropriate return to its investors while providing a lower-cost alternative to the public.[4]

Our first year of review reinforces previous findings that Steward acquired community hospitals in deteriorating financial condition and with significant deferred capital investment needs. Our review of Steward's impact in its first year of operations indicates it is striving to meet its stated objective. From the outset of the Caritas transaction, Steward has stated that implementation of its business model is a multiyear process requiring significant investments in its care delivery system. One year of mature performance information does not provide a reasonable basis to predict or draw conclusions about Steward's ongoing performance or whether it will continue to meet its stated objective.

The AGO is pleased to issue these two Reports reflecting information from its first year of Steward monitoring.

Sincerely,

Martha Coakley
Attorney General of the
Commonwealth of Massachusetts

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[3] OFF. OF ATT'Y GEN. MARTHA COAKLEY, STATEMENT OF THE ATTORNEY GENERAL AS TO THE CARITAS CHRISTI TRANSACTION app. at A9 (2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-m.pdf ("In the event that a community-hospital based health care system can provide effective care in a local setting without raising costs to the public, reducing services, or limiting access or choice, the public would be well served, and the Attorney General wants to document and understand the basis of that success. In the event the effort is not successful, the Attorney General wants to document and understand the basis of that failure. [. . . .] The evaluations undertaken as part of the Assessment and Monitoring Agreement will further that objective.").

[4] *Id.* at A8; *see also* Letter from Counsel for Caritas Christi to the Off. of the Att'y Gen. 11 (May 5, 2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-l.pdf (describing Steward's intention to "provide high-quality, lower-cost care in a community setting, as a complement to the highly-specialized care offered by Boston's academic medical centers").

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY

Interim Report on Steward Health Care System Compliance with Asset Purchase Agreements Pursuant to 2010 & 2011 Assessment & Monitoring Agreements

January 30, 2013

In this Compliance Monitoring Report, the Office of the Attorney General ("AGO") assesses whether Steward Health Care System LLC ("Steward") is in compliance with specific provisions of the Asset Purchase Agreements ("APA") that Steward executed in acquiring substantially all of the assets of the Caritas Christi, Morton, and Quincy health systems.

This Compliance Monitoring Report has two parts. Part I provides a brief overview of the Steward acquisitions and the AGO's monitoring role that arises out of those transactions. Part II assesses Steward's compliance with its APA commitments and finds that Steward has timely met one commitment and is currently in compliance with the other, ongoing commitments.

I. ORIGINS OF THE AGO'S MONITORING OF STEWARD

In May 2010, Caritas Christi Health Care ("Caritas") provided notice to the AGO under G.L. c. 180, § 8A(d) of its intent to sell substantially all of its assets to Steward Health Care System LLC, an affiliate of private equity firm Cerberus Capital Management, L.P.[1] In acquiring the Caritas assets, Steward described its business objective as developing a high quality, lower-cost, community-based health care system that can serve as a viable alternative to more expensive models of care, such as those often centered at urban academic medical centers.[2] Steward based its model in part on evidence of significant patient migration from local communities to Boston academic medical centers for care.[3]

The AGO engaged in a comprehensive review of the proposed acquisition (the "Transaction") and issued a statement on October 6, 2010 finding that the Transaction

[1] See *Caritas Christi Health Care System Transaction*, ATT'Y GEN. MARTHA COAKLEY, http://www.mass.gov/ago/caritas (last visited Nov. 9, 2012), for Caritas's May 5, 2010 notice and other documents relevant to that transaction. See *Morton Hospital & Medical Center Transaction*, ATT'Y GEN. MARTHA COAKLEY, http://www.mass.gov/ago/morton (last visited Nov. 9, 2012), and *Quincy Medical Center Transaction*, ATT'Y GEN. MARTHA COAKLEY, http://www.mass.gov/ago/quincy (last visited Nov. 9, 2012), for documents relevant to those transactions.

[2] *E.g.*, Letter from Counsel for Caritas Christi to the Off. of the Att'y Gen. 11 (May 5, 2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-l.pdf (describing Steward's intention to "provide high-quality, lower-cost care in a community setting, as a complement to the highly-specialized care offered by Boston's academic medical centers").

[3] *See, e.g.*, DIV. OF HEALTH CARE FIN. & POLICY, MASS. EXEC. OFF. OF HEALTH & HUMAN SERVS., MASSACHUSETTS HEALTH CARE COST TRENDS: TRENDS IN HEALTH EXPENDITURES, at 20 (2011), *available at* http://www.mass.gov/chia/docs/cost-trend-docs/cost-trends-docs-2011/health-expenditures-report.pdf (showing that in 2009, 52% of commercial spending on inpatient care in Massachusetts was for care obtained at Boston area tertiary, teaching, or specialty hospitals).

complied with the charities law and public interest requirements of G.L. c. 180, § 8A(d).[4] The AGO's findings included:

A. That Caritas was in a precarious and unstable financial situation and would likely be unable to meet its capital needs in light of its aging facilities, its underfunded pension liability, and its debt obligations;
B. That it was impracticable, if not impossible, for Caritas to continue to operate the system as a public charity;
C. That doing so would leave the pensions of some 13,000 current and former employees substantially underfunded, uninsured, and at risk; and
D. That at least one of the Caritas hospitals would likely have to close.[5]

The AGO determined that "[w]hile there are risks to the public inherent in any transfer of ownership of a hospital, under any tax or ownership structure, those risks are outweighed in this case by the known and quantifiable risks of not proceeding with the Transaction. On that basis alone, the Attorney General finds that the Transaction is in the public interest."[6]

The AGO also found certain provisions of the Transaction related to the public interest, including Steward's commitment to assume Caritas's full pension liability, its commitment not to close or limit the purposes of the Caritas hospitals for a period of years, and its commitment to make necessary investments in the infrastructure of the system. In connection with its review of the Transaction, the AGO secured amendments to the APA between Caritas and Steward to increase Steward's commitments on such "public interest" issues.[7] Recognizing that Caritas would not be in a position to enforce many of these APA commitments, the AGO also executed an Enforcement Agreement with Steward confirming the AGO would have the right to enforce those provisions on behalf of the public (the "AGO Enforceable Provisions").[8]

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[4] OFF. OF ATT'Y GEN. MARTHA COAKLEY, STATEMENT OF THE ATTORNEY GENERAL AS TO THE CARITAS CHRISTI TRANSACTION 7–9 (2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-m.pdf.

[5] *Id.* at 14.

[6] *Id.* at 26.

[7] Caritas Christi & Steward Health Care Sys. LLC, Amendment No. 1 to APA (Oct. 5, 2010) [hereinafter Amendment to Caritas APA], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/amendment-1-to-apa.pdf. Similarly, in connection with its review of the Morton Hospital and Quincy Medical Center transactions, the AGO secured amendments to those APAs to enhance Steward's commitments relating to the public interest. *See* Morton Hosp. & Med. Ctr., Inc. et al. & Steward Med. Holdings Subsidiary Three, Inc., Amendment No. 1 to APA (Sept. 6, 2011) [hereinafter Amendment to Morton APA], *available at* http://www.mass.gov/ago/docs/nonprofit/morton/amendment-1-to-apa.pdf; Quincy Med. Ctr., Inc. et al. & Steward Med. Holdings Subsidiary Five, Inc. et al., Second Amendment to APA (Sept. 7, 2011) [hereinafter Amendment to Quincy APA], *available at* http://www.mass.gov/ago/docs/nonprofit/quincy/amendment-2-to-apa.pdf.

[8] Att'y Gen. of the Comm. of Mass., Caritas Christi et al. & Steward Health Care Sys. LLC et al., Enforcement Agreement (Oct. 20, 2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-n.pdf; *see also* Att'y Gen. of the Comm. of Mass., Steward Health Care Sys. LLC, RCAB & Trs. of the Caritas Christi Ret. Plan, Pension Transfer Enforcement Letter-Agreement (Oct. 20, 2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-o.pdf.

In connection with its review of the Caritas, Morton, and Quincy transactions under G.L. c. 180, § 8A(d), the AGO also entered into three substantively identical Assessment and Monitoring Agreements with Steward.[9] These agreements allow the AGO to monitor and report on the Steward system in two respects. First, the agreements authorize the AGO to collect information and report on Steward's compliance with the AGO Enforceable Provisions – the subject of this first Compliance Monitoring Report. Second, the agreements authorize the AGO to report on the overall "impact of the Transaction[s] on the provision of health care services to the Communities" served by Steward – the subject of the AGO's first Impact Monitoring Report.

These twin Reports reflect the AGO's commitment to monitoring Steward Health Care System pursuant to the Assessment and Monitoring Agreements. In future years of monitoring, we look forward to building on the framework presented in these first Interim Reports.

II. STEWARD'S COMPLIANCE WITH SPECIFIC APA PROVISIONS

During 2011 and 2012, the AGO, through its Non-Profit Organizations/Public Charities Division**,** requested information and documents relevant to Steward's compliance with the AGO Enforceable Provisions. AGO staff reviewed the information Steward submitted, requested clarification of certain aspects of the information, and reviewed Steward's responses to those subsequent requests. The AGO's review of this information indicates that Steward has met one commitment in a timely manner and is currently in compliance with the other AGO Enforceable Provisions, which contain ongoing commitments. We address Steward's compliance with each of the AGO Enforceable Provisions below.

A. Offers of Employment[10]

Each of the three transactions (Caritas, Morton, Quincy) included a commitment that Steward would offer employment to most members of the workforce of the sellers. There was no guarantee regarding the duration of that employment. Steward has confirmed compliance with these commitments, and the AGO has not received any information of non-compliance.

[9] *E.g.*, Att'y Gen. of the Comm. of Mass., Caritas Christi & Steward Health Care Sys. LLC, Assessment & Monitoring Agreement ¶ 1 (Oct. 20, 2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-p.pdf.

[10] *See* Caritas Christi & Steward Health Care Sys. LLC, APA § 8.6(a) (Mar. 19, 2010) [hereinafter Caritas APA], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-b.pdf; Morton Hosp. & Med. Ctr., Inc. et al. & Steward Med. Holdings Subsidiary Three, Inc., APA § 10.1(a) (Mar. 29, 2011) [hereinafter Morton APA], *available at* http://www.mass.gov/ago/docs/nonprofit/morton/complaint-exhibit-a.pdf; Quincy Med. Ctr., Inc. et al. & Steward Med. Holdings Subsidiary Five, Inc. et al., APA § 9.1 (June 30, 2011) [hereinafter Quincy APA], *available at* http://www.mass.gov/ago/docs/nonprofit/quincy/exhibit-a.pdf.

B. Capital and Related Expenditures[11]

Each transaction included a commitment that Steward would spend or commit to spend a specified minimum amount in capital improvements or related expenditures to address significant deferred capital investment needs. The specific terms of each commitment, including the time horizons for meeting the commitment, vary among the three APAs. Steward has reported substantial investments in its delivery system infrastructure through projects undertaken or planned, and thus appears on track to meet its APA commitments.[12] Examples of projects at the six former Caritas hospitals include:

- Emergency department renovations at Good Samaritan Medical Center, Holy Family Hospital, and St. Anne's Hospital ($38.8 million)
- Improvements to the Carney Hospital surgery suite and adolescent behavioral health unit ($12.1 million)
- Radiation oncology facilities at St. Elizabeth's Medical Center ($10.5 million)
- A cardiac catheterization laboratory at Norwood Hospital ($4.2 million)

Examples of projects Steward has undertaken or planned at Morton and Quincy include:

- A maternity surgery suite, an orthopedics suite, and lobby renovations at Quincy Medical Center ($27.4 million)
- Emergency department and lobby renovations at Morton Hospital ($24 million)
- Information technology investments at both facilities ($16.8 million)

C. Charity Care and Community Benefits[13]

Each transaction included a commitment by Steward to maintain the charity and indigent care policies in effect at each hospital immediately prior to Steward's acquisition. Steward has since standardized charity and indigent care policies across its hospitals. The new

[11] *See* Caritas APA, *supra* note 10, § 8.8(a) (committing to spend at least $400 million in the first four years "to promote the financial health, well being and/or growth of the Health Care System, including amounts that would qualify as capital expenditures by the Health Care System under GAAP"); Morton APA, *supra* note 10, § 11.6(a) (committing to spend at least $85 million in capital expenditures and investments in the first five years following the acquisition, of which at least $25.5 million is to be spent or committed in the first 12 months and at least $59.5 million in the next 48 months, with additional capital commitments of $25-$35 million in years six through ten following the acquisition); Quincy APA, *supra* note 10, § 8.20(b) (committing to spend at least $34 million in capital expenditures and investments in the first five years following the acquisition, of which at least $15 million is to be spent or committed in the first year and at least $10 million in the second year, with additional capital commitments of approximately $4 million per year in years six through ten).

[12] At the time of our review last year, none of the initial deadlines for expenditures had been reached. Accordingly, this Report highlights expenditures and demonstrates significant investment by Steward, but does not assess whether any of the spending commitments has been fully satisfied.

[13] *See* Caritas APA, *supra* note 10, §§ 8.9, 8.10; Morton APA, *supra* note 10, § 11.6(c); Quincy APA, *supra* note 10, § 8.20(a).

policies are consistent with the pre-acquisition policies and with Massachusetts regulations governing hospital credit and collection policies.

Steward agreed in each transaction to comply with the AGO's Community Benefits Guidelines and to report on community benefits and charity care under those Guidelines.[14] Information on the community benefits and charity care levels at each Steward hospital is thus available on the AGO's website.[15] These filings indicate that FY11 community benefits and charity care expenditures at the six former Caritas hospitals equaled or exceeded pre-acquisition levels.[16]

D. Maintenance/No Closure of Services[17]

Each transaction included a slightly different commitment with respect to maintenance of services at the acquired hospitals. Information we received indicates that Steward is currently in compliance with these commitments.[18]

E. Use of Names[19]

Steward committed to maintaining the use of names – including names of the hospitals and of certain named portions of the hospitals – following the transactions. Steward has represented its compliance with these commitments and we have not received any information that indicates otherwise.

[14] The AGO's Community Benefits Guidelines for Non-Profit Hospitals are applicable to non-profit, tax-exempt acute care hospitals and outline principles for developing, implementing, and reporting on this component of charitable activity in the communities those hospitals serve. Steward agreed to maintain and report on community benefit activities at the acquired hospitals under the Guidelines, even though it is not entitled to tax exemption and accordingly, unlike non-profit hospitals, pays real estate and other taxes in those communities. Steward has stated that in its first year of operations it paid more than $60 million in taxes.

[15] *Hospital and HMO Annual Reports - FY2011*, ATT'Y GEN. MARTHA COAKLEY, http://www.cbsys.ago.state.ma.us/cbpublic/public/annual_reports_start.aspx (last visited Nov. 9, 2012).

[16] Comparisons of expenditures between 2009 and subsequent years are made more challenging as a result of revisions to the AGO's Community Benefits Guidelines. Reports about community benefits expenditures at Morton and Quincy post-acquisition are not yet due.

[17] *See* Amendment to Caritas APA, *supra* note 7, ¶ 5; Amendment to Morton APA, *supra* note 7, ¶ 4(c); Quincy APA, *supra* note 10, § 8.20(d); Amendment to Quincy APA, *supra* note 7, ¶ 7.

[18] In July 2011, Carney Hospital submitted a plan to the Massachusetts Department of Public Health for renovations to its inpatient adolescent psychiatric unit. According to the plan description, during construction, only five adolescent psychiatric service beds would be available at a time, effectively taking 11 beds temporarily out of service. The renovations were completed several months ago, and the original complement of inpatient behavioral health beds is again in service.

[19] *See* Caritas APA, *supra* note 10, § 8.15; Amendment to Morton APA, *supra* note 7, ¶ 4(d); Amendment to Quincy APA, *supra* note 7, ¶ 8.

F. Regulatory Cooperation[20]

Steward agreed to cooperate fully with any investigation, inquiry, study, report, or evaluation conducted by the Attorney General under her office's oversight authority of the non-profit charitable hospital industry to the same extent and subject to the same protections and privileges as if it were still a public charity. Steward is currently in compliance with this commitment.

G. Local Governing Boards[21]

Steward agreed in each transaction to establish a local governing board at each acquired hospital that would be responsible for certain decisions in accordance with Massachusetts Department of Public Health ("DPH") Determination of Need regulations.[22] Steward has provided information indicating that it is in compliance with this commitment and with the related DPH regulations. Steward has also stated it is revising the membership of its local governing boards.

H. No "Change in Control" Transaction[23]

Steward agreed in each transaction, in slightly varying terms, not to sell all or a substantial portion of its system or control over the system for at least several years following each acquisition (a "change in control" transaction). Steward is currently in compliance with this commitment.

I. Obligations of Successors[24]

In case of a "change in control" transaction, Steward agreed to ensure that a successor-in-interest assume any commitments in the AGO Enforceable Provisions that have not expired at the time of the change in control. Because Steward has not engaged in any "change in control" transaction, this commitment has not been triggered. We note the commitment here because it is within the scope of the AGO's compliance monitoring responsibilities, and we will continue to monitor any circumstances that would trigger this commitment.

The AGO is pleased to report Steward's compliance with the AGO Enforceable Provisions contained in the APAs for the Caritas, Morton, and Quincy transactions. We look forward to Steward's continued cooperation as the AGO's monitoring continues in future years.

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[20] *See* Amendment to Caritas APA, *supra* note 7, ¶ 6; Amendment to Morton APA, *supra* note 7, ¶ 4(d); Amendment to Quincy APA, *supra* note 7, ¶ 8.

[21] *See* Caritas APA, *supra* note 10, § 8.7; Morton APA, *supra* note 10, § 11.8; Amendment to Morton APA, *supra* note 7, ¶ 5; Quincy APA, *supra* note 10, § 8.20(e).

[22] 105 MASS. CODE REGS. 100.602 (2012).

[23] *See* Caritas APA, *supra* note 10, § 8.11; Amendment to Caritas APA, *supra* note 7, ¶ 3; Amendment to Morton APA, *supra* note 7, ¶ 4(c); Amendment to Quincy APA, *supra* note 7, ¶ 4.

[24] *See* Amendment to Caritas APA, *supra* note 7, ¶ 6; Morton APA, *supra* note 10, § 10.1(h); Amendment to Quincy APA, *supra* note 7, ¶ 8.

OFFICE OF ATTORNEY GENERAL MARTHA COAKLEY

Interim Report on Steward Health Care System Performance & Impact Pursuant to 2010 & 2011 Assessment & Monitoring Agreements

January 30, 2013

The Office of the Attorney General ("AGO") is pleased to issue this Impact Monitoring Report. This Report, along with the AGO's Compliance Monitoring Report issued today, are the first pursuant to a five-year monitoring commitment undertaken by the AGO as part of its approval of Steward Health Care System's ("Steward") acquisition of substantially all the assets of the Caritas Christi, Morton, and Quincy health systems.

Consistent with the agreements the AGO executed with Steward in each transaction, this Impact Monitoring Report assesses the overall "impact of the Transaction[s] on the provision of health care services to the Communities" served by Steward.[1] To do so, the Report documents Steward's performance in its first year of operations (2011), and compares that performance to the performance of Caritas Christi Health Care ("Caritas") prior to Steward's acquisition.

This Impact Monitoring Report has five parts. Part I reviews the origins of the AGO's monitoring commitment and describes the monitoring approach reflected in this Report, including data relied upon and limitations of that data. Part II summarizes the AGO's findings from its first year of monitoring. Part III reviews Caritas's performance prior to Steward's acquisition to establish a baseline for assessing Steward's impact post-acquisition. Part IV reports on Steward's first year of operations, reviewing the same performance metrics examined in Part III for Caritas. Based on the results of the AGO's first year of monitoring, Part V identifies metrics to watch in future years of monitoring.

I. BACKGROUND AND APPROACH TO STEWARD MONITORING

A. Origins of the AGO's Monitoring Commitment

In May 2010, Caritas Christi provided notice to the AGO under G.L. c. 180, § 8A(d) of its intent to sell substantially all of its assets to Steward Health Care System LLC, an affiliate of

[1] Att'y Gen. of the Comm. of Mass., Caritas Christi & Steward Health Care Sys. LLC, Assessment & Monitoring Agreement ¶ 1 (Oct. 20, 2010) [hereinafter Caritas A&M], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-p.pdf. In approving the Caritas acquisition, the AGO stated its commitment to monitoring the impact of the transaction over time, in order to "document and understand" Steward's performance in meeting its stated objective of developing a high quality, lower-cost, community-based health care system. OFF. OF ATT'Y GEN. MARTHA COAKLEY, STATEMENT OF THE ATTORNEY GENERAL AS TO THE CARITAS CHRISTI TRANSACTION app. at A9 (2010) [hereinafter AGO STATEMENT AS TO CARITAS CHRISTI TRANSACTION], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-m.pdf.

private equity firm Cerberus Capital Management.[2] In purchasing Caritas, Steward described its business objective as developing a high quality, lower-cost, community-based health care system that can serve as a viable alternative to more expensive models of care, such as those often centered at urban academic medical centers.[3]

The AGO engaged in a comprehensive review of the proposed acquisition and issued a statement on October 6, 2010 finding that the transaction complied with the charities law and public interest requirements of G.L. c. 180, § 8A(d).[4] In connection with its review, the AGO executed an Assessment and Monitoring Agreement whereby, for the five-year period following Steward's acquisition of Caritas's assets, the AGO would monitor (1) Steward's compliance with certain provisions of the Asset Purchase Agreement between Caritas and Steward relating to the public interest and (2) the "impact of the Transaction on the provision of health care services to the Communities" served by Steward.[5]

In committing to monitor Steward's impact, the AGO recognized that the Caritas acquisition represented a significant increase in for-profit health systems in Massachusetts, and that Steward's stated business strategy of developing a lower-cost option that keeps more care in the community would have broader implications for the health care market, including competitor providers, insurers, consumers, and other stakeholders. As explained in the October 2010 Statement of the Attorney General as to the Caritas Christi Transaction[6]:

> Steward's stated objective is to improve and further develop a community-hospital based health care system capable of (i) managing risk, (ii) providing high quality, local, and accessible care, and (iii) reducing out-migration of patients who now obtain services, otherwise available at a Caritas Hospital, at higher cost, less accessible settings. By keeping significantly more of that patient care, and the associated revenues, within the Steward system, Steward states it will provide an

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[2] See *Caritas Christi Health Care Sys. Transaction*, ATT'Y GEN. MARTHA COAKLEY, http://www.mass.gov/ago/caritas (last visited Nov. 9, 2012), for Caritas's May 5, 2010 notice and other documents relevant to the transaction.

[3] *E.g.*, Letter from Counsel for Caritas Christi to the Off. of the Att'y Gen. 11 (May 5, 2010) [hereinafter May 2010 Caritas Letter], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-l.pdf (describing Steward's intention to "provide high-quality, lower-cost care in a community setting, as a complement to the highly-specialized care offered by Boston's academic medical centers"). *Cf.* DIV. OF HEALTH CARE FIN. & POLICY, MASS. EXEC. OFF. OF HEALTH & HUMAN SERVS., MASSACHUSETTS HEALTH CARE COST TRENDS: TRENDS IN HEALTH EXPENDITURES, at 20 (2011), *available at* http://www.mass.gov/chia/docs/cost-trend-docs/cost-trends-docs-2011/health-expenditures-report.pdf (showing that in 2009, 52% of commercial spending on inpatient care in Massachusetts was for care obtained at Boston area tertiary, teaching, or specialty hospitals).

[4] AGO STATEMENT AS TO CARITAS CHRISTI TRANSACTION, *supra* note 1.

[5] Caritas A&M, *supra* note 1. In September 2011, the AGO executed two substantively identical Assessment and Monitoring Agreements in connection with its review of Steward's proposed acquisition of Morton Hospital and Quincy Medical Center, thereby bringing those transactions within the scope of its monitoring responsibilities. *E.g.*, Att'y Gen. of the Comm. of Mass., Morton Hosp. & Med. Ctr., Inc. et al. & Steward Health Care Sys. LLC, Assessment & Monitoring Agreement (Sept. 30, 2011), *available at* http://www.mass.gov/ago/docs/nonprofit/morton/complaint-exhibit-l.pdf.

[6] AGO STATEMENT AS TO CARITAS CHRISTI TRANSACTION, *supra* note 1, app. at A8-9.

> appropriate return to its investors while providing a lower-cost alternative to the public. [. . . .] In the event that a community-hospital based health care system can provide effective care in a local setting without raising costs to the public, reducing services, or limiting access or choice, the public would be well served, and the Attorney General wants to document and understand the basis of that success. In the event the effort is not successful, the Attorney General wants to document and understand the basis of that failure. . . . [T]he Attorney General strongly supports transparency, believes solutions must be system-wide, and views her role as working, with others, to better inform the executive branch, the legislature, policy makers, and the public. The evaluations undertaken as part of the Assessment and Monitoring Agreement will further that objective.

B. Monitoring Approach and Structure

The AGO structured its review of Steward's impact around three categories of provider performance metrics:

- **Medical System Organization**. We examine how Steward is organized and how its medical system has changed over time, including changes to the system's delivery of acute care, sub-acute care, and physician services.

- **Market Position**. We examine Steward's competitive position within the markets it serves, and the impact of its activities, and those of its competitors, on these markets. This includes monitoring Steward's market share in its communities and referral patterns for its patients by provider type and service line; measuring Steward's cost and efficiency compared to its competitors; and evaluating the impact of Steward's competitive efforts on other providers and the markets it serves.[7]

- **Financial Performance**. We examine the financial results of Steward's business operations. This includes measuring changes in Steward's financial condition over time and the impact of specific business initiatives on Steward's financial state.

In addition to these performance categories, the Commonwealth is also monitoring Steward's **Clinical Performance** with respect to access to services, including quality and safety. The Department of Public Health ("DPH"), which shares responsibilities under the Assessment and Monitoring Agreements,[8] has primary oversight of Steward's clinical performance. We are

[7] The market analysis contained in this Report is designed to monitor the impact of Steward's business activity and does not constitute a market analysis for antitrust purposes. The particular approach in this Report to defining primary service areas and using these primary service areas to calculate market share is one of a number that would have served the Report's monitoring and transparency purposes.

[8] *E.g.,* Caritas A&M, *supra* note 1, ¶ 4 (noting that DPH is to evaluate the impact of the transaction on "the availability of, and access to, health care services" within the communities served by Steward).

coordinating closely with DPH and will continue to be mindful of its monitoring work in conducting our own review.

Focusing on the same performance metrics for Caritas and Steward, this Impact Monitoring Report presents detailed information on the Caritas system prior to Steward's acquisition to establish a baseline against which to evaluate Steward's impact (Part III). The Report then presents comparable information on Steward's activities through September 30, 2011, the latest fiscal year ("FY") for which we have data (Part IV). Our comparison of this FY11 data to Caritas's baseline information resulted in our initial monitoring findings summarized in Part II, and further discussed in Part V of this Report.

There are a number of ways the AGO could have approached monitoring the performance categories described above. For example, regarding financial performance, providers report a range of financial statistics, in different ways and for different purposes. In this Report, we provide information on the individual financial performance of Steward's provider entities (e.g., its hospitals, physician groups, and home health organization), as well as the financial performance of the system as a whole. Steward entities operate in different geographic areas across eastern Massachusetts, provide different services, and have distinct financial profiles. As such, we believe it is important to provide information on their individual performance. At the same time, an analysis of Steward's performance at the system level provides the most accurate picture of the interrelationship among the different affiliated entities, the operations and strategy of the system as a whole, and the overall financial state of the system.

In future reports, the AGO will present information on Steward's activity year-over-year to enable longitudinal assessment of Steward's impact. By adding more years of data in future reports, the AGO will be able to analyze trends more effectively than is possible with one post-transaction data point. Over time, with increased transparency of provider organization performance, the AGO and our entire health care market will benefit from improved ability to assess the individual performance of provider organizations, and to compare the performance and impact of competing provider organizations.[9]

[9] This first Impact Monitoring Report highlights the importance of reliable and comparable information that can be used to measure and promote efficient health care provider performance. The categories of performance metrics presented in this Report, if consistently available for all health systems, would better enable the market to compare the performance of competing provider organizations. Under Chapter 224 of the Acts of 2012, Massachusetts will continue to improve systems to monitor health care performance by registering provider organizations, conducting market impact reviews, and certifying risk-bearing and accountable care organizations. In the development of this regulatory framework, foundational questions such as *which* provider entities should report information, *what* metrics should be tracked, and *how* comprehensive reporting can best be integrated with the oversight functions it ultimately supports, will be critical to answer as we seek to move toward more accountable, cost-effective health systems. We expect our office's experience monitoring one complex provider organization will provide unique insight as Massachusetts develops its framework to promote increased transparency for all provider organizations.

C. Data Reliance and Limitations

In developing this Report, the AGO obtained and relied upon information from Steward and a number of other sources, including state agencies, public authorities such as the Massachusetts Development Authority and the federal Municipal Securities Rulemaking Board, health insurers such as Blue Cross Blue Shield ("BCBS"), Fallon Community Health Plan ("FCHP"), Harvard Pilgrim Health Care ("HPHC"), and Tufts Health Plan ("THP"), and private organizations focused on the collection of health care business and financial data. We appreciate the cooperation of Steward and other producing entities in support of our review.

With the assistance of experts, the AGO collected information from these sources, assessed its consistency, marshaled it into a unified framework, and created, where relevant, a reliable comparison of Steward's performance to Caritas baseline information. Even with the cooperation of Steward and other entities, development of a comprehensive framework for performance comparison is challenging given the varied data sources and lack of timely data in certain areas. For these reasons, this Report and our initial monitoring findings are subject to certain limitations, described further below, resulting from the type, quantity, and quality of information gathered.

1. Public Agency Information

Health care provider organizations in Massachusetts are currently subject to a range of public reporting requirements that vary depending on how the organization is owned, operated, and licensed. The AGO gathered information from public sources, including state agencies such as DPH, the Division of Health Care Finance and Policy ("DHCFP") (now the Center for Health Information and Analysis), the Division of Insurance ("DOI"), and the Attorney General's Non-Profit Organizations/Public Charities Division ("Charities Division"). Although this publicly available information is useful, it tends to focus on specific aspects of how a health care provider operates and does not present a complete picture. For example, reporting requirements for DPH and DHCFP generally focus on individual facilities (such as hospitals) or professionals (such as nurses), but do not encompass the entire health care business organization. Similarly, because DOI gathers information on insurers, it does not currently have information on the financial condition of providers who are bearing risk, and has only limited information on health plans that feature specific provider partners, such as limited network plans designed around the Steward system. The Charities Division collects information from more than twenty thousand public charities, including non-profit health systems like Caritas, but does not generally collect information from for-profit organizations like Steward.

The Massachusetts DOI oversees well-established public reporting requirements for insurers. Pursuant to Chapter 224 of the 2012 Acts, larger providers and risk-bearing organizations should also be required to report timely, comprehensive, and accurate information. As more providers adopt alternative payment methods, and as more consumers enroll in insurance products that tie care delivery to specific health care systems, the need for timely and reliable information will increase.

2. Private Entity Information

The AGO also gathered data from private sources, including (a) Steward, pursuant to 2011 Assessment and Monitoring Information Requests[10]; (b) other market participants, such as health insurers, pursuant to the AGO's ongoing review of health care costs in Massachusetts[11]; (c) private organizations that collect health care business and financial data, such as Fitch Ratings and the Massachusetts Health Data Consortium ("MHDC"); and (d) information from more than a dozen meetings and discussions with providers, insurers, consumer advocates, health care experts, and other stakeholders regarding Steward's activities.

To assist in the collection and review of information from public and private sources, the AGO engaged consultants with extensive experience evaluating provider systems and their impact on the health care market.[12] Working with these experts, the AGO tested the accuracy and consistency of the data collected wherever possible, but also had to rely in large part on the producing party for the quality of the information provided.[13] While some data limitations can be addressed with expert assistance, others cannot. Most notably, access to information is constrained by the amount of time it takes producing entities to provide reliable data for business purposes. In order to analyze varied information sources and produce a report by early 2013, we examined data available as of mid-2012 (i.e., FY11 data). Thus, although this Report is mindful of Steward's activities in FY12, it analyzes those operations that occurred through the end of FY11.[14] For example, this Report covers the eight hospitals and approximately 1,840 physicians that were part of Steward in FY11, but not those facilities acquired in FY12 (Morton Hospital, New England Sinai Hospital, and Quincy Medical Center). The AGO will examine the impact of those acquisitions compared to their pre-transaction baselines in our next monitoring report.

[10] The requests address the following topics: (1) organizational structure; (2) size, utilization, and finances of provider affiliates; (3) size and finances of non-provider affiliates; (4) patient services, referral patterns, and limited network partnerships; (5) payment rates and network development; (6) physician recruitment practices; (7) physician contracting practices; (8) payer contracts; (9) financial and quality performance; and (10) discharge policies and procedures.

[11] *See* Caritas A&M, *supra* note 1, ¶ 1 (providing that "certain aspects of the evaluation and assessment may incorporate, rely upon, or support otherwise independent investigations by the Attorney General of costs within the Massachusetts health care system").

[12] Kane Consulting Group, including principal Dr. Nancy M. Kane.

[13] The AGO collected information pursuant to the terms of the Assessment and Monitoring Agreements, and not through law enforcement subpoenas. Producing parties were thus not subject to statutory production obligations as in a law enforcement investigation.

[14] Additionally, Steward acquired Caritas near, but not at, the start of FY11 (on November 6, 2010, five weeks after the start of FY11 on October 1, 2010). Steward therefore developed two sets of financial statements for FY11: audited 11-month financials for the period of Steward ownership from November 6, 2010 to September 30, 2011; and unaudited 12-month financials that include the "stub" month from October 1, 2010 to the start of Steward ownership on November 6. Audited financial statements with consolidating schedules and footnotes are the "gold standard" in financial reporting, and we present that data wherever possible. At the same time, this audited data does not capture five weeks of FY11 activity. Therefore, in select places, we include unaudited 12-month figures to provide a more complete picture of Caritas and Steward operating performance during this transition period.

Information held by private entities can be subject to unique data parameters that can make comparisons over time or across organizations challenging, particularly when such information is held for internal management purposes and not for uniform public reporting. Even within an organization, changes in systems and data parameters can make meaningful trend analysis subject to error. For example, in the course of our review, we learned that pre-transaction data from Caritas's older information systems contained certain inaccuracies and inconsistencies compared to newer data compiled from Steward's upgraded systems. Steward also analyzes data somewhat differently than Caritas, and calculates certain business metrics according to different methodologies. We note in this Report where comparison of data from Caritas to Steward may be subject to such recordkeeping and analytic differences. Additionally, for-profit and nonprofit systems may be subject to different incentives and financial requirements as a result of their different ownership and organizational models. For example, a comparison of Caritas and Steward should take into account differing tax obligations as well as differences in incentives to hold large cash balances.[15]

Subject to the data limitations outlined in this Report, we believe our review presents a reliable comparison of Steward's first year of operations to Caritas baseline information. In future reports, the AGO will present information on Steward's activity year-over-year to enable longitudinal assessment of Steward's impact. Steward has consistently stated that implementation of its business model is a multiyear process; accordingly, one year of mature information does not provide a reasonable basis to predict or draw conclusions about Steward's ongoing performance and impact.

II. SUMMARY OF FINDINGS FROM FIRST YEAR OF MONITORING

A. Medical System Organization

In reviewing the characteristics of Steward's medical system, we found:

- Organization and Governance. To acquire Caritas's assets, Steward created a new organization of multiple for-profit subsidiaries (e.g., one for each hospital) controlled by a parent, Steward Health Care System LLC. Steward largely retained Caritas's senior management team and established a seven-person Management Board chaired by the parent's chief executive officer. Full-time equivalents (FTEs) at Steward's principal medical holdings (the hospitals, employed physician group, and home care organization) grew roughly 3% in FY11, to 9,277.

[15] According to AGO experts, nonprofit hospitals borrowing in tax-exempt markets tend to be rewarded with lower interest rates when they have large cash balances, while investors in for-profit systems tend to view large balances as a suboptimal use of company resources. Similarly, nonprofits and for-profits differ in their tax obligations; for-profits, unlike nonprofits, are required to pay real estate and other taxes that benefit the community. Steward has stated that in its first year of operations it paid more than $60 million in taxes.

- Facility Expansion and Improvement. In FY11, Steward acquired two hospitals from for-profit Essent Healthcare (Merrimack Valley Hospital and Nashoba Valley Medical Center) and signed contracts to acquire two more Massachusetts hospitals (Morton Hospital and Quincy Medical Center). Principal capital expenditures included new emergency rooms at Good Samaritan Medical Center, Holy Family Hospital, and St. Anne's Hospital totaling $38.8 million; $15.5 million for surgery suites at Carney Hospital and St. Anne's Hospital; $10.5 million for radiation oncology facilities at St. Elizabeth's Medical Center; $4.2 million for a catheterization laboratory at Norwood Hospital; and about $25 million in information technology spending, which Steward has stated included funds directed toward integrating the information technology at the former Caritas hospitals.

- Payer Mix. There were no significant changes in payer mix at the Steward hospitals from 2010 to 2011. Medicare continued to be the largest payer, followed by the major commercial insurers (e.g., BCBS, HPHC). Steward became a Medicare Pioneer Accountable Care Organization in 2011 and entered or continued global payment contracts with each of the major commercial insurers. In 2011, the two insurers with which Steward has developed partnerships to offer Steward-focused limited network products (FCHP and THP) continued to be relatively minor payers, together representing 4% to 9% of each hospital's net patient revenue. Important monitoring questions include whether Steward successfully grows positive-margin business from payers featuring its limited network product and how any changes in payer mix at Steward may impact the payer mix of its competitors in each of its local markets.

- Physician Recruitment. Steward's physician network grew by 14% in FY11, to over 1,800 affiliated physicians. The competitive implications of this growth are not yet fully apparent, but important monitoring questions include whether continued acquisitions of hospitals and physicians materially change how important insurers view the Steward system to their respective networks, the competitive impact of Steward's physician recruitment practices, and how Steward's strategy for growing its physician network interplays with changes in its patient volume and financial performance.

B. Market Position

The market analysis contained in this Report is designed to monitor the impact of Steward's business activity and does not constitute a market analysis for antitrust purposes. Steward's providers operate in geographic areas across eastern Massachusetts, provide different services, and compete with different entities for business.[16] Our review of the market position of the Steward hospitals and health system found:

[16] For the purposes of this Report, a hospital market is defined as its primary service area, as described in Part III.C.1 below. For information on the performance of multi-hospital systems across Massachusetts, see *infra* note 89 and Attachment 1 to this Report.

- Inpatient Market Share and Service Mix. While detailed FY11 discharge data was not available in time to be included in this Report, FY10 data shows that the six Caritas hospitals that became the Steward system had a strong share of inpatient discharges in some markets (e.g., Norwood Hospital at 31.5%), and a weak share in other markets (e.g., Carney Hospital at 8.5%). In each market, the Caritas hospital tended to provide a higher mix of medical and psychiatric services than its tertiary and community competitors. In future years, based on improvements in market transparency, we hope to monitor market share for additional service categories, such as outpatient and home health services.

- Patient Referral Patterns. Data from one major insurer indicates that in 2011, patients with Steward primary care providers were more likely to receive their hospital care – especially outpatient care – from the Steward system than in 2010. This data is consistent with the general increase in outpatient volume at the Steward hospitals during 2011. In future years, based on improvements in market transparency, we anticipate monitoring patient referral patterns in each local Steward market.

- Prices. While 2011 prices were not available for this Report, 2009 and 2010 data shows that prices for the Caritas hospitals vary insurer by insurer, and by inpatient versus outpatient services, with the result that some Caritas hospitals are on par with competitors, others are less expensive, and others are more expensive. Given this variation in price by local market and service category, whether Steward's activities will raise or lower costs in its markets ultimately depends on a variety of factors, from "endogenous" factors like the services Steward chooses to develop and the prices it seeks for those services, to factors "exogenous" to Steward, such as market activity by its competitors and changes in the regulatory landscape.

- Total Medical Expenses ("TME"). In 2011, Steward's commercial TME (as measured by the three largest insurers in Massachusetts) continued to be lower than the TME of some of its competitors, and higher than the TME of other competitors. We will continue to monitor trends in Steward's TME, including the TME of each of the major physician groups that comprise the Steward network, which often operate in different geographies.[17]

- New Insurance Products. In 2011, Steward developed partnerships with FCHP and THP to offer Steward-focused limited network products to small and large employer groups in eastern Massachusetts. These products offer members the option of obtaining care primarily from Steward for a lower premium. Future years of monitoring will examine

[17] Note that provider TME is currently only reported for patients enrolled in Health Maintenance Organization ("HMO") plans, whereas membership in Preferred Provider Organization ("PPO") plans is now about half of the Massachusetts market. This Report highlights the value of developing approaches to monitoring the TME of providers' PPO patients as well as their HMO patients to understand medical spending trends for the PPO half of the market.

whether these products have increased volume at Steward's facilities, whether they have lowered medical spending, and whether their costs support insurers' initial assumptions in pricing these products.

C. System Financial Performance

In comparing Steward's FY11 financial performance to Caritas's baseline results from the years leading up to Steward's acquisition, our review reinforces previous findings that Steward acquired a system in deteriorating financial condition. Steward has consistently stated that implementation of its business model is a multiyear process requiring significant investment in its care delivery system; as such, one year of mature information does not provide a reasonable basis to draw conclusions about Steward's ongoing performance or future success in meeting its business objectives. In examining Steward's first year of operations, we found:

- Operating Performance. In FY11, Steward reported an operating loss of $14.6 million, a total margin of -4.3%, and a current ratio below 1.0.[18] At the hospitals, while outpatient volume generally increased, profits overall declined from FY10 because expenses outpaced revenues.

- Sources and Uses of Cash. In FY11, Steward spent heavily on capital improvements and hospital and physician acquisitions. To support this spending, the system supplemented the initial Cerberus Capital equity investment of $246 million with a revolving bank line of credit, under which it had borrowed $96.3 million as of the close of FY11.

- Special Non-Operating Areas Affecting Financial Performance. Steward's financial condition, even more so than Caritas's, is complicated by special expenses such as necessary contributions to its significantly underfunded pensions and its commitments in connection with its provider acquisitions. It will be important to monitor how these expenses affect Steward's long-term financial performance.

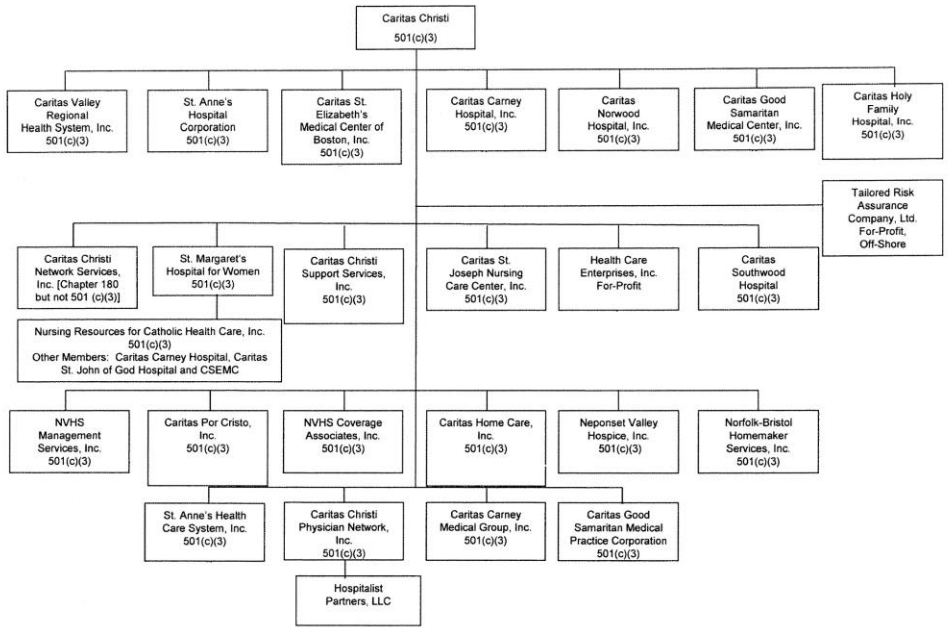
[18] A current ratio is usually defined as an entity's available (or "current") assets divided by its short-term liabilities, representing the number of times the entity would be able to meet its short-term liabilities.

III. BASELINE ANALYSIS OF CARITAS CHRISTI PRIOR TO STEWARD'S ACQUISITION (FY2010)

A. Organization and Governance

In 2010, Caritas Christi was a nonprofit multi-hospital and physician health system with over $1.1 billion in annual net patient service revenue ("NPSR").[19] The system consisted of a parent corporation, Caritas Christi, with six acute care hospitals in eastern Massachusetts and over 1,650 active medical staff (physicians with admitting privileges to one or more Caritas hospitals). Roughly 1,600 physicians on the active medical staff were members of an affiliated physician network called Caritas Christi Network Services, which negotiated managed care contracts on behalf of those physicians ("network physicians"). Approximately 445 of the network physicians were directly employed by Caritas[20] and organized into three practices serving in Caritas hospitals and other provider settings. In addition, the system operated several non-acute care and support organizations. The organization chart below describes the Caritas organization in FY10, before it was acquired by Steward.

Figure 1 – Caritas Christi Organization Chart (FY2010)



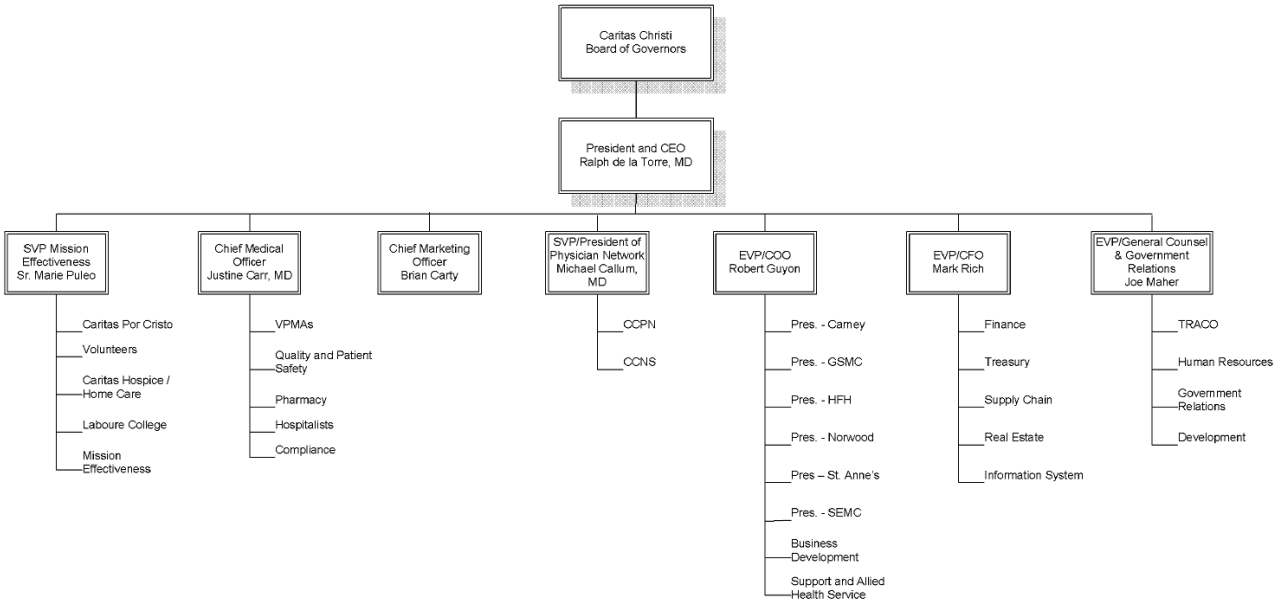
[19] ERNST AND YOUNG LLP, CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION: CARITAS CHRISTI – SUPPLEMENTAL CONSOLIDATING INFORMATION 43 (2011) [hereinafter CARITAS FY10 AFS], *available at* http://www.charities.ago.state.ma.us/charities/index.asp (search for charity name "TAS-CC"). All references to NPSR in this Report are net of provision for bad debt. For information on the NPSR associated with other Massachusetts hospitals, see Div. of Health Care Fin. & Policy, Mass. Exec. Off. of Health & Human Servs., Hospital Financial Performance FY11 Databook, http://www.mass.gov/chia/docs/r/qtr/fy11-annual/hosp-fy11-databook.xls (last visited Dec. 5, 2012).

[20] Caritas Christi & Steward Health Care Sys. LLC, Asset Purchase Agreement § 2.37 (Mar. 19, 2010) [hereinafter Caritas APA], *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/complaint-exhibit-b.pdf.

The parent, Caritas Christi, served as the sole corporate member of six hospital organizations and their affiliates, a collection of physician practice groups and associated imaging and managed care contracting organizations, a professional liability corporation, a home care organization, and a volunteer medical services organization. Certain actions undertaken by Caritas's board were subject to approval by the Roman Catholic Archdiocese of Boston ("RCAB"), including dissolution, liquidation, sale, merger, consolidation, or matters related to the system's Catholic identity.[21] The parent controlled matters such as policy, budgeting, capital spending, finance, cash management, banking relations, investment management, and human resources.[22]

The hospitals, each with a president and senior management team, were primarily responsible for clinical care. Each hospital's management team reported to the system's chief operating officer/executive vice president, as shown in the reporting structure described in Figure 2 below. Physician practices reported to a separate senior vice president who was the president of the physician network.

Figure 2 – Caritas Christi Management Structure (FY2010)



B. Medical System

As described above, Caritas's medical holdings consisted of hospitals, physician organizations, and a handful of other, mostly post-acute, providers. This section presents select financial and patient utilization data for each of these provider categories to provide a snapshot

[21] CARITAS FY10 AFS, *supra* note 19, at 7–8.

[22] *See* Caritas Christi, Official Statement Relating to Series B Bonds app. at A-13 (Mar. 20, 2002) [hereinafter Caritas Bonds OS] (on file with MassDevelopment).

of the Caritas medical system in FY10, and to establish a baseline against which we will evaluate the impact of Steward's business strategy on its medical holdings.

1. Acute Care Hospitals

The six Caritas acute care hospitals were located in Boston and in four smaller cities and towns northwest and south of Boston. The active medical staff, licensed beds, service area, and teaching status of these six hospitals as of FY10 are summarized in Table 1 below. Part IV of this Report examines Steward's first year of performance (FY11), during which it acquired two additional hospitals – Merrimack Valley Hospital and Nashoba Valley Medical Center – from for-profit Essent Healthcare. Data on these two hospitals is included below to provide a comparable FY10 baseline for the hospitals that became the Steward system in FY11.

Table 1 - Physical Plant and Service Area (FY2010)

Hospital	Location	Med. Staff	Beds[23]	Principal Counties Served[24]	Teaching Status[25]
Carney	Dorchester	268	159	Suffolk, Norfolk	50 residents
GSMC	Brockton	312	231	Norfolk, Plymouth, Bristol	-
Holy Family	Methuen	385	223	Essex, Rockingham (NH)	-
Norwood	Norwood	214	263	Norfolk, Bristol	-
St. Anne's	Fall River	154	160	Bristol, Newport (RI)	-
St. Elizabeth's	Brighton	319	252	Suffolk, Middlesex, Eastern MA	165 residents/fellows $8 million in research
Merrimack	Haverhill	91	122	Essex, Rockingham (NH)	-
Nashoba	Ayer	80	57	Middlesex, Worcester	-

Below is a map of these hospitals and their primary service areas ("PSA"), defined using FY10 MHDC inpatient discharge data that Steward provided to the AGO. In FY10, roughly 90% of the patients discharged from a Caritas hospital lived in one of ten counties in eastern Massachusetts or adjacent areas of southern New Hampshire or northeastern Rhode Island.[26] Focusing on patient discharges originating from these ten counties, we determined the geographic area from which each hospital drew most of its inpatient discharges (i.e., the hospital's PSA). We included in each hospital's PSA any zip code that contributed at least 2% of the hospital's total discharges for FY10. Defined thus, the PSA of each Caritas hospital (with the exception of St. Elizabeth's[27]) captured 70–85% of the hospital's total discharges for FY10,

[23] Dep't of Pub. Health, Mass. Exec. Off. of Health & Human Servs., Mass. Licensed or Certified Health Care Facility Listing (Aug. 20, 2012) (including data on 2010 licensed beds).

[24] Based on MHDC FY10 discharge data provided by Steward to the AGO.

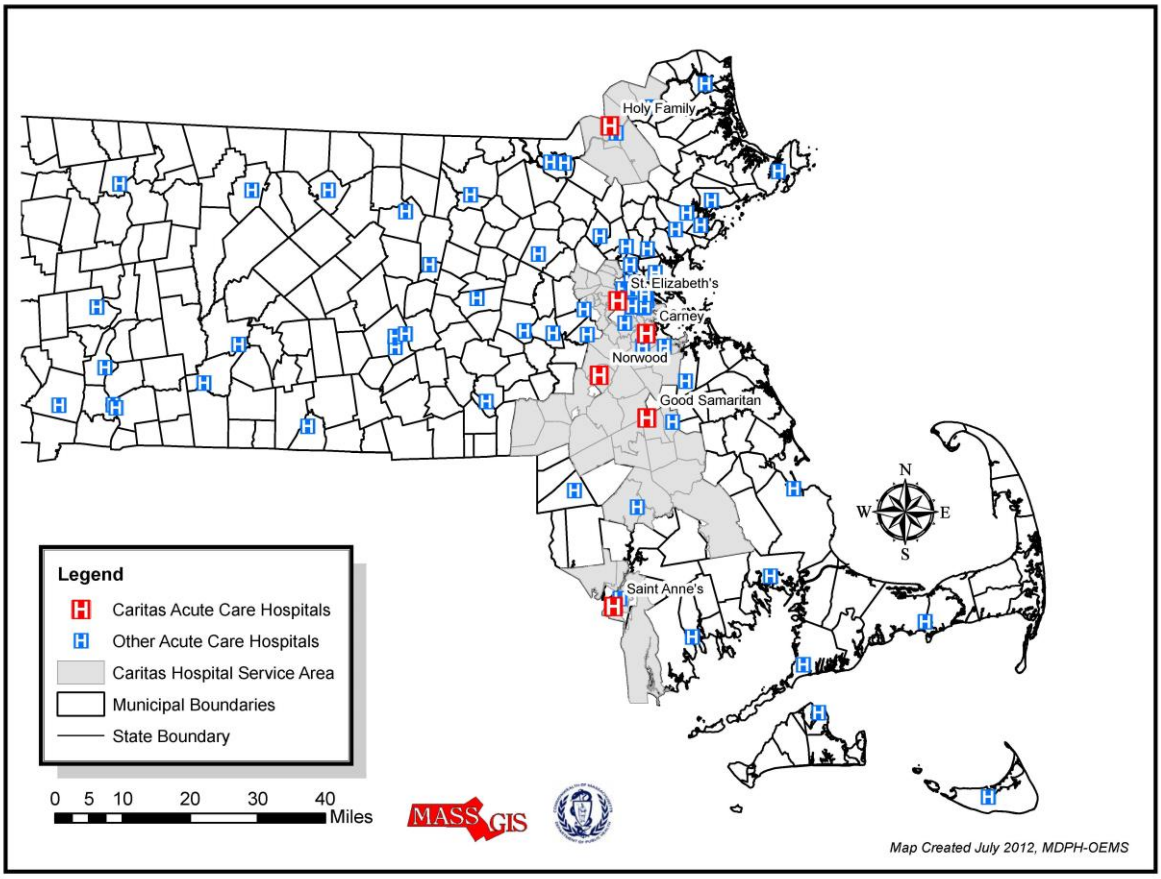
[25] CARITAS FY10 AFS, *supra* note 19, at 43 (size of research program).

[26] Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties in Massachusetts; Hillsborough and Rockingham counties in New Hampshire; and Newport county in Rhode Island.

[27] As the system's main teaching hospital, St. Elizabeth's draws patients from zip codes across eastern Massachusetts. Thus, to define a coherent PSA for St. Elizabeth's, in addition to any zip code that contributed at least 2% of St. Elizabeth's total discharges for FY10, we included select zip codes from the counties surrounding St.

showing the significance of the PSA to the hospital. As the below map shows, the Caritas PSAs were neither fully overlapping nor fully contiguous; rather, they represented several local areas, each with their own local and tertiary competitors, dominant health plans, and patient characteristics.

Figure 3 – Primary Service Areas of the Six Caritas Hospitals (FY2010)



The next table shows patient utilization and financial performance data for each of the Caritas and Essent hospitals from FY08 to FY10. These metrics provide a baseline of the level of patient volume (inpatient discharges and outpatient visits) and financial condition (revenues, profits, and assets) of the hospitals prior to their acquisition by Steward. In general, the Caritas hospitals performed better than the Essent hospitals over the period, but neither group was financially robust, and both faced nearly flat (Caritas) or declining (Essent) inpatient volume. Outpatient services were the only source of volume growth for these hospitals.

Elizabeth's: (1) any Suffolk zip code that contributed at least 2% of St. Elizabeth's total discharges for Suffolk county and (2) any Middlesex zip code that contributed at least 2% of St. Elizabeth's total discharges for Middlesex county. Defined thus, St. Elizabeth's PSA captured 50% of the hospital's total discharges for FY10. The corresponding figures for Caritas's five community hospitals were: Carney (PSA captured 71% of Carney's total FY10 discharges), Good Samaritan (70%), Holy Family (77%), Norwood (73%), St. Anne's (85%).

Table 2 - Utilization and Financial Data for Caritas and Essent Hospitals (FY2008-2010)

	Carney	Good Samaritan	Holy Family	Norwood	St. Anne	St. Elizabeth	MVH	NVMC
IP Discharges[28]								
FY2008	6,447	15,994	11,668	12,527	6,336	14,180	4,172	1,914
FY2009	6,409	16,529	10,889	12,778	5,874	13,203	4,134	1,791
FY2010	6,545	15,671	10,977	13,425	6,638	14,131	3,873	1,787
OP Visits								
FY2009	115,647	126,949	117,399	98,973	138,307	161,678	81,592	122,185
FY2010	116,666	127,349	120,611	98,322	147,014	172,362	82,770	126,653
OP Surgery Visits								
FY2009	5,333	6,298	7,173	6,790	3,956	8,507	2,604	1,401
FY2010	5,359	6,452	8,982	7,090	4,317	8,729	2,475	1,511
NPSR ($000)[29]								
FY2008	108,140	171,585	142,778	142,988	129,394	255,714	54,190	43,782
FY2009	111,349	187,832	142,224	151,754	134,832	260,705	55,608	43,643
FY2010	110,636	191,552	142,691	160,492	142,075	267,470	54,764	43,893
Op. Income ($000)								
FY2008	1,192	142	-517	-3,754	5,019	5,600	-3,275	-428
FY2009	5,870	12,664	3,547	3,473	9,087	21,995	-1,296	604
FY2010	3,452	10,971	3,656	2,493	10,770	21,891	-4,073	-807
Operating Margin								
FY2008	1.0%	0.1%	-0.4%	-2.6%	4.0%	1.5%	-6.0%	-1.0%
FY2009	4.8%	6.5%	2.4%	2.2%	7.0%	5.5%	-2.3%	1.4%
FY2010	2.8%	5.6%	2.48%	1.53%	7.0%	5.5%	-7.4%	-1.8%
Total Assets ($000)								
FY2008	43,547	86,909	109,742	117,717	121,523	228,073	n/a	n/a
FY2009	47,938	98,701	107,216	113,642	137,186	239,081	n/a	n/a
FY2010	44,516	99,617	110,045	108,413	147,640	254,887	n/a	n/a

[28] *Hospital Summary Information*, MHDC, http://mahealthdata.org/data/inpatient (last visited Sept. 21, 2012). Discharge data is by fiscal year ending September 30, which is the same as Caritas's fiscal year.

[29] NPSR is net of provision for bad debt. For the Caritas hospitals, data on NPSR, operating income, operating margin, and total (unrestricted) assets is derived from Caritas's audited financial statements. *See* CARITAS FY10 AFS, *supra* note 19, at 43; ERNST AND YOUNG LLP, CARITAS CHRISTI: AUDITED CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION 36 (2010) [hereinafter CARITAS FY09 AFS], *available at* http://www.charities.ago.state.ma.us/charities/index.asp (search for charity name "TAS-CC"); ERNST AND YOUNG LLP, CARITAS CHRISTI AUDITED CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION 34 (2009) [hereinafter CARITAS FY08 AFS], *available at* http://www.charities.ago.state.ma.us/charities/index.asp. For the Essent hospitals, financial data is from DHCFP FY10 hospital fact sheets. *See* Div. of Health Care Fin. & Policy, Mass. Exec. Off. of Health & Human Servs., Merrimack Valley Hospital FY10 Fact Sheet, http://www.mass.gov/chia/docs/r/qtr/fy10-annual/merr-val.pdf (last visited Dec. 5, 2012); Div. of Health Care Fin. & Policy, Mass. Exec. Off. of Health & Human Servs., Nashoba Valley Medical Center FY10 Fact Sheet, http://www.mass.gov/chia/docs/r/qtr/fy10-annual/nash-val.pdf (last visited Dec. 5, 2012).

The final hospital metric we report is payer mix, which measures how much of a provider's business comes from different insurance sources. Monitoring payer mix enables us to track shifts in revenue from the different types of payers for the Steward hospitals. This can provide insight into the hospital's financial performance, since some payers pay higher rates than others. Certain payers like Medicaid and Commonwealth Care are associated with the care of patients needing safety-net services; monitoring their payer mix can provide insight as to the system's level of commitment to such patients. Monitoring payer mix also provides information on how well Steward is growing its revenue from the payers offering Steward-focused limited network plans. Growth in revenue from limited network plans will likely have financial and market share implications for Steward and its competitors, and may also signal a need to monitor patient access and quality trends.

We received information from Steward on hospital days and revenue by payer showing that the Caritas hospitals received revenue from dozens of payers in 2010. We grouped these payers into the major categories shown in Table 3 below, and identify the proportion of the hospital's total net revenue for 2010 that each payer category represents. For example, we grouped the commercial, non-Medicare health plans into (1) health plans with which Steward has developed limited network products (FCHP and THP), (2) other major commercial plans (Aetna, BCBS, HPHC, United), and (3) Medicaid and Commonwealth Care plans (BMC HealthNet, CeltiCare, Neighborhood Health, Network Health).[30] At all six hospitals, the biggest payer, both in terms of revenue and days, was Medicare, followed by the major commercial health plans. In general, neither of the health plans with which Steward is partnering to offer limited network products was a major payer for these six hospitals in 2010.

[30] Our analysis is limited by the categories of payer information we received. For example, the data we received did not always break out revenue from the different lines of business at each payer. For payers with mixed lines of business, such as Neighborhood Health Plan ("NHP"), which sells commercial, Commonwealth Care, and Medicaid products, we took the approach of categorizing the payer by its major lines of business. Thus, we categorized NHP as a Medicaid and Commonwealth Care plan and included all its revenues and days in this category. In future years, we anticipate receiving information broken out by additional payer categories, such as information on the Steward limited network products, that will allow us to assess the specific impact of these products.

Table 3 – Payer Mix for Caritas Hospitals (2010)

Carney Hospital	**Net Patient Revenue**			**% Total Net Patient Revenue**		
	Inpatient	**Outpatient**	**Total**	**Inpatient**	**Outpatient**	**Total**
Private (non-Medicare)						
Major commercial plans	$ 5,396,790	$ 9,569,766	$ 14,966,556	9%	24%	15%
Medicaid & CommCare plans	$ 3,735,853	$ 4,929,798	$ 8,665,651	6%	13%	9%
Plans with Steward limited ntwk	$ 913,286	$ 3,968,433	$ 4,881,719	1%	10%	5%
Private (Medicare plans)	$ 1,240,286	$ 613,436	$ 1,853,722	2%	2%	2%
Medicare	$ 32,990,832	$ 8,886,677	$ 41,877,509	54%	23%	42%
MassHealth (including MBHP[31])	$ 9,064,711	$ 4,370,589	$ 13,435,300	15%	11%	13%
Health Safety Net	$ 1,914,791	$ 1,135,969	$ 3,050,760	3%	3%	3%
Self Pay	$ -	$ 35,579	$ 35,579	0%	0%	0%
Subtotal (all above payers)	$ 55,256,549	$ 33,510,247	$ 88,766,796	90%	85%	88%
All Other	$ 5,942,516	$ 5,879,603	$ 11,822,119	10%	15%	12%
TOTAL	$ 61,199,065	$ 39,389,850	$ 100,588,915	100%	100%	100%

Good Samaritan Med Ctr	**Net Patient Revenue**			**% Total Net Patient Revenue**		
	Inpatient	**Outpatient**	**Total**	**Inpatient**	**Outpatient**	**Total**
Private (non-Medicare)						
Major commercial plans	$ 18,901,962	$ 21,853,848	$ 40,755,810	16%	32%	22%
Medicaid & CommCare plans	$ 5,090,431	$ 5,563,197	$ 10,653,628	4%	8%	6%
Plans with Steward limited ntwk	$ 5,578,403	$ 6,161,487	$ 11,739,890	5%	9%	6%
Private (Medicare plans)	$ 11,751,067	$ 3,783,748	$ 15,534,815	10%	6%	8%
Medicare	$ 52,132,270	$ 12,821,474	$ 64,953,744	45%	19%	35%
MassHealth (including MBHP)	$ 9,056,362	$ 4,870,867	$ 13,927,229	8%	7%	8%
Health Safety Net	$ 2,417,230	$ 1,489,792	$ 3,907,022	2%	2%	2%
Self Pay	$ 15,377	$ 50,001	$ 65,378	0%	0%	0%
Subtotal (all above payers)	$ 104,943,102	$ 56,594,414	$ 161,537,516	91%	84%	88%
All Other	$ 10,929,359	$ 10,937,371	$ 21,866,730	9%	16%	12%
TOTAL	$ 115,872,461	$ 67,531,785	$ 183,404,246	100%	100%	100%

Holy Family Hospital	**Net Patient Revenue**			**% Total Net Patient Revenue**		
	Inpatient	**Outpatient**	**Total**	**Inpatient**	**Outpatient**	**Total**
Private (non-Medicare)						
Major commercial plans	$ 13,789,965	$ 21,872,346	$ 35,662,311	19%	33%	25%
Medicaid & CommCare plans	$ 4,362,378	$ 6,545,658	$ 10,908,036	6%	10%	8%
Plans with Steward limited ntwk	$ 3,151,972	$ 8,274,330	$ 11,426,302	4%	12%	8%
Private (Medicare plans)	$ 2,048,587	$ 1,643,654	$ 3,692,241	3%	2%	3%
Medicare	$ 36,075,368	$ 13,353,100	$ 49,428,468	49%	20%	35%
MassHealth (including MBHP)	$ 6,792,148	$ 4,056,935	$ 10,849,083	9%	6%	8%
Health Safety Net	$ 1,508,678	$ 767,366	$ 2,276,044	2%	1%	2%
Self Pay	$ 8,343	$ 116,979	$ 125,322	0%	0%	0%
Subtotal (all above payers)	$ 67,737,439	$ 56,630,368	$ 124,367,807	92%	84%	88%
All Other	$ 6,040,467	$ 10,465,410	$ 16,505,877	8%	16%	12%
TOTAL	$ 73,777,906	$ 67,095,778	$ 140,873,684	100%	100%	100%

[31] "MBHP" refers to the Massachusetts Behavioral Health Partnership. *See* MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP ONLINE, http://www.masspartnership.com (last visited Sept. 21, 2012).

Norwood Hospital	**Net Patient Revenue**			**% Total Net Patient Revenue**		
	Inpatient	**Outpatient**	**Total**	**Inpatient**	**Outpatient**	**Total**
Private (non-Medicare)						
Major commercial plans	$ 19,458,392	$ 23,514,612	$ 42,973,004	19%	40%	27%
Medicaid & CommCare plans	$ 2,021,065	$ 2,701,232	$ 4,722,297	2%	5%	3%
Plans with Steward limited ntwk	$ 4,294,141	$ 6,130,993	$ 10,425,134	4%	10%	7%
Private (Medicare plans)	$ 10,274,107	$ 3,036,275	$ 13,310,382	10%	5%	8%
Medicare	$ 50,553,581	$ 9,294,730	$ 59,848,311	51%	16%	38%
MassHealth (including MBHP)	$ 3,451,400	$ 2,552,623	$ 6,004,023	3%	4%	4%
Health Safety Net	$ 1,390,180	$ 695,907	$ 2,086,087	1%	1%	1%
Self Pay	$ 33,448	$ 116,797	$ 150,245	0%	0%	0%
Subtotal (all above payers)	$ 91,476,314	$ 48,043,169	$ 139,519,483	92%	82%	88%
All Other	$ 8,411,697	$ 10,479,939	$ 18,891,636	8%	18%	12%
TOTAL	$ 99,888,011	$ 58,523,108	$ 158,411,119	100%	100%	100%

St. Anne's Hospital	**Net Patient Revenue**			**% Total Net Patient Revenue**		
	Inpatient	**Outpatient**	**Total**	**Inpatient**	**Outpatient**	**Total**
Private (non-Medicare)						
Major commercial plans	$ 7,056,365	$ 21,668,120	$ 28,724,485	13%	25%	20%
Medicaid & CommCare plans	$ 3,883,952	$ 12,105,840	$ 15,989,792	7%	14%	11%
Plans with Steward limited ntwk	$ 924,403	$ 4,090,694	$ 5,015,097	2%	5%	4%
Private (Medicare plans)	$ 4,313,121	$ 4,264,659	$ 8,577,780	8%	5%	6%
Medicare	$ 25,479,491	$ 19,312,964	$ 44,792,455	46%	23%	32%
MassHealth (including MBHP)	$ 3,534,896	$ 6,188,381	$ 9,723,277	6%	7%	7%
Health Safety Net	$ 609,126	$ 1,411,458	$ 2,020,584	1%	2%	1%
Self Pay	$ 15,245	$ 79,239	$ 94,484	0%	0%	0%
Subtotal (all above payers)	$ 45,816,599	$ 69,121,355	$ 114,937,954	83%	81%	82%
All Other	$ 9,245,423	$ 16,321,307	$ 25,566,730	17%	19%	18%
TOTAL	$ 55,062,022	$ 85,442,662	$ 140,504,684	100%	100%	100%

St. Elizabeth's Hospital	**Net Patient Revenue**			**% Total Net Patient Revenue**		
	Inpatient	**Outpatient**	**Total**	**Inpatient**	**Outpatient**	**Total**
Private (non-Medicare)						
Major commercial plans	$ 38,995,663	$ 31,333,528	$ 70,329,191	23%	35%	27%
Medicaid & CommCare plans	$ 7,051,927	$ 5,414,344	$ 12,466,271	4%	6%	5%
Plans with Steward limited ntwk	$ 10,128,869	$ 10,776,499	$ 20,905,368	6%	12%	8%
Private (Medicare plans)	$ 8,467,038	$ 2,366,317	$ 10,833,355	5%	3%	4%
Medicare	$ 72,373,734	$ 17,537,169	$ 89,910,903	43%	19%	35%
MassHealth (including MBHP)	$ 9,671,720	$ 5,352,084	$ 15,023,804	6%	6%	6%
Health Safety Net	$ 3,136,898	$ 1,322,316	$ 4,459,214	2%	1%	2%
Self Pay	$ 19,305	$ 151,411	$ 170,716	0%	0%	0%
Subtotal (all above payers)	$ 149,845,154	$ 74,253,668	$ 224,098,822	88%	82%	86%
All Other	$ 19,549,177	$ 16,131,756	$ 35,680,933	12%	18%	14%
TOTAL	$ 169,394,331	$ 90,385,424	$ 259,779,755	100%	100%	100%

2. Physicians

In 2010, there were about 1,652 physicians on Caritas's medical staff (physicians with admitting privileges to one or more of the Caritas hospitals). Physicians in the Caritas contracting network were a subset of the active medical staff, and Caritas's employed physicians were a subset of its network physicians. Caritas employed physicians through three subsidiaries: Caritas Christi Physician Network, Inc., Caritas Carney Medical Group, Inc., and Caritas Good Samaritan Medical Practice Corporation.[32] The table below consolidates the operations of the employed physician entities into Caritas Physician Initiatives ("CPI"), and reports on patient volume and financial statistics for CPI. The operating revenue for CPI shown below derived from two sources: patient revenue and "other operating revenue" (primarily subsidies from the Caritas hospitals[33]). Both sources of revenue grew significantly in FY10: while expenses (not shown below) grew by approximately $50 million, patient revenue grew by $32 million and "other revenue" grew by almost $28 million. Thus, CPI reduced its operating loss in FY10 by almost $11 million.

Table 4 – Utilization and Financial Data for Caritas Physicians (FY2008-2010)

2010 Active Medical Staff	1,652
FY2010 Network Physicians, Non-Employed	1,172
FY2010 Network Physicians, Employed	445 (306 FTEs)
FY2010 Claims for CPI, Patients Over Age 18[34]	626,631
Total Operating Revenue Net of Bad Debt (CPI) ($000)[35]	
FY2008	$135,124
FY2009	$137,211
FY2010	$190,701
Operating Income (CPI) ($000)	
FY2008	-$20,805
FY2009	-$20,554
FY2010	-$9,632
Total Assets (CPI) ($000)	
FY2008	$35,917
FY2009	$48,039
FY2010	$31,705

[32] CARITAS FY10 AFS, *supra* note 19, at 7.

[33] In general, hospitals and provider systems provide funding to their physicians for a number of reasons, such as support for information technology to facilitate care management and funding for services that physicians provide hospitals.

[34] This figure does not include claims for specialties for which billing was outsourced (behavioral health, emergency medicine, pathology, and radiology).

[35] Data on operating revenue, operating income, and total assets is from Caritas's audited financial statements. *See* CARITAS FY10 AFS, *supra* note 19, at 41, 43, 45, 47; CARITAS FY08 AFS, *supra* note 29, at 32, 34.

3. Other Providers

Besides the network physicians, the other main affiliates of the Caritas system were: St. Joseph Nursing Care Center, a 123-bed skilled nursing facility located in Dorchester; Good Samaritan Hospice, located in Brighton; Caritas Home Care; PET Imaging; and Tailored Risk Assurance Company, a liability insurance company organized in the Cayman Islands ("TRACO").[36] TRACO had approximately $50 million in investment assets, but otherwise the assets and operations of the non-physician affiliates were not material in relation to the system.[37]

In Table 5 below, we present patient utilization and financial statistics for Caritas Home Care, the largest of the non-physician affiliates as measured by revenue. From FY09 to FY10, home care visits decreased by about 8%, while expenses grew by more than 14%. As a result, as shown in the table below, operating income decreased from about $1 million in FY09 to $52,000 in FY10. Over the same period, Caritas's mix of home care services did not change materially (e.g., in both years, rehabilitation visits for physical, occupational, and speech therapy represented about 28% of all visits).

Table 5 - Utilization and Financial Data for Caritas Home Care (FY2008-2010)

	FY2008	FY2009	FY2010
NPSR Net of Bad Debt ($000)[38]	$21,596	$21,344	$23,227
Operating Income ($000)	$1,159	$1,019	$52
Visits by Service Type for Patients Over Age 18			
Nursing	n/a	77,292	72,531
Physical Therapy	n/a	30,958	27,495
Occupational Therapy	n/a	7,710	7,670
Speech Therapy	n/a	350	335
Social Work	n/a	1,937	2,130
Home Health Aide	n/a	18,775	16,343
Total	n/a	137,022	126,504

C. Market Position

This next section of the Report examines Caritas's pre-acquisition market activity from multiple perspectives, using several different data sources. First, we examine patient discharge data, which provides one measure of the geographies from which the Caritas hospitals primarily

[36] *See* Caritas Bonds OS, *supra* note 22, at A1–2, A9–11.
[37] *See* CARITAS FY10 AFS, *supra* note 19, at 41–44 (indicating that the operations of Caritas's non-physician affiliates accounted for less than 3% of the system's total operating revenue in FY10).
[38] Data on NPSR and operating income is from Caritas's audited financial statements. *See* CARITAS FY10 AFS, *supra* note 19, at 44; CARITAS FY09 AFS, *supra* note 29, at 37; CARITAS FY08 AFS, *supra* note 29, at 35.

draw their patients (PSAs). Monitoring discharge data for all hospital patients from the Caritas PSAs provides information on Caritas's major competitors in each PSA, and any shifts in inpatient discharges among the Caritas hospital and its community and tertiary competitors.

We also examine insurers' claims data showing where patients went for inpatient and outpatient care when their primary care provider ("PCP") was in the Caritas network. Here, too, we measure Caritas's share of services compared to its competitors. In addition to inpatient services, the insurers' data allows us to examine outpatient and professional services, as well as the amount insurers paid for the care of these patients over whom Caritas presumably had the greatest influence.

Finally, we examine another source of data from insurers, which measures the cost of care delivered by Caritas compared to competing provider systems. We report two measures of cost: (1) Caritas's price for specific types of services (e.g., hospital, physician) compared to its competitors' prices and (2) the TME of patients with Caritas PCPs compared to patients with PCPs at competing provider systems. These metrics provide information on the potential cost impact of any shifts in Caritas's share of hospital and professional services, as identified in the first two data sources.

1. Inpatient Market Share and Service Mix

This subsection examines market share of inpatient volume in the PSA of each of the six Caritas hospitals and the two Essent hospitals acquired by Steward in FY11. For the purposes of this Report, we define market share as a hospital's share of the total discharges for the PSA in FY10.[39] For each PSA, we present the market share of the Caritas hospital in the PSA as well as the share of its community and tertiary competitors. This provides information on how often patients in the PSA were getting their inpatient care from the Caritas hospital, versus from other community hospitals or from tertiary hospitals. We also present the mix of inpatient services delivered to patients within the PSA, and compare this to the mix of services provided by the Caritas hospital and by Caritas's community and tertiary competitors. Like payer mix, service mix can provide insight into a hospital's financial performance, since some services are better reimbursed than others (e.g., surgery tends to be more profitable than medical services). Our market share and service mix calculations are based on patient discharge data for each PSA, as further described below, and we define each PSA as described in Part III.B.1 above.

In FY10, roughly 90% of the patients discharged from a Caritas hospital lived in one of ten counties in eastern Massachusetts or adjacent areas of southern New Hampshire or northeastern Rhode Island.[40] Focusing on discharges originating from these ten counties, Table

[39] This approach does not constitute a market analysis for antitrust purposes.

[40] Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester counties in Massachusetts; Hillsborough and Rockingham counties in New Hampshire; and Newport county in Rhode Island.

6a shows, for each PSA, the inpatient market share of the Caritas hospital in the PSA compared to the inpatient market share of its community and tertiary competitors. For example, as shown below, Carney had 8.5% of the total discharges originating from its PSA in FY10, while South Shore, another community hospital, had 7.7%. Carney's market share of 8.5% amounted to 4,671 actual discharges. The vast majority of patients in Carney's PSA did not get their inpatient care from community hospitals, but rather from tertiary hospitals[41] (60.9%). In three of the six Caritas PSAs, Steward subsequently acquired one of Caritas's competitor hospitals; market shares of those hospitals are marked with an asterisk. For the Norwood PSA, the community hospital with the second largest share of discharges, after Norwood, is another Caritas hospital, Good Samaritan. For this PSA, we list the two community hospitals with the next largest share of discharges after Norwood and Good Samaritan. The final column of the table shows the combined market share of all other Massachusetts hospitals for the PSA, after accounting for the market share of the Caritas hospital in the PSA, the share of Caritas's top two community competitors for the PSA, and the share of tertiary hospitals (i.e., the market share percentages in each row sum to 100%). The below figures set a baseline for monitoring whether Steward grows inpatient market share in the communities it serves, and how any changes in Steward's market share impact the market share of its competitors.

Table 6a - Inpatient Market Share Statistics for Each Caritas Primary Service Area (FY2010)

	Caritas Hospital Market Share and Actual Discharges	Market Share of Top Two Community Hospitals (* Steward acquisition)	Market Share of Tertiary Hospitals	Market Share of All Other MA Hospitals
Carney PSA	8.5% 4,671	South Shore - 7.7% Quincy Medical* - 6.9%	60.9%	16%
Good Samaritan PSA	24.1% 11,038	Signature Brockton - 23.2% Morton* - 11.3%	23.7%	17.7%
Holy Family PSA	25.4% 8,465	Lawrence General - 31.7% Merrimack Valley* - 7.4%	21.5%	14%
Norwood PSA	30.1% 9,803	*Good Samaritan - 7.2%* Newton-Wellesley - 7.1% Sturdy Memorial - 6.4%	29.4%	19.8%
St. Anne PSA	26.9% 5,631	Charlton - 59.2% St. Luke's - 2.6%	7.4%[42]	3.9%
St. Elizabeth PSA	9.1% 7,071	Mt. Auburn - 9.1% Newton-Wellesley - 8.1%	53.7%	20%

[41] Defined as the following eleven Massachusetts hospitals: Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham and Women's Hospital, Children's Hospital, Dana Farber Cancer Institute, Lahey Clinic, Massachusetts Eye & Ear Infirmary, Massachusetts General Hospital, New England Baptist Hospital, Tufts Medical Center, and UMass Memorial Medical Center.

[42] The dataset we received from Steward only includes the patients in a PSA who obtained care from a Massachusetts hospital. There are likely patients living in St. Anne's PSA who went to tertiary hospitals in nearby Providence, Rhode Island for inpatient care, who are not reflected in the data set. *See*, *e.g.*, R.I. HEALTH & EDUC. BLDG. CORP., WOMEN & INFANTS HOSP. OF R.I. ISSUE — SERIES 1992 app. at A-2 (1992) (indicating that a Providence tertiary hospital's service area includes southeastern Massachusetts).

Table 6b – Inpatient Market Share Statistics for Each Essent Primary Service Area (FY2010)

	Essent Hospital Market Share and Actual Discharges	Market Share of Top Two Community Hospitals	Market Share of Tertiary Hospitals	Market Share of All Other MA Hospitals
Merrimack PSA	24.2% 3,018	Anna Jaques - 19.9% Lawrence General - 12.9%	22.6%	20.4%
Nashoba PSA	17.7% 1,455	Emerson - 25.2% Lowell - 8.8%	29%	19.3%

In addition to monitoring the impact of Steward's operations on its inpatient market share, we track the mix of services captured by each hospital's market share. Patients living in each PSA receive a mix of inpatient services, from obstetrics to surgery. Since some services are better-reimbursed than others, monitoring service mix can provide insight into a hospital's financial performance. Table 7a shows FY10 data on the overall mix of inpatient services delivered to patients living in each PSA, the mix of services delivered by the Caritas hospital in each PSA, and the mix of services delivered by tertiary hospitals to the PSA. For each service mix calculation, the table includes corresponding detail on the number of discharges underlying the percentage figure. Except for St. Elizabeth's, the Caritas hospitals had a higher medical and psychiatric mix and a lower surgical and obstetrics mix than the mix in the PSA overall. Much of the surgical and obstetrics mix went to Boston tertiary hospitals. The below figures set a baseline for monitoring whether Steward grows inpatient market share in specific services, and how any changes in Steward's service-specific market share impact the service mix of its competitors.

Table 7a – Inpatient Service Mix Statistics for Each Caritas Primary Service Area (FY2010)

	Overall Service Mix in PSA		Service Mix of Caritas Hospital		Service Mix of Tertiary Hospitals[43]	
Carney PSA						
Medical[44]	49%	26,945	64%	2,973	45%	14,876
Surgical[45]	25%	13,698	19%	901	28%	9,284
Obstetrics[46]	19%	10,512	0%[47]	15	25%	8,206
Psychiatry[48]	6%	3,513	17%	782	3%	940

[43] *See supra* note 41.
[44] Includes Cardiology, General Medicine, Medical Oncology/Hematology, Neurology, and Transitional Care Unit.
[45] Includes Cardiac Catheterization, Cardiac Electrophysiology, Cardiac Surgery, Ear Nose Throat, General Surgery, Gynecology, Neurosurgery, Ophthalmology, Orthopedics, Spine, Thoracic Surgery, Transplant, Trauma, Urology, and Vascular Services.
[46] Includes Obstetrics and Neonates.
[47] Neither Carney nor St. Anne's offers routine obstetrical services; the few recorded discharges in FY10 reflect unusual circumstances.
[48] Includes Psychiatry and Substance Abuse.

	Overall Service Mix in PSA		Service Mix of Caritas Hospital		Service Mix of Tertiary Hospitals	
Good Samaritan PSA						
Medical	51%	23,467	57%	6,317	38%	4,096
Surgical	25%	11,665	20%	2,221	46%	5,007
Obstetrics	17%	7,766	14%	1,541	15%	1,613
Psychiatry	6%	2,958	9%	959	2%	167
Holy Family PSA						
Medical	45%	15,061	48%	4,012	38%	2,682
Surgical	26%	8,677	18%	1,490	49%	3,495
Obstetrics	21%	6,975	20%	1,643	12%	846
Psychiatry	7%	2,445	15%	1,279	1%	100
Norwood PSA						
Medical	48%	15,734	62%	6,090	37%	3,530
Surgical	29%	9,374	21%	2,087	46%	4,395
Obstetrics	16%	5,283	8%	742	16%	1,550
Psychiatry	7%	2,211	9%	884	1%	110
St. Anne PSA[49]						
Medical	57%	11,832	76%	4,292	38%	595
Surgical	25%	5,256	19%	1,047	56%	870
Obstetrics	14%	2,914	0%	20	4%	63
Psychiatry	4%	928	5%	272	1%	23
St. Elizabeth PSA						
Medical	45%	35,115	47%	3,337	42%	17,598
Surgical	26%	19,733	25%	1,745	30%	12,397
Obstetrics	22%	16,736	14%	1,005	25%	10,404
Psychiatry	8%	5,902	14%	984	3%	1,193

As shown in Table 7b below, the inpatient service mix for Merrimack and Nashoba was even more heavily weighted towards medical discharges than the service mix of most of the Caritas hospitals. Like Table 7a, the below table includes corresponding detail on the number of discharges underlying each service mix calculation.

[49] Patients residing in St. Anne's PSA who travel to nearby Providence, Rhode Island for care are not reflected in these numbers. *See supra* note 42.

Table 7b – Inpatient Service Mix Statistics for Each Essent Primary Service Area (FY2010)

	Overall Service Mix in PSA		Service Mix of Essent Hospital		Service Mix of Tertiary Hospitals	
Merrimack PSA						
Medical	46%	5,707	73%	2,194	37%	1,039
Surgical	26%	3,284	18%	552	51%	1,455
Obstetrics	19%	2,402	0%[50]	2	11%	298
Psychiatry	9%	1,094	9%	270	1%	35
Nashoba PSA						
Medical	44%	3,610	78%	1,140	36%	865
Surgical	31%	2,525	19%	277	54%	1,292
Obstetrics	18%	1,475	0%	1	9%	210
Psychiatry	7%	605	3%	37	1%	36

2. Physician Referral Patterns

Physician referral patterns are another metric for monitoring the impact of Steward's operations on its market position. Insurers track information on "referral patterns" or "site of service" to understand where their members are getting health care services. For example, for patients with Steward PCPs, insurers can analyze claims data to see how often those patients get health care services from within the Steward system, and how often they go to a non-Steward provider for care. For patients in insurance products that require the patient to select a PCP (and to obtain referrals from that PCP for specialist and hospital care), the expectation is that the PCP can impact where the patient goes for services. Steward has stated that its business strategy is to keep more patient care within its own system, asserting that (1) receiving care from within a single system should lead to better coordinated and more efficient care and (2) redirecting patients from more expensive providers to Steward should lower overall costs, while providing Steward a viable business model.[51] Monitoring insurer data on how often patients are getting their care from Steward as opposed to community or tertiary competitors helps us measure, over time, the impact of Steward's "care-retention" strategy on the markets it serves.

The following tables provide baseline data on referral patterns in 2009 and/or 2010 for patients with Caritas PCPs, as measured by the three largest commercial insurers in

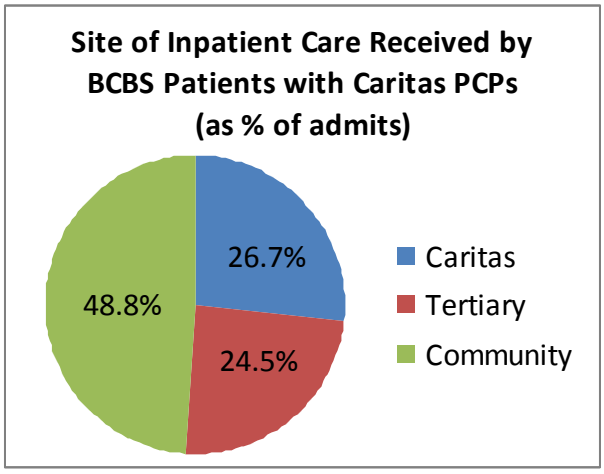
[50] Neither Merrimack nor Nashoba offers routine obstetrical services; the few recorded discharges in FY10 reflect unusual circumstances.

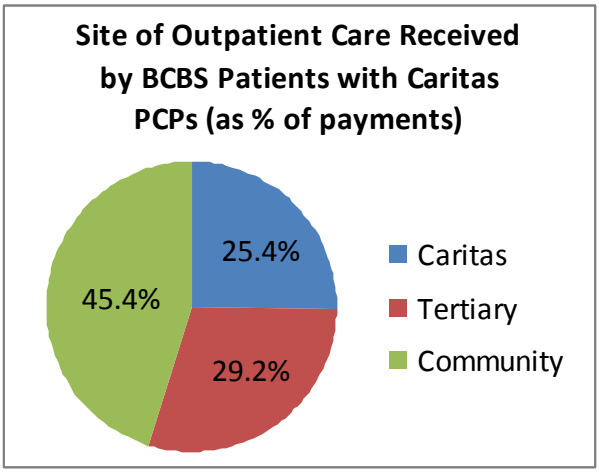
[51] *See, e.g.*, AGO STATEMENT AS TO CARITAS CHRISTI TRANSACTION, *supra* note 1, app. at A8 ("Steward's stated objective is to improve and further develop a community-based health care system capable of (i) managing risk, (ii) providing high quality, local, and accessible care, and (iii) reducing out-migration of patients who now obtain services, otherwise available at a Caritas hospital, at higher cost, less accessible settings."); May 2010 Caritas Letter, *supra* note 3 (describing Steward's intention to "provide high-quality, lower-cost care in a community setting, as a complement to the highly-specialized care offered by Boston's academic medical centers").

Massachusetts (BCBS, HPHC, THP). Each table tracks how often patients with Caritas PCPs received hospital care from Caritas hospitals, as opposed to other community or tertiary hospitals. One insurer (THP) includes information on referral patterns for physician specialist care as well. In general, insurers track the proportion of patient care at Caritas versus other providers using two metrics: (1) units of care at Caritas versus other providers[52] and (2) dollars paid to Caritas versus other providers. Overall, in 2009–10, patients with Caritas PCPs at these three insurers received 55–75% of their hospital care outside the Caritas system, as measured in both admissions and payments. These patients were generally more likely to leave the system for inpatient care than for outpatient care. The care these patients received outside of Caritas was split between tertiary and community hospitals, with tertiary hospitals receiving fewer admissions but a greater proportion of payments than community hospitals. The data varies by insurer, as illustrated in Tables 8a, 8b, and 8c below.

Table 8a – Site of Hospital Services Received by BCBS Patients with Caritas PCPs (CY2010)

	Inpatient Care		Outpatient Care[53]
Hospital Category	**% of Total Admissions**	**% of Total Payments**	**% of Total Payments**
Caritas[54]	27%	24%	26%
Tertiary[55]	24%	42%	29%
Community	49%	34%	45%



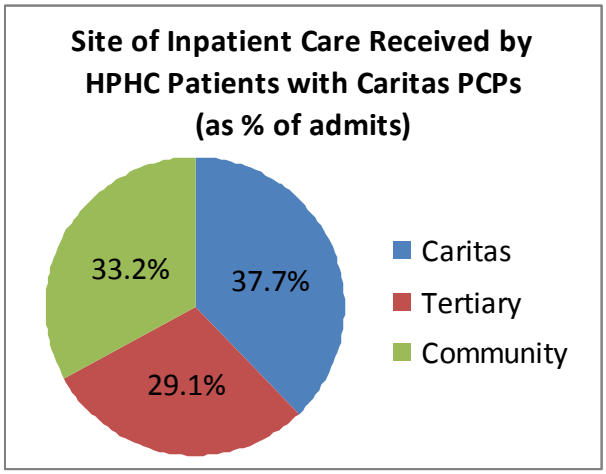


[52] Units of inpatient care are measured as "admissions"; units of outpatient care are measured as "visits."
[53] Referral pattern data for outpatient visits is unavailable.
[54] Includes Carney Hospital, Good Samaritan Medical Center, Holy Family Hospital, Norwood Hospital, St. Anne's Hospital, and St. Elizabeth's Medical Center.
[55] Includes Beth Israel Deaconess, Boston Medical Center, Brigham and Women's Hospital, Children's Hospital, Dana Farber Cancer Institute, Lahey Clinic, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, New England Baptist Hospital, Tufts Medical Center, and UMass Memorial Medical Center.

In addition to the information presented in the table and charts above, BCBS provided referral pattern data broken out by service line. In general, Caritas retained more medical/surgical inpatient care than maternity care. For outpatient care, Caritas retained more surgical and radiology care than laboratory care.

Table 8b - Site of Hospital Services Received by HPHC Patients with Caritas PCPs (CY2010)

	Inpatient Care		Outpatient Care	
Hospital Category	**% of Total Admissions**	**% of Total Payments**	**% of Total Visits**	**% of Total Payments**
Caritas	38%	37%	46%	42%
Tertiary	29%	36%	21%	30%
Community	33%	27%	33%	28%



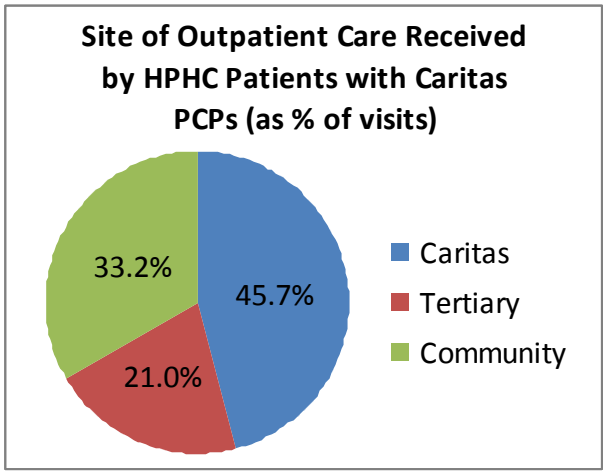
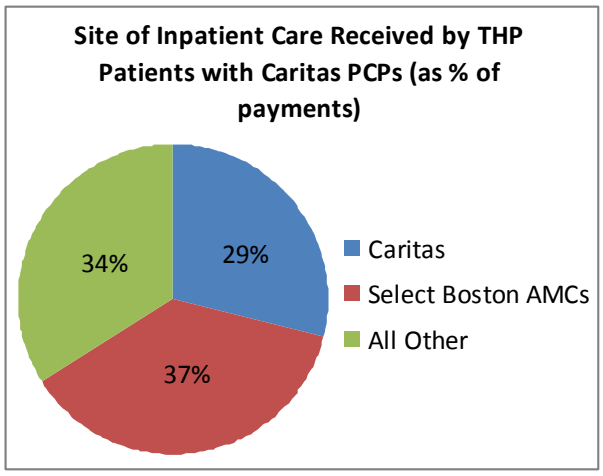
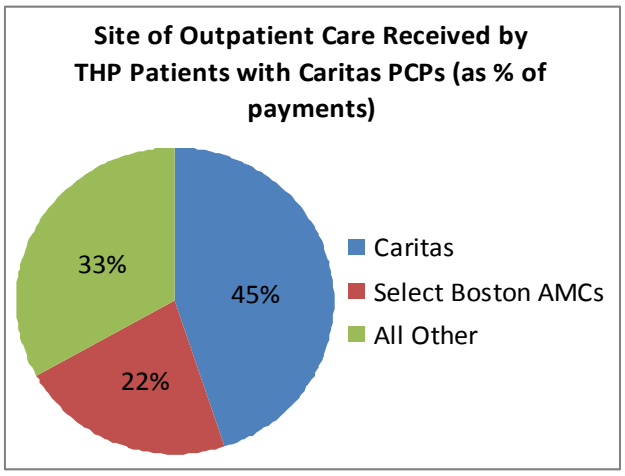


Table 8c - Site of Services Received by THP Patients with Caritas PCPs (CY2009–2010)[56]

Provider Type	% Total IP Payments	% Total OP Payments	% Total Specialist Payments	% Total Payments for All Services
Caritas	29%	45%	53%	40%
Select Boston Tertiary Systems[57]	37%	22%	23%	24%
All Other[58]	34%	33%	24%	36%

[56] Referral pattern data by units of care not available.
[57] As reported by THP, includes Beth Israel Deaconess; Children's Hospital/Pediatric Physicians' Organization; Partners HealthCare System; and Tufts Medical Center/New England Quality Care Alliance.
[58] Remaining Massachusetts providers not included in other two categories (includes tertiary providers such as Boston Medical Center and all non-Caritas community providers).





3. Prices and Total Medical Expenses

In conjunction with market share, service mix, and referral patterns, price and TME are important metrics for monitoring Steward's impact on health care costs and the communities it serves. Price and TME are both measures of cost. Price measures the amount an insurer pays a provider for its services. In this Report, we compare Steward's prices to the prices of other providers to see the relative amount insurers pay Steward versus other providers for hospital and physician services.

To establish a baseline of the prices in Steward's communities prior to Steward's entry, Caritas's 2009 hospital prices compared to its competitors are shown below for the three major commercial insurers in Massachusetts (an asterisk denotes a hospital that Steward later acquired). While each insurer calculates its relative prices somewhat differently, they all reflect an aggregate composite of the prices or payments for all hospital services and insurance products (e.g., HMO, PPO). This "all-in" price is either adjusted for, or neutral to, case mix depending on the insurer, and is indexed either to the insurer's average payment or its standard price.[59] Table 9 shows that in 2009, prices for the Caritas hospitals varied by insurer and by geography (as well as by service category, not shown below), with the result that some Caritas hospitals were on par with competitors, others were less expensive, and others were more expensive. In future years, we anticipate reporting hospital prices by major service category as we track Steward's service mix. This will enable us to monitor whether Steward gains market share in higher-priced or lower-priced services, and the corresponding impact on competitors and health care costs. We also expect to continue reporting payer mix, including Steward's mix of public versus commercial payers.

[59] For more information on how each insurer calculates its hospital relative prices/payments, please see OFF. OF ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS & COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(B): REPORT FOR ANNUAL PUBLIC HEARING 10–11, app. at 1–6 (2011).

Table 9 – Hospital Prices by Commercial Insurer (CY2009)

Hospital	BCBS	HPHC	THP
Boston			
Caritas – Carney Hospital	***0.91***	***0.79***	***0.92***
Beth Israel Deaconess Medical Center	1.11	0.92	1.11
Boston Medical Center	0.88	0.70	0.68
Partners – Brigham & Women's Hospital	1.42	1.26	1.30
Partners – Massachusetts General Hospital	1.44	1.24	1.29
Quincy Medical Center*	0.75	0.55	0.66
South Shore Hospital	1.06	1.18	1.00
Tufts Medical Center	0.96	0.90	0.88
Caritas - St. Elizabeth's Medical Center	***1.07***	***0.98***	***1.01***
Beth Israel Deaconess Medical Center	1.11	0.92	1.11
Boston Medical Center	0.88	0.70	0.68
Mount Auburn Hospital	0.94	0.91	0.99
Partners – Brigham & Women's Hospital	1.42	1.26	1.30
Partners – Massachusetts General Hospital	1.44	1.24	1.29
Tufts Medical Center	0.96	0.90	0.88
Brockton			
Caritas - Good Samaritan Medical Center	***0.93***	***0.90***	***0.88***
Morton Hospital & Medical Center*	0.86	0.62	0.62
Signature Healthcare Brockton Hospital	0.82	0.76	0.76
Fall River			
Caritas - St. Anne's Hospital	***1.08***	***1.33***	***0.93***
Southcoast - Charlton Memorial Hospital	0.95	0.81	0.81
Merrimack Valley			
Caritas - Holy Family Hospital	***0.82***	***0.80***	***0.83***
Essent - Merrimack Valley Hospital	**0.85**	**0.60**	**0.61**
Essent - Nashoba Valley Medical Center	**0.83**	**0.70**	**0.82**
Lawrence General Hospital	0.82	0.62	0.66
Lowell General Hospital	0.79	0.75	0.79
Norwood			
Caritas - Norwood Hospital	***0.87***	***0.89***	***0.92***
Beth Israel Deaconess - Needham Hospital	0.83	0.87	0.97
Partners - Newton-Wellesley Hospital	1.04	1.12	0.98

The next table shows Caritas's 2009 physician prices relative to its competitors for the three major Massachusetts insurers. These prices reflect a composite of the prices for all

physician services and insurance products and are indexed to the insurer's average price.[60] Table 10 shows that in 2009, for BCBS, Caritas's physician prices were lower than almost all of its competitors' prices, and for HPHC and THP, Caritas's prices were sometimes lower and sometimes higher than competitors' prices. In future years, based on improvements in market transparency, we hope to report prices for additional provider categories, such as home health.

Table 10 – Physician Prices by Commercial Insurer (CY2009)

Provider	BCBS	HPHC	THP
Caritas Christi	***0.86***	***1.01***	***1.07***
Atrius Health	1.99	1.29	1.29
Beth Israel Deaconess PO	0.99	1.08	1.17
Boston Medical Center Management Service	n/a	0.81	0.82
Lawrence General IPA	0.84	0.88	0.87
Lowell General PHO	1.06	0.97	0.88
Mount Auburn Cambridge IPA	1.40	1.13	1.01
New England Quality Care Alliance	1.01	0.94	0.98
Partners Community Healthcare, Inc.	1.12	1.22	1.24
Signature Brockton PHO	1.07	0.91	1.07
Southcoast Physicians Network	0.97	0.94	0.77
South Shore PHO	0.95	1.01	0.95

Total medical expenses measure the total cost of care for a patient over a period of time, such as a month or a year. For analytic purposes, a patient's TME can be attributed to the provider system where the patient has his/her PCP. The TME associated with Caritas measures the amount spent on all the units of health care services received by patients with Caritas PCPs. Thus, TME reflects both the number of services received and the price of those services. Table 11 below shows, on a health status adjusted basis,[61] Caritas's average per member, per month TME compared to its competitors for the three major commercial insurers. In many cases, Caritas's 2009 TME was lower than its competitors, and in some cases, it was higher. In future

[60] For more information on the methodology for calculating these physician relative prices, please see CTR. FOR HEALTH INFO. & ANALYSIS, HEALTH CARE PROVIDER PRICE VARIATION IN THE MASSACHUSETTS COMMERCIAL MARKET: BASELINE REPORT, at 50, 52 (2012), *available at* http://www.mass.gov/chia/docs/cost-trend-docs/cost-trends-docs-2012/price-variation-report-11-2012.pdf.

[61] The insurers provided us with standardized health status scores that reflect differences in the demographics and sickness of the different populations cared for by providers in their network. Since some providers care for patients who are sicker than others, it is standard industry practice to adjust for health status differences when comparing TME, so a provider caring for a sicker population will not appear as higher spending solely for that reason. The TME data we present is adjusted using the health status scores provided by each insurer, to minimize bias in comparison due to differences in the sickness of the populations measured. Note that each insurer calculated health status scores for its network according to its own methodology, such that the reader should not necessarily compare TME *across* insurers.

years, based on improvements in market transparency, we hope to include reporting of TME for public payers, such as Medicare, MassHealth, and Commonwealth Care.

Table 11 – Health Status Adjusted TME by Commercial Insurer (CY2009)

Provider	BCBS	HPHC	THP
Caritas Christi	***$376.83***	***$373.85***	***$329.16***
Atrius Health	$464.64	$380.39	$340.22
Beth Israel Deaconess PO	$387.77	$376.31	$343.00
Boston Medical Center Management Service	$369.33	$323.96	$293.51
Lawrence General IPA	$346.75	$341.01	$312.79
Lowell General PHO	$362.38	$353.52	$307.32
Mount Auburn Cambridge IPA	$479.66	$396.58	$349.43
New England Quality Care Alliance	$378.61	$346.09	$323.64
Partners Community Healthcare, Inc.	$420.89	$415.35	$387.34
Signature Brockton PHO	$382.10	$347.44	$336.87
Southcoast Physicians Network	n/a	$387.54	$342.42
South Shore PHO	$426.43	$416.76	$381.66

D. System Financial Performance

This section reports the financial results of the Caritas system as a whole. It is organized into three areas of financial performance: (1) operating performance; (2) sources and uses of cash; and (3) special non-operating areas affecting financial performance, particularly pension expenses and liabilities. Operating performance measures Caritas's performance on its income statement and balance sheet using standard industry ratios, such as operating and total margins (profitability), current ratio and days cash on hand (liquidity), debt service coverage and equity financing (solvency), and age of plant (adequacy of capital investment). Sources and uses of cash, which we aggregate over a three-year period to focus on long term funds flow, adds the perspective of whether a system is generating cash from its operating activities (necessary for long term sustainability), how much of that cash is invested in property, plant and equipment (important for long term competitive position), and how much cash is generated and/or used for financing the system (how much cash comes from outside borrowing versus from equity). Special non-operating areas include analysis of the system's pension obligations, including amounts owed in the future but not yet funded, and amounts the system must fund now and in the near future to comply with pension regulations.

1. Operating Performance

Table 12 below shows standard financial metrics for the Caritas system and compares them to the corresponding median measures for all Massachusetts hospitals and for Massachusetts disproportionate share hospitals ("DSH"). For all metrics except plant age, a higher value is more favorable than a lower value.

Table 12 – Caritas Financial Condition (FY2010)

	Caritas System[62]	All MA Hospitals[63]	DSH[64]
Total Margin	1.8%	2.6%	1.9%
Operating Margin	1.1%	2.0%	1.2%
Current Ratio	0.86	1.55	1.39
Days Cash on Hand[65]	25/61	n/a	n/a
Equity Financing	0.29	0.39	0.40
Debt Service Coverage	2.2X	3.0X	2.13X
Average Age of Plant	14.1	n/a	n/a

As Table 12 suggests, Caritas's financial performance in FY10 was weak compared to other hospitals in Massachusetts, including hospitals serving disproportionate percentages of low-income and Medicare patients.

2. Sources and Uses of Cash

Sources and uses of cash for the Caritas system aggregated over FY08–10 are shown in Table 13. Capital expenditures over the three years prior to Steward's acquisition were about 1.6 times depreciation and amortization expenses. This was quite favorable relative to industry standards. In 2010, for instance, the median equivalent ratio for all 248 hospitals and health systems rated by Fitch Ratings was 1.16.[66] While this was a healthy level of capital expenditure, little cash remained to fund pension liabilities (for which the system had curtailed or halted funding during this period). Additionally, the drawdown of third party reserves (amounts received from insurers but set aside in the event that amounts are owed back upon final settlement of the contract period) represented over 60% of the system's total surplus, which reduced Caritas's "cushion" against the future impact of fluctuating third party payment settlements upon income.

[62] All figures for the Caritas system are derived from Caritas's FY10 audited financial statements. *See* CARITAS FY10 AFS, *supra* note 19.

[63] DIV. OF HEALTH CARE FIN. & POLICY, MASS. EXEC. OFF. OF HEALTH & HUMAN SERVS., MASSACHUSETTS ACUTE HOSPITAL FINANCIAL PERFORMANCE FISCAL YEAR 2010, at 3–4, 7, 10–11, 27–28, 30, 33–34 (2011), *available at* http://www.mass.gov/chia/docs/r/pubs/11/hospital-financial-performance-fy10.pdf (data shown are median ratios).

[64] *Id.* DSH are defined as hospitals with 63% or more of patient revenue attributable to Medicare, Medicaid, and other government payers, including Commonwealth Care and Health Safety Net.

[65] Twenty-five days based on cash only; 61 days based on cash plus unrestricted investments (board designated/ undesignated assets).

[66] FITCH RATINGS, 2011 MEDIAN RATIOS FOR NONPROFIT HOSPITALS AND HEALTHCARE SYSTEMS 7 (2011). Fitch Ratings is a private rating agency that assesses the financial performance of various securities, institutions, and other entities, including periodic reports on the financial performance of U.S. hospitals and health care systems.

Table 13 – Caritas Aggregate Sources and Uses of Cash (FY2008-2010)[67]

Sources of Cash	Amount ($000)	%	Uses of Cash	Amount ($000)	%
Noncash expenses (mostly depreciation & amortization)	$161,600	50%	Investment in property, plant & equipment	$253,102	79%
Surplus	$35,187	11%	Repayment of long term debt, net of increases	$28,381	9%
Working capital minus third party reserve drawdown	$47,155	15%	Drawdown of third party reserves (noncash revenue)	$21,754	7%
Increase in other noncurrent liabilities	$15,019	5%	Increase in investment in other noncurrent assets	$11,710	4%
Transfers from restricted funds	$32,344	10%	Transfer to other entities	$6,370	2%
Drawdown of cash & other sources	$30,012	10%			
Total sources	$321,317	100%	Total uses	$321,317	100%

3. Special Non-Operating Areas Affecting Financial Performance

In 2010, approximately 13,000 current and former Caritas system employees were covered by three defined benefit pension plans. The largest plan, the Caritas Christi Retirement Plan, was structured under the Roman Catholic Archdiocese of Boston. The other two plans were associated with the Good Samaritan and Norwood hospitals. As reported on Caritas's FY10 financial statements, these plans were collectively underfunded by an estimated $226 million as of FYE10.[68] Pursuant to accounting rules, the underfunded amount of the Good Samaritan and Norwood plans was reported as a liability on the Caritas financial statements, while the underfunded amount of the RCAB plan was not.

IV. ANALYSIS OF STEWARD'S FIRST YEAR OF PERFORMANCE (FY2011)

Part IV examines the same categories of performance metrics presented in Part III, and updates each analysis with information on Steward's first year of performance (FY11). Our analysis reflects data on FY11 available as of mid-2012. We compare Steward's performance to Caritas's where possible, with caveats where comparisons are complicated by factors such as changes in reporting practices. Before presenting our analysis of Steward's organization and governance, medical system, market position, and financial performance, we summarize the main elements of Steward's acquisition of Caritas at the beginning of FY11.

[67] *See* CARITAS FY10 AFS, *supra* note 19, at 5–6; CARITAS FY08 AFS, *supra* note 29, at 5–6.

[68] CARITAS FY10 AFS, *supra* note 19, at 16, 28. Note that in estimating plan liabilities, actuaries may apply different standards and assumptions depending on a number of factors, including the purpose of the estimate and changes in economic conditions. For example, the actuarial standards associated with estimating the "termination value" of a plan (where the actuary assumes a plan is not an ongoing entity, but must immediately settle all benefits) may differ from the assumptions associated with estimating liability for ongoing commitments, where changes in interest rates or demographic variables may affect the estimate of liabilities over time. For purposes of this Report, in monitoring Steward's financial condition, we rely primarily on information reported in Steward's audited financial statements, as well as Steward's own projections that it has estimated for its business use.

Steward's acquisition of Caritas's assets and liabilities followed a methodology laid out in the Caritas Asset Purchase Agreement ("APA"). As of the closing date of the acquisition, November 6, 2010, two major financing actions were completed:

1. Steward used Caritas's unrestricted cash and investment holdings to retire all but about $57 million of the system's long-term debt, which amounted to approximately $250 million.[69]

2. Cerberus Capital made a cash equity investment of $246 million in the parent corporation of the newly-formed Steward Health Care System. This was an amount sufficient to cover the cash payments that Steward would have to make at closing, plus meet the 1.25X minimum current ratio specified in the Caritas APA.[70]

At closing, Steward paid out $78 million of the $246 million: $57 million went to Caritas and $21 million went toward closing costs. Steward also assumed substantially all of Caritas's non-debt liabilities,[71] including pension liabilities under the Caritas Christi, Good Samaritan, and Norwood defined benefit plans,[72] and other liabilities such as accounts payable and capital/equipment leases.[73]

In addition to the above costs, Steward made a number of other commitments pursuant to its acquisition of Caritas on issues ranging from community benefits to capital expenditures, as reflected in the Caritas APA and in an October 2010 amendment to the Caritas APA.[74]

A. Organization and Governance

To implement its acquisition of Caritas's assets, Steward created a new organization consisting of multiple corporations owned and controlled by a parent corporation named

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[69] CARITAS FY10 AFS, *supra* note 19, at 2; ERNST & YOUNG LLP, CONSOLIDATED FINANCIAL STATEMENTS & SUPPLEMENTAL INFORMATION: STEWARD HEALTH CARE SYS. 2 (2012) [hereinafter STEWARD FY11 AFS].

[70] CARITAS FY10 AFS, *supra* note 19, at 17. This minimum ratio of 1.25X was required only at the completion of the acquisition and did not apply to subsequent periods.

[71] "Debt" as used in this analysis refers to a specific form of liability representing obligations to repay borrowed funds (e.g., revenue bonds). Certain liabilities – primarily those relating to pre-closing matters such as violations of law, taxes, workers compensation, and malpractice – were excluded from the transaction. *See* Caritas APA, *supra* note 20, § 1.5.

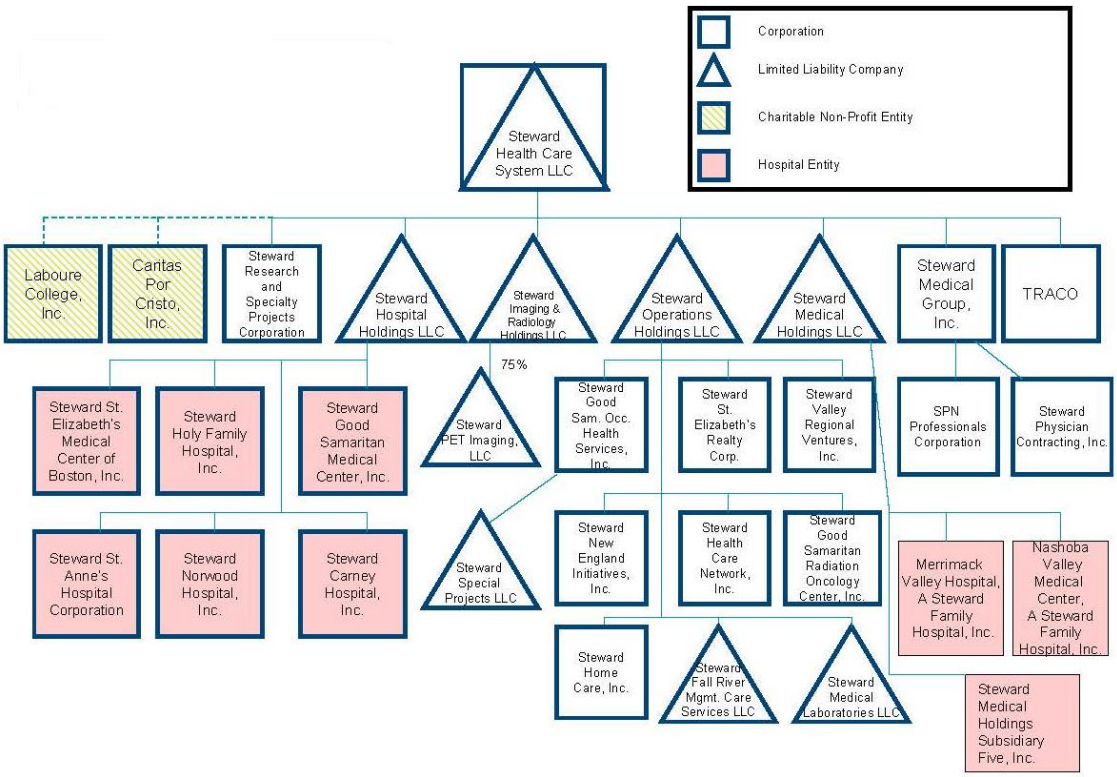
[72] Pursuant to a Pension Transfer Agreement between Steward, the Trustees of the Caritas Christi Retirement Plan, and the RCAB, Steward agreed to assume responsibility for the Caritas Christi Retirement Plan within a three year transition period from its acquisition of Caritas, and to make quarterly payments of $1.625 million to the RCAB during this period. *See* STEWARD FY11 AFS, *supra* note 69, at 25.

[73] Steward has estimated other liabilities of about $319 million, including accounts payable and accruals ($251.6 million), third party settlement reserves ($18.6 million), malpractice liability reserves ($36.8 million), equipment leases ($2.8 million), and other long-term liabilities ($8.9 million). *See also* STEWARD FY11 AFS, *supra* note 69, at 8–9 (estimating total non-debt liabilities assumed).

[74] *See* Caritas Christi & Steward Health Care Sys. LLC, Amendment No. 1 to APA (Oct. 5, 2010), *available at* http://www.mass.gov/ago/docs/nonprofit/caritas/amendment-1-to-apa.pdf.

Steward Health Care System LLC.[75] On November 6, 2010, Steward and its newly-formed subsidiaries acquired substantially all of the assets and assumed substantially all of the remaining (non-debt) liabilities of the Caritas system. Figure 4 shows the corporate structure that existed for the fiscal year following the acquisition.

Figure 4 – Steward Organization Chart (FY2011)



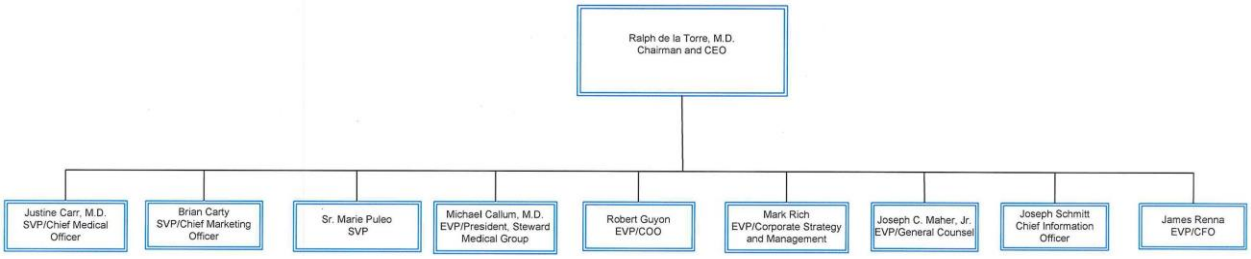
As shown in the chart above, Steward changed the Caritas Christi organization to include the use of new intermediate holding companies through which the Steward parent owned its principal operating subsidiaries. For example, the parent became the sole shareholder of Steward Hospital Holdings LLC, which in turn was the sole shareholder of six corporations, each of which owned one of the former Caritas hospitals. The employed physicians were reorganized as employees of Steward Medical Group, or one of its subsidiaries. Steward also consolidated and repositioned the assets of many of the smaller Caritas affiliates that were formerly subsidiaries of the Caritas hospitals.

As the management chart below indicates, with few changes, the Caritas senior management team remained in place, with Dr. Ralph de la Torre continuing as chief executive officer. The Caritas Board of Directors was replaced by a seven-person Management Board chaired by Dr. de la Torre. FTEs at Steward's principal medical holdings (hospitals, employed

[75] Steward had one class of equity which was wholly-owned by Steward Healthcare Holdings, LLC ("Holdings"). All of Holdings' equity was owned by Steward Healthcare Investors LLC ("Investors"). Based on available information, it appears that Holdings and Investors are single purpose corporations with no activities other than ownership of these equity investments. Both corporations are "controlled affiliates" of Cerberus Capital Management, LP. STEWARD FY11 AFS, *supra* note 69, at 22–23.

physicians, and home care) were 9,277 in FY11, roughly 3% more than in FY10. The largest percent increases in FTEs were at Steward Home Care (21%), Good Samaritan Medical Center (14%), and St. Anne's Hospital (9%).[76]

Figure 5 – Steward Management Structure (FY2011)



B. Medical System

As in our presentation of FY10 data, the following description of Steward's medical system includes hospitals, physicians, and other providers. The information below provides a snapshot of how Steward's major provider types performed during Steward's first year of ownership, and how that FY11 performance compares to Caritas's performance in FY10.

1. Acute Care Hospitals

During FY11, Steward acquired two more acute care hospitals in Massachusetts: Merrimack Valley Hospital and Nashoba Valley Medical Center, both formerly of for-profit Essent Healthcare. The principal terms of those transactions, which closed on May 1, 2011, include total consideration of $25.1 million[77] and a number of commitments to the state's Public Health Council and the city of Haverhill (where Merrimack Valley Hospital is located).[78]

The map below shows the eight hospitals comprising the Steward system in FY11 (in red) and their PSAs (in gray), defined using FY10 MHDC discharge data (FY11 MHDC data was not available in time to be included in our analysis). The map also shows the location, but not PSAs, of the two additional acute care hospitals that Steward acquired at the beginning of FY12 (Morton Hospital and Quincy Medical Center, in green). As was the case for the Caritas PSAs, the Steward PSAs for its eight FY11 hospitals represent several local areas, each with their own local and tertiary competitors, dominant health plans, and patient characteristics.

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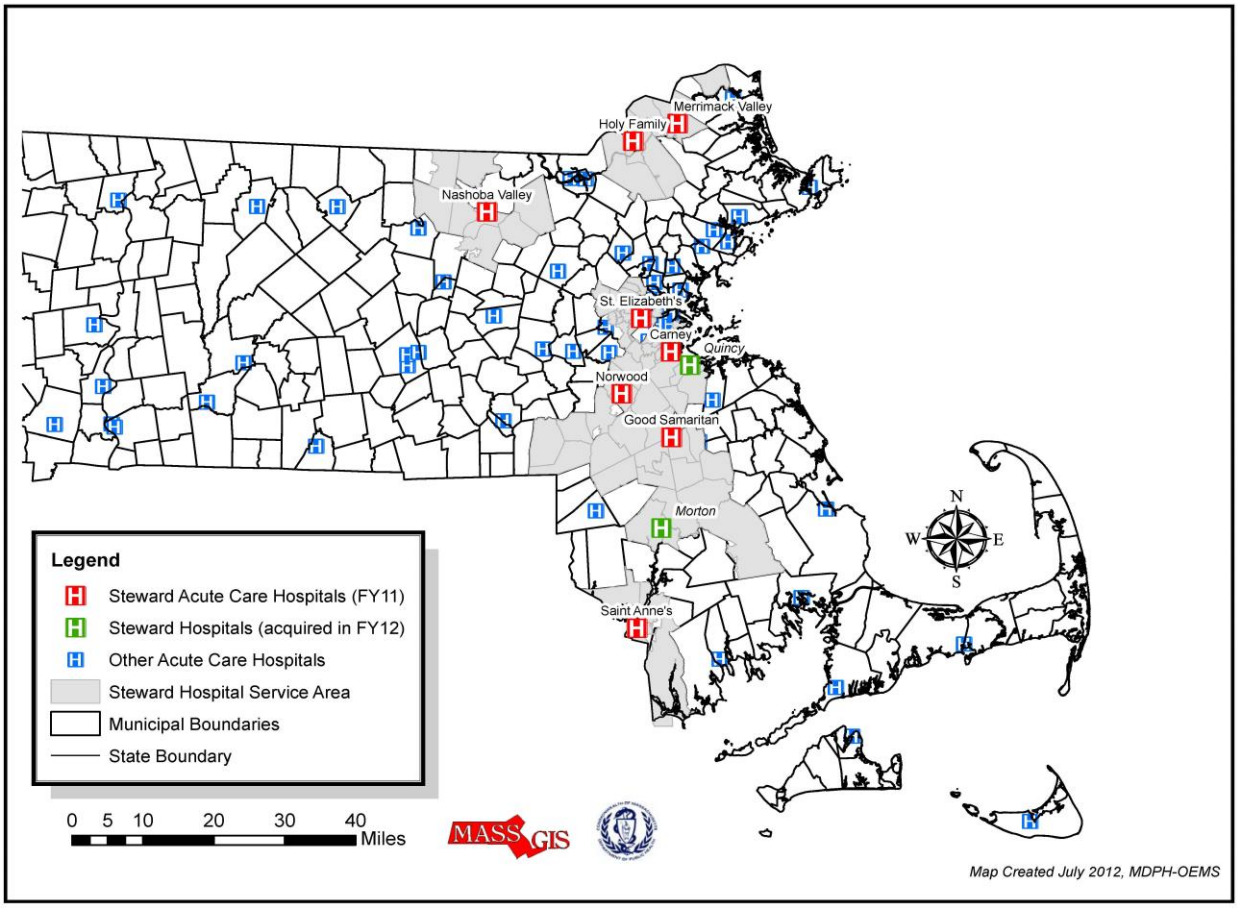
[76] Salary and benefits expenses at the Steward parent also increased in FY11, suggesting possible staff increases. *Compare* CARITAS FY10 AFS, *supra* note 19, at 44, *with* STEWARD FY11 AFS, *supra* note 69, at 40.

[77] STEWARD FY11 AFS, *supra* note 69, at 10.

[78] These commitments relate to capital investment; maintenance of community benefits, services, and salaries and benefits; and commitments not to close facilities for at least three to five years after purchase. *See* Mass. Dep't of Public Health, Minutes of the Public Health Council Meeting of April 13, 2011, at 9–11, 13–15, 18, 21 (Apr. 13, 2011) [hereinafter 4/13/11 PHC Meeting], *available at* http://www.mass.gov/eohhs/docs/dph/public-health-council/2011/20110413-minutes.pdf.

Figure 6 – Primary Service Areas of the Eight FY2011 Steward Hospitals



Next, we present patient utilization and financial performance data for Steward's eight hospital subsidiaries in FY11. These metrics enable us to track the impact of Steward's operations on the level of patient activity and financial condition of its hospitals.

Table 14 – Utilization and Financial Data for Steward Hospitals (FY2011)

	Carney	Good Samaritan	Holy Family	Norwood	St. Anne	St. Elizabeth	MVH	NVMC
IP Discharges[79]	5,835	16,134	11,359	13,173	6,992	13,913	3,697	1,913
Growth Over FY10	*-10.8%*	*3%*	*3.5%*	*-1.9%*	*5.3%*	*-1.5%*	*-4.5%*	*7.1%*
OP Visits	118,107	129,561	125,169	99,311	180,879	187,802	n/a	n/a
Growth Over FY10	*1.2%*	*1.7%*	*3.8%*	*1.0%*	*23.0%*	*9.0%*	*n/a*	*n/a*
OP Surgery Visits	4,978	6,334	9,175	6,807	9,197	9,387	n/a	n/a
Growth Over FY10	*-7.2%*	*-1.8%*	*2.1%*	*-4.0%*	*113.0%*	*7.5%*	*n/a*	*n/a*

[79] *2011 Discharges by Hospital Summary*, MHDC, http://www.mahealthdata.org/Resources/Documents/2012/MHDC_InpatientDischarges2011.pdf (last visited Oct. 19, 2012).

	Carney	Good Samaritan	Holy Family	Norwood	St. Anne	St. Elizabeth	MVH	NVMC
Tot. Op. Rev. ($000)[80]	106,540	179,438	145,755	149,728	157,716	257,841	21,477	16,555
FY10 Tot. Op. Rev.[81]	*123,726*	*196,751*	*147,131*	*163,276*	*146,253*	*416,996*	*n/a*	*n/a*
Op. Income ($000)[82]	-1,281	108	-2,198	-4,277	12,664	-20,930	-1,166	-193
FY10 Op. Income	*3,452*	*10,971*	*3,656*	*2,493*	*10,770*	*21,891*	*-4,073*	*-807*
Operating Margin	-1.2%	0.1%	-1.5%	-2.9%	8.0%	-8.1%	-5.4%	-1.2%
FY10 Op. Margin	*2.8%*	*5.6%*	*2.48%*	*1.53%*	*7.0%*	*5.5%*	*-7.4%*	*-1.8%*
Total Assets ($000)	56,114	79,320	96,171	83,788	90,751	160,854	18,528	16,534
FY10 Total Assets	*44,516*	*99,617*	*110,045*	*108,413*	*147,640*	*254,887*	*n/a*	*n/a*

In FY11, hospital outpatient visits were generally up considerably for the former Caritas hospitals, for an overall increase of 7.5%. Some hospitals saw very little growth (Carney, Good Samaritan, Norwood), while others experienced very high growth (St. Anne's and St. Elizabeth's). Categories of outpatient visits that grew in FY11 (not shown in Table 14) include laboratory (by 26% overall, and particularly at Good Samaritan, St. Anne's, and St. Elizabeth's, where it doubled) and urgent care (by 12%). Moderate growth occurred for high-tech radiology (6% overall, with an increase of 61% at St. Anne's), mental health (6% overall, especially at Norwood and St. Anne's), and cardiac catheterizations (4.5% overall, mostly at St. Anne's and St. Elizabeth's). Volume was flat for other radiology and oncology visits.

In FY11, profits at the former Caritas hospitals declined, with the exception of St. Anne's. The decline at St. Elizabeth's is partially due to Steward shifting the reporting of certain managed care contracts from St. Elizabeth's to the parent corporation. The two newly-acquired former Essent hospitals continued to lose money, but at a slower pace in FY11 than in FY10.

The next table provides updated 2011 payer mix information for the same six hospitals reported in Table 3. There were no significant changes between 2010 and 2011. For example, Medicare continued to be the biggest payer,[83] and FCHP and THP, which began offering a Steward-focused limited network product in 2012, were still relatively small payers in 2011.

[80] STEWARD FY11 AFS, *supra* note 69, at 41–44 (data on FY11 total operating revenue, operating income, operating margin, and total assets).

[81] CARITAS FY10 AFS, *supra* note 19, at 43 (data on FY10 total operating revenue, operating income, operating margin, and total assets for Caritas hospitals); *see also supra* note 29 (FY10 financial data for Essent hospitals).

[82] In calculating operating income for the former Caritas hospitals, the AGO allocated "acquisition expenses" from Steward's FY11 AFS ($25.2 million) to the parent entity, and "reorganization expenses" ($14.3 million) among the system's major affiliates.

[83] In 2012, Steward began participating in the new Medicare Pioneer Accountable Care Organization initiative. Steward's participation in that initiative is not reflected in the 2011 data analyzed in this Report.

Table 15 – Payer Mix for Steward Hospitals (2011)

Carney Hospital	Net Patient Revenue			% Total Net Patient Revenue		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Private (non-Medicare)						
Major commercial plans	$ 5,071,494	$ 8,982,556	$ 14,054,050	9%	23%	15%
Medicaid & CommCare plans	$ 3,452,001	$ 5,529,278	$ 8,981,279	6%	14%	10%
Plans with Steward limited ntwk	$ 3,795,023	$ 3,725,792	$ 7,520,815	7%	10%	8%
Private (Medicare plans)	$ 1,309,749	$ 728,775	$ 2,038,524	2%	2%	2%
Medicare	$ 29,575,399	$ 8,917,209	$ 38,492,608	53%	23%	41%
MassHealth (including MBHP)	$ 7,912,848	$ 3,876,913	$ 11,789,761	14%	10%	12%
Health Safety Net	$ 1,643,076	$ 1,077,426	$ 2,720,502	3%	3%	3%
Self Pay	$ -	$ 106,697	$ 106,697	0%	0%	0%
Subtotal (all above payers)	$ 52,759,590	$ 32,944,646	$ 85,704,236	95%	84%	91%
All Other	$ 2,599,678	$ 6,123,802	$ 8,723,480	5%	16%	9%
TOTAL	$ 55,359,268	$ 39,068,448	$ 94,427,716	100%	100%	100%

Good Samaritan Med Ctr	Net Patient Revenue			% Total Net Patient Revenue		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Private (non-Medicare)						
Major commercial plans	$ 18,993,618	$ 19,145,130	$ 38,138,748	16%	30%	21%
Medicaid & CommCare plans	$ 8,948,545	$ 6,489,222	$ 15,437,767	7%	10%	8%
Plans with Steward limited ntwk	$ 2,902,357	$ 5,932,156	$ 8,834,513	2%	9%	5%
Private (Medicare plans)	$ 10,673,069	$ 3,466,181	$ 14,139,250	9%	5%	8%
Medicare	$ 56,378,335	$ 13,072,051	$ 69,450,386	47%	21%	38%
MassHealth (including MBHP)	$ 9,215,552	$ 4,694,971	$ 13,910,523	8%	7%	8%
Health Safety Net	$ 2,568,525	$ 1,103,522	$ 3,672,047	2%	2%	2%
Self Pay	$ 43,133	$ 54,835	$ 97,968	0%	0%	0%
Subtotal (all above payers)	$ 109,723,134	$ 53,958,068	$ 163,681,202	91%	85%	89%
All Other	$ 10,400,832	$ 9,573,346	$ 19,974,178	9%	15%	11%
TOTAL	$ 120,123,966	$ 63,531,414	$ 183,655,380	100%	100%	100%

Holy Family Hospital	Net Patient Revenue			% Total Net Patient Revenue		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Private (non-Medicare)						
Major commercial plans	$ 13,348,931	$ 20,607,895	$ 33,956,826	16%	30%	22%
Medicaid & CommCare plans	$ 6,142,321	$ 7,313,055	$ 13,455,376	7%	11%	9%
Plans with Steward limited ntwk	$ 2,546,474	$ 8,688,929	$ 11,235,403	3%	13%	7%
Private (Medicare plans)	$ 3,309,065	$ 1,446,043	$ 4,755,108	4%	2%	3%
Medicare	$ 40,423,033	$ 14,691,159	$ 55,114,192	49%	21%	36%
MassHealth (including MBHP)	$ 6,551,167	$ 3,817,035	$ 10,368,202	8%	6%	7%
Health Safety Net	$ 1,752,488	$ 851,945	$ 2,604,433	2%	1%	2%
Self Pay	$ 20,356	$ 108,278	$ 128,634	0%	0%	0%
Subtotal (all above payers)	$ 74,093,835	$ 57,524,339	$ 131,618,174	90%	83%	87%
All Other	$ 8,346,540	$ 11,519,150	$ 19,865,690	10%	17%	13%
TOTAL	$ 82,440,375	$ 69,043,489	$ 151,483,864	100%	100%	100%

Norwood Hospital	Net Patient Revenue			% Total Net Patient Revenue		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Private (non-Medicare)						
Major commercial plans	$ 21,180,741	$ 21,793,413	$ 42,974,154	21%	37%	27%
Medicaid & CommCare plans	$ 3,144,238	$ 3,473,099	$ 6,617,337	3%	6%	4%
Plans with Steward limited ntwk	$ 3,945,604	$ 6,588,088	$ 10,533,692	4%	11%	7%
Private (Medicare plans)	$ 8,246,469	$ 3,286,843	$ 11,533,312	8%	6%	7%
Medicare	$ 50,081,905	$ 10,686,466	$ 60,768,371	51%	18%	38%
MassHealth (including MBHP)	$ 2,975,526	$ 2,422,174	$ 5,397,700	3%	4%	3%
Health Safety Net	$ 1,358,569	$ 618,958	$ 1,977,527	1%	1%	1%
Self Pay	$ 64,208	$ 94,744	$ 158,952	0%	0%	0%
Subtotal (all above payers)	$ 90,997,260	$ 48,963,785	$ 139,961,045	92%	83%	89%
All Other	$ 7,845,712	$ 10,270,169	$ 18,115,881	8%	17%	11%
TOTAL	$ 98,842,972	$ 59,233,954	$ 158,076,926	100%	100%	100%

St. Anne's Hospital	Net Patient Revenue			% Total Net Patient Revenue		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Private (non-Medicare)						
Major commercial plans	$ 6,140,064	$ 25,670,157	$ 31,810,221	11%	24%	19%
Medicaid & CommCare plans	$ 4,310,416	$ 14,526,574	$ 18,836,990	8%	14%	11%
Plans with Steward limited ntwk	$ 866,081	$ 5,237,415	$ 6,103,496	2%	5%	4%
Private (Medicare plans)	$ 4,143,589	$ 5,799,744	$ 9,943,333	7%	5%	6%
Medicare	$ 28,122,454	$ 22,756,474	$ 50,878,928	49%	21%	31%
MassHealth (including MBHP)	$ 3,452,892	$ 5,729,266	$ 9,182,158	6%	5%	6%
Health Safety Net	$ 853,050	$ 1,154,114	$ 2,007,164	1%	1%	1%
Self Pay	$ 4,087	$ 80,668	$ 84,755	0%	0%	0%
Subtotal (all above payers)	$ 47,892,633	$ 80,954,412	$ 128,847,045	83%	76%	79%
All Other	$ 9,530,069	$ 25,486,567	$ 35,016,636	17%	24%	21%
TOTAL	$ 57,422,702	$ 106,440,979	$ 163,863,681	100%	100%	100%

St. Elizabeth's Hospital	Net Patient Revenue			% Total Net Patient Revenue		
	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
Private (non-Medicare)						
Major commercial plans	$ 35,291,151	$ 30,246,475	$ 65,537,626	21%	31%	25%
Medicaid & CommCare plans	$ 10,228,735	$ 7,444,294	$ 17,673,029	6%	8%	7%
Plans with Steward limited ntwk	$ 10,115,489	$ 13,150,284	$ 23,265,773	6%	14%	9%
Private (Medicare plans)	$ 6,480,537	$ 2,472,618	$ 8,953,155	4%	3%	3%
Medicare	$ 70,908,351	$ 19,976,205	$ 90,884,556	43%	21%	35%
MassHealth (including MBHP)	$ 10,951,531	$ 5,425,000	$ 16,376,531	7%	6%	6%
Health Safety Net	$ 3,615,213	$ 1,405,708	$ 5,020,921	2%	1%	2%
Self Pay	$ 206,442	$ 160,797	$ 367,239	0%	0%	0%
Subtotal (all above payers)	$ 147,797,449	$ 80,281,381	$ 228,078,830	89%	83%	87%
All Other	$ 18,062,155	$ 15,991,127	$ 34,053,282	11%	17%	13%
TOTAL	$ 165,859,604	$ 96,272,508	$ 262,132,112	100%	100%	100%

2. Physicians

In 2011, the active medical staff for the six former Caritas hospitals grew from about 1,652 to 2,135. The biggest increases were at Good Samaritan (from 312 to 386 medical staff), Norwood (from 214 to 354), and St. Anne's (from 154 to 325). At the two former Essent hospitals, medical staff increased by a total of 19.

Steward's contracting network grew from roughly 1,600 physicians in FY10 to about 1,840 physicians in FY11. Among these network physicians, employed physicians grew from about 445 to 510, and non-employed physicians grew from about 1,170 to 1,330. The physician groups that joined Steward's network in FY11 were: in January 2011, Cape Cod IPA, a group of about 297 physicians; in May 2011, the physicians affiliated with the former Essent hospitals (nine physicians with Merrimack Valley Hospital Physicians and 65 physicians with Nashoba IPA); in June 2011, a 23-physician anesthesia group (Guardian Anesthesia) and a 17-physician radiology group (LMRAD Co.); and in July 2011, a 12-physician primary care practice, Associates in Internal Medicine.[84]

Financial results for the employed physicians (Steward Medical Group or "SMG") improved from a $9.6 million loss in FY10 (and annual losses of roughly $20 million in FY08 and FY09) to an operating profit of $3.2 million in FY11, although total revenue did not grow. In FY11, revenue from patients was down about 2%, and "other revenue" (largely subsidies from the hospitals) was up about 3%. The number of patient claims that SMG billed grew by about 17%. Table 16 below summarizes the FY11 performance of SMG as well as the growth in Steward's network physicians.

Table 16 – Utilization and Financial Data for Steward Physicians (FY2011)

Active Medical Staff	2,325
Network Physicians, Non-Employed	1,327
Network Physicians, Employed	510 (357 FTEs)
Claims for SMG, Patients Over Age 18[85]	732,442
Growth Over FY10 Claims	*16.9%*

[84] Note that while more than 400 physicians joined Steward's contracting network in FY11, the net growth of the network was less than 400 due to physicians leaving the network. In addition, changes in reporting software between Caritas and Steward account for some further variances between the figures reported by Caritas in FY10 and those reported by Steward in FY11. For example, Caritas's FY10 figures include physicians who left the network during FY10 (thus, the FY10 figures tend to overstate the number of network physicians), while Steward's FY11 figures take into account physicians who left the network during FY11.

[85] This figure does not include claims for specialties for which billing was outsourced (behavioral health, emergency medicine, pathology, and radiology).

Total Revenue (SMG)[86] ($000)	$190,188
FY10 Total Revenue (CPI)[87] ($000)	*$190,701*
Operating Income (SMG) ($000)	$3,209
FY10 Operating Income (CPI) ($000)	*-$9,632*
Total Assets (SMG) ($000)	$67,811
FY10 Total Assets (CPI) ($000)	*$31,705*

3. Other Providers

In FY11, Steward Home Care, like Caritas Home Care, continued to be the system's largest non-physician affiliate (as measured by revenue). Table 17 below summarizes patient utilization and financial statistics for Steward Home Care in FY11, including changes from FY10. Monitoring home health volume provides information on whether Steward is retaining more post-acute business within its system, and can inform analysis of whether Steward is achieving greater care coordination across a continuum of services. Changes in volume may also signal a need to monitor referral, discharge, and other business practices that are associated with observed changes in home health volume. As shown below, total volume for Steward Home Care, as measured in visits, increased 9% in FY11, while net patient revenue remained flat. Service mix (not shown below) changed very little, with a slight decrease in the proportion of home health aide visits, and a slight increase in the proportion of rehabilitation visits (physical, occupational, and speech therapy), from 28% of all visits in FY10 to 29.6% of all visits in FY11.

Table 17 – Utilization and Financial Data for Steward Home Care (FY2011)

	FY2011	FY2010
NPSR Net of Bad Debt ($000)[88]	$23,226	$23,311
Operating Income ($000)	-$1,430	$52
Visits by Service Type for Patients Over Age 18	FY2011	Growth in Visits Over FY2010
Nursing	79,204	9%
Physical Therapy	32,033	16.5%
Occupational Therapy	8,496	10.8%
Speech Therapy	401	19.7%
Social Work	2,344	10%
Home Health Aide	15,588	-4.6%
Total	138,066	9%

[86] STEWARD FY11 AFS, *supra* note 69, at 39–40 (FY11 data on total revenue, operating income, and total assets).
[87] CARITAS FY10 AFS, *supra* note 19, at 43 (FY10 data on total revenue, operating income, and total assets).
[88] STEWARD FY11 AFS, *supra* note 69, at 46 (FY11 data on NPSR and operating income); CARITAS FY10 AFS, *supra* note 19, at 44 (FY10 data on NPSR and operating income).

C. Market Position

1. Inpatient Market Share and Service Mix

FY11 MHDC patient discharge data was not available at the time of preparation of this Report, so our office is still updating the FY10 inpatient market share and service mix analysis we presented in Part III.C.1 above. Comparing Steward's inpatient market share in FY11 and future years to that of Caritas in FY10 will provide an indication of the effect of Steward's operations (e.g., growth of its physician network, developments in its care management and referral practices, introduction of Steward-focused limited network products) on Steward's market position relative to its competitors in the communities it serves.

To deepen our understanding of the markets in which Steward operates, and as context for our ongoing analysis of Steward's impact, we include below the financial condition of major community hospital competitors[89] to Steward. Table 18 below summarizes FY11 financial metrics for these competitor hospitals, and their trend in profitability from FY10. The metrics reflect the health care system to which each hospital belongs, and in each case the hospital accounts for the bulk of the assets and revenues of its system.[90]

Table 18 – Financial Condition of Community Hospital Competitors to Steward (FY2011)[91]

	Anna Jaques (Seacoast)	Brockton (Signature)	Lawrence General	Charlton (Southcoast)	South Shore
NPSR ($000s)	$113,560	$247,851	$176,321	$717,521	$419,659
Op. Income ($000s)	-$147	$7,515	$4,262	$7,513	$9,906
Total Income ($000s)	-$2,452	$8,431	$3,829	$32,200	$10,153

[89] We identified these competitors based on their significant share of discharges for the hospital PSAs shown in Table 6 in Part III.C.1 above. For information on the FY11 performance of other Massachusetts hospitals, see DIV. OF HEALTH CARE FIN. & POLICY, MASS. EXEC. OFF. OF HEALTH & HUMAN SERVS., MASSACHUSETTS ACUTE HOSPITAL FINANCIAL PERFORMANCE, at 11 (2012), *available at* http://www.mass.gov/chia/docs/r/qtr/fy11-annual/hosp-fy11-annual.pdf and Attachment 1 to this Report. This annual DHCFP report shows hospital financial results grouped by health system. Results for Steward's ten acute hospitals are shown together with results for Partners (seven acute hospitals), Care Group (five), UMass Memorial (five), Baystate (three), Berkshire (two), Cape Cod (two), and Vanguard (two). Note that FY11 results for Steward include two hospitals not yet owned by Steward in FY11 (Morton and Quincy), and two others that Steward owned for less than half of FY11 (Merrimack and Nashoba).

[90] Anna Jaques, Brockton, and South Shore are the principal subsidiaries in systems headed by a parent corporation and including one or more affiliates. Lawrence General is itself the controlling member of several affiliates that, together with the hospital, constitute one health care system. Charlton and St Luke's are controlled within a system headed by Southcoast Health System, Inc.

[91] Data is from the FY11 audited financial statements for the parent organization for each hospital, available at http://www.charities.ago.state.ma.us/charities/index.asp. *See* ERNST & YOUNG LLP, CONSOLIDATED FINANCIAL STATEMENTS & SUPPLEMENTAL INFORMATION: SEACOAST REGIONAL HEALTH SYSTEMS, INC. (2012); PRICEWATERHOUSECOOPERS LLP, SIGNATURE HEALTHCARE CORPORATION CONSOLIDATED FINANCIAL STATEMENTS WITH SUPPLEMENTARY CONSOLIDATING INFORMATION (2012); FEELY & DRISCOLL, P.C., LAWRENCE GENERAL HOSPITAL CONSOLIDATED FINANCIAL STATEMENTS 3 (2012); DELOITTE & TOUCHE LLP, SOUTHCOAST HEALTH SYSTEM, INC.: CONSOLIDATED FINANCIAL STATEMENTS 3 (2012); DELOITTE & TOUCHE LLP, SOUTH SHORE HEALTH & EDUCATIONAL CORPORATION: COMBINED FINANCIAL STATEMENTS 3 (2012).

	Anna Jaques (Seacoast)	Brockton (Signature)	Lawrence General	Charlton (Southcoast)	South Shore
Operating Margin	-0.1%	2.9%	2.3%	1.0%	2.2%
Total Margin	-2.1%	3.2%	2.1%	4.2%	2.5%
Current Ratio	2.3X	0.4X	2.6X	1.7X	1.5X
Days Cash on Hand	37	6.6	61	74	48
Equity Ratio	28%	-2.2%	66%	55%	30%
Debt Service Cover. Ratio	1.5X	0.3X	4.3X	4.5X	1.5X
FY11 v. FY10 Profit Trend	Down	Down	Up	Up	Stable
Steward Competitor	Merrimack	GSMC	Holy Family	St. Anne's	Carney

The community hospital competitors present a range of financial profiles. For example, four of the five reported positive operating and total income in both FY11 and FY10 (FY10 not shown). One had low net worth, liquidity, and debt service coverage notwithstanding positive profitability in both FY10 and FY11. In general, in comparing Table 18 with Table 22 further below, which presents FY11 financial metrics for Steward, a number of the competitors compare favorably with Steward on many of the selected ratios.

2. Physician Referral Patterns

Referral pattern data for one major insurer indicates that patients with Steward PCPs were more likely to receive their hospital care in-system in 2011 compared to 2010, especially their outpatient care. This data is consistent with the general increase in outpatient volume at Steward hospitals in 2011, shown in Table 14 above. The referral pattern data also shows changes in the proportion of care that patients with Steward PCPs received at tertiary hospitals and at other community hospitals.

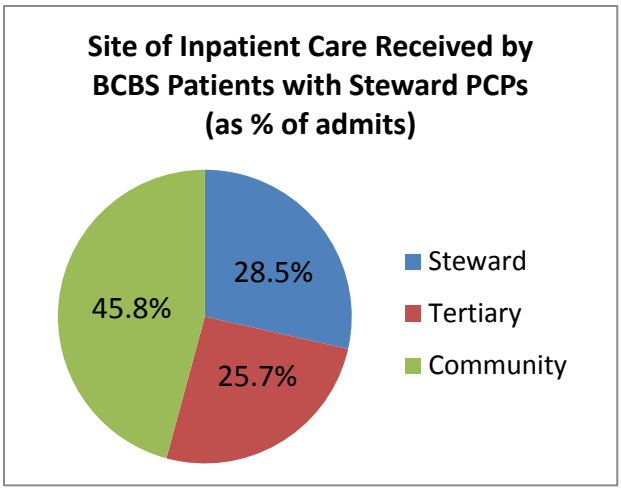
Table 19 - Site of Hospital Services Received by BCBS Patients with Steward PCPs (CY2011)

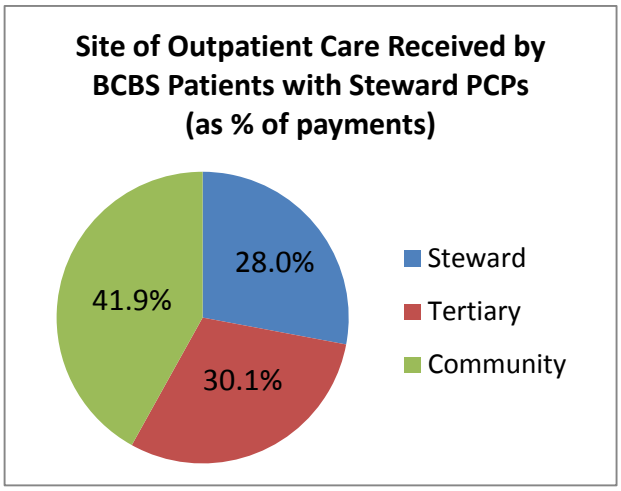
	Inpatient Care				Outpatient Care[92]	
Hospital Category	**% of Total Admissions**	**Change from 2010 Share**	**% of Total Claims Payments**	**Change from 2010 Share**	**% of Total Claims Payments**	**Change from 2010 Share**
Steward[93]	28.5%	+1.9%	23.0%	-0.6%	28.0%	+2.6%
Tertiary[94]	25.7%	+1.1%	42.6%	+0.8%	30.1%	+0.9%
Community	45.8%	-3.0%	34.4%	-0.2%	41.9%	-3.4%

[92] Data for outpatient visits is unavailable.

[93] *See supra* note 54. We report on the same six former Caritas hospitals shown in Table 8 in Part III.C.2 above, to consistently track their share of hospital services over time.

[94] *See supra* note 55.





Inpatient data by service line for 2011 (not shown in the table and charts above) indicates that, in general, Steward continued to retain more medical/surgical inpatient care than maternity care. For outpatient care, Steward also continued to retain more medical/surgical and radiology care than laboratory care. From 2010 to 2011, the service line for which Steward experienced the single highest increase in retention, as measured by payments, was radiology (increasing from a retention rate of 25.4% to 33.6%).

Our process of obtaining and analyzing 2011 referral pattern data for the other two major insurers is not yet complete. Nor do we yet have data to monitor referral patterns by the individual physician groups that comprise the Steward network. This will provide insight into the physician referral patterns and trends in the local markets that Steward serves. For example, the proportion of hospital and specialist care that patients with Steward PCPs receive outside of Steward is likely to differ depending on the local market (e.g., patients with PCPs affiliated with Carney may be going outside of Steward more often than patients with PCPs affiliated with St. Anne's). For future years of monitoring, we will continue to seek data that will enable us to monitor referral patterns by local physician group.

3. Prices and Total Medical Expenses

We will continue to monitor prices and TME to understand how Steward's prices and TME trend over time, how Steward's prices and TME compare to those of its competitors, and how any changes in Steward's market share impact overall health care costs. Our process of obtaining and analyzing insurer data on 2011 prices is not yet complete. Table 20 below presents TME trends from 2009 to 2011 – first Caritas's trend from 2009 to 2010, and then Steward's trend from 2010 to 2011. The system's TME trends were often, but not always, in line with network trends. For example, the system's TME trends for THP were generally in line with THP's overall network trends from 2009 to 2011. By contrast, for BCBS, Caritas's TME increased more than three percentage points faster than the network from 2009 to 2010.

Table 20 – Steward TME Trend Compared to Insurer Network Average TME Trend[95]

	Risk Adjusted Trend in TME from 2009 to 2010		Risk Adjusted Trend in TME from 2010 to 2011	
	Caritas	Network	Steward	Network
BCBS	6.0%	2.9%	n/a	n/a
HPHC	-2.8%	-0.6%	-1.6%	-1.7%
THP	0.9%	1.3%	1.2%	0.9%

Table 21 below shows, on a health status adjusted basis, Steward's average per member, per month TME compared to its competitors for the three major insurers. In many cases, Steward's 2011 TME was lower than its competitors, and in other cases, it was higher.

Table 21 – Health Status Adjusted TME by Commercial Insurer (CY2011)[96]

Provider	BCBS	HPHC	THP
Steward	***$426.47***	***$377.47***	***$345.05***
Atrius Health	$492.75	$376.87	$347.90
Beth Israel Deaconess PO[97]	$403.49	$379.48	$350.60
Boston Medical Center Management Service	n/a	$330.76	$318.17
Lawrence General IPA[98]	n/a	$284.43	$282.63
Lowell General PHO	$425.91	$347.95	$323.90
Mount Auburn Cambridge IPA	$503.80	$361.44	$345.71
New England Quality Care Alliance[99]	$432.34	$362.95	$346.67
Partners Community Healthcare, Inc.	$451.25	$403.38	$400.42
Signature Medical Group[100]	$438.50	$331.80	$338.40
South Shore PHO	$450.22	$382.01	$378.18

[95] Trend shown reflects the TME of a consistent set of physician groups within Caritas and Steward over time. E.g., while Cape Cod IPA joined Steward in 2011, the TME for Cape Cod IPA is not included in Steward's TME trend from 2010 to 2011, to measure trend for a consistent set of physician groups.

[96] The purpose of this table is to show differences in TME across provider groups in 2011, not necessarily to track a given provider's TME over time (for example, by comparing a provider's TME in this table with its 2009 TME shown in Table 11 above). One consideration in tracking a provider's TME over time is whether the composition of that provider has changed, since physicians joining or leaving a group can impact that group's TME. Because the purpose of this table is not necessarily to track a provider's TME over time, we show TME for each provider that reflects the provider's composition in 2011.

[97] Most of the physicians comprising Lawrence General IPA joined Beth Israel Deaconess PO ("BIDPO") in January 2011, so their 2011 TME is included in BIDPO's TME figures in this table. Broken out, the TME of these physicians in 2011 was $341.18 (THP) (comparable data for BCBS and HPHC was not available).

[98] This row shows the TME of the Lawrence General IPA physicians who did not join BIDPO in 2011. To provide a sense of how many physicians joined BIDPO, note that the number of members attributed to Lawrence General IPA decreased significantly from 2010 to 2011 (HPHC member months decreased from 30,629 to 10,720; THP member months decreased from 41,539 to 13,600; BCBS member months were unavailable).

[99] Southcoast joined NEQCA in January 2011, so its TME is included in NEQCA's TME figures in this table. Broken out, Southcoast's TME in 2011 was $454.87 (BCBS), $385.46 (HPHC), and $368.82 (THP).

[100] In January 2010, Brockton PHO joined Signature Medical Group. Signature includes physician groups besides Brockton PHO, so the patient population for Signature shown in this table is different than the population for Brockton PHO in 2009, shown in Table 11 above.

4. New Insurance Products

In FY11, Steward began to develop partnerships with insurers to create lower-priced, Steward-focused insurance products. As the patient discharge and referral pattern analyses in Tables 6 and 8 indicate, well more than 20% (and often a significantly higher proportion) of patients in local communities travel to tertiary (and generally more expensive) hospitals for their care, particularly for obstetrics and surgical care. If enough local patients can be redirected to Steward facilities, and if those Steward facilities are sufficiently less expensive than those other sites of care, then a Steward-focused insurance product holds the promise of lowering costs, and therefore premiums. Thus, in the last 18 months, as one prong in its strategy to "keep care local," Steward has entered into agreements with two health insurers, FCHP and THP, to be the provider network for new limited network products offered by each insurer.[101] We provide a brief overview of each new partnership below to provide a baseline for future years of monitoring, which will examine, among other questions, whether these new products affect volume at Steward's facilities, whether they impact medical spending, and whether their costs support insurers' initial assumptions in pricing these products.

THP Steward Community Choice[102]

The THP Steward Community Choice product, offered since January 1, 2012, is being sold to small and large employer groups in eastern Massachusetts, southern New Hampshire, and parts of Rhode Island. Members enrolled in this product must obtain their care primarily from Steward providers, with the exception of select services that are not available or "cannot be handled"[103] within the Steward system. Care that is not available in the Steward network, including select highly specialized services like transplants, are available from Brigham and Women's Hospital and Massachusetts General Hospital ("MGH"), subject to an authorization process. Pediatric care is provided both by Steward and certain Partners-affiliated pediatricians, and tertiary pediatric care is provided at MGH.

[101] In accordance with Massachusetts law, contracting providers have the right to opt out of any product that uses a limited or tiered network. *See* MASS. GEN. LAWS ch. 176O, § 9A (2010); *see also* 211 MASS. CODE REGS. § 152.04(1)(a) (2012).

[102] Summary based on review of documents for Steward Community Choice. *See Enrollment Materials*, TUFTS HEALTH PLAN, http://www.tuftshealthplan.com/pdf/Steward_Community_Choice_Member_Kit.pdf (last visited June 6, 2012); *Steward Cmty. Choice*, TUFTS HEALTH PLAN, http://www.tuftshealthplan.com/pdf/Steward_CC_ER.pdf (last visited June 6, 2012); *Steward Cmty. Choice Copay*, TUFTS HEALTH PLAN, http://www.tuftshealthplan.com/pdf/Steward_CC_bensum_copay_SG_PlanYear.pdf (last visited June 6, 2012); *Steward Cmty. Choice Deductible 1000*, TUFTS HEALTH PLAN, http://www.tuftshealthplan.com/pdf/Steward_CC_bensum_ded_SG_PlanYear.pdf (last visited June 6, 2012); *Steward Cmty. Choice Plans for Mass. Employers*, TUFTS HEALTH PLAN, http://www.tuftshealthplan.com/employers/employers.php?sec=products&content=steward_community_choice_plans (last visited June 6, 2012).

[103] Tufts Health Plan, Small Group Rate Filing for Rates Effective January–March 2012, at Attachment 11 (Sept. 30, 2011) [hereinafter THP Jan-Mar 2012 Filing] (on file with the MA DOI).

This product is being offered with two benefit designs, Steward Community Choice Copay (no deductible) and Steward Community Choice Deductible ($1,000 individual/$2,000 family deductible). Both products also have a specially designed prescription drug benefit that requires maintenance drugs to be obtained from THP's mail order pharmacy vendor, and imposes a higher copayment for select high cost generic drugs than for other generics. THP's rate filings for this product with the Division of Insurance show premiums that are on average 16.3% lower than rates for THP's full network products with comparable benefits.[104] According to the filings, the premium reduction is based on "favorable contract rates relative to Tufts Health Plan's full network products" and the "concentration of care among lower cost providers."[105]

Steward providers also participate in THP's Select Network product, another limited network plan, and in THP's tiered network products. In these latter products, providers are grouped into tiers based on THP's analysis of cost and quality information, and consumers have financial incentives, in the form of lower cost-sharing, to receive care from providers that are in more cost-effective tiers.[106]

In the THP tiered network product offered by the Group Insurance Commission, Tufts Health Plan Spirit, hospitals are grouped into two tiers for inpatient care based on quality and cost efficiency ratings. Tier 1 denotes an "Excellent" quality and cost efficiency rating, while Tier 2 means "Good" quality and cost efficiency. Steward hospitals are in different categories, depending on type of service. For obstetrical care, of the eight hospitals comprising the Steward system in FY11, three were in the more cost effective Tier 1 (Good Samaritan, Holy Family, and Norwood), while the others were in Tier 2. For adult medical surgical inpatient care, four of the eight hospitals were in Tier 1 (Carney, Holy Family, Norwood, and St. Anne's). For pediatric inpatient care, only one hospital (St. Anne's) was in Tier 1. None of the eight hospitals was in Tier 1 for all three services, while Merrimack and Nashoba were consistently in Tier 2.[107]

FCHP Steward Community Care

Fallon's Steward Community Care product, available as of April 1, 2012, is being marketed to small and large employer groups in eastern Massachusetts, within Steward's service area. Members enrolled in this product have access to most types of care only from the providers in the Steward Community Care Network. Specialty care not available at Steward

[104] Tufts Health Plan, Large Group Rate Filing for Rates Effective January–June 2012, Attachment 3, at 5 (Sept. 30, 2011) (on file with the MA DOI).
[105] THP Jan-Mar 2012 Filing, *supra* note 103. Other factors may also affect pricing of such products, such as whether limited network products attract healthier members who get less care, thereby altering the risk pool for other products.
[106] *See Select Network Plans (Limited Provider Network)*, TUFTS HEALTH PLAN, http://www.tuftshealthplan.com/employers/employers.php?sec=products&content=select_network_plans (last visited June 6, 2012).
[107] Tufts Associated Health Maint. Org., Inc., Amendment to Steward Community Choice HMO Limited Network Filing, SERF Tracking Number THPC-127634484 (Oct. 14, 2011) (on file with the MA DOI).

hospitals is available to members at Massachusetts General Hospital and Brigham and Women's Hospital. The product is available with any FCHP benefit design (i.e., different copayments and deductibles). At most employers, FCHP's limited network products, including Steward Community Care, are offered as part of "triple option" or "quadruple option" arrangements, in which employees have a choice among a broad network HMO product, a PPO product, and one or two limited network products. In general, the premium contribution structure is designed by the employer to give a financial incentive for employees to select the lowest premium product, which is typically the product with the most limited provider network.

Based on FCHP's filings with the DOI,[108] the average premium for the Steward Community Care product is 20% lower than rates for comparable benefit designs with FCHP's broad Select Care network, an HMO product that covers all of Massachusetts and southern New Hampshire. Steward Community Care is 8% less expensive than comparable benefit designs with FCHP Direct Care, a limited network product reflecting a network that is smaller than Select Care. According to the rate filings, the 20% premium reduction for Steward Community Care is based on an expectation of lower utilization, and unit prices that reflect "improvements anticipated due to the contracting arrangements and collaborative efforts with FCHP's Care Management Team."[109] The Steward relationship is a new one for FCHP; Steward hospitals have not previously contracted with FCHP, and have not been part of the Direct Care Network. As part of this relationship, Steward is assuming significant financial risk for the cost and quality of care delivered through Steward Community Care, with the risk assumed by Steward increasing over time.

Retailers Association Group Purchasing Plan[110]

The Retailers Association of Massachusetts ("RAM") Health Insurance Cooperative was one of the first groups to offer FCHP Steward Community Care. The RAM Cooperative, certified by the DOI in January 2012 as one of the first small business group purchasing cooperatives pursuant to Chapter 288 of the 2010 Acts,[111] began offering health coverage as of April 1, 2012. The RAM Cooperative benefits plan is being offered to eligible small employer members of RAM

[108] Fallon Cmty. Health Plan, HMO Merged Market Rate Filings, SERF Tracking Number FCHC-127943901 (Dec. 30, 2011) (on file with the MA DOI).
[109] *Id*.
[110] Summary based on review of Retailers Association of Massachusetts's Group Purchasing Cooperative Application and related materials. *See* Letter from Health Care Access Bureau, Mass. Div. of Ins., Retailers Ass'n of America & Retailers Ass'n of Mass. (Jan. 3, 2012) (on file with the MA DOI); Letter from Health Care Access Bureau, Mass. Div. of Ins., to Retailers Ass'n of America & Retailers Ass'n of Mass. (Dec. 15, 2011) (on file with the MA DOI); Letter from Health Care Access Bureau, Mass. Div. of Ins., to Retailers Ass'n of America (Sept. 30, 2011) (on file with the MA DOI); Retailers Ass'n of Mass., Amendment to Group Purchasing Cooperative Application Supplement (Dec. 21, 2011) [hereinafter RAM Application Amendment] (on file with the MA DOI); Retailers Ass'n of Mass., Group Purchasing Cooperative Application (Aug. 15, 2011) (on file with MA DOI).
[111] MASS. GEN. LAWS ch. 176J, § 12(a) (2010); *see* 211 MASS. CODE REGS. § 151.07 (2012).

and the Massachusetts Package Store Association. In its application to the DOI, the Cooperative estimated it would have 15,000 members covered under the plan by July 2012.[112]

The Steward Community Care product is one of several product options available to RAM Cooperative members: three of the options are based on the Steward network, while the other three offer broader provider networks. Small employers that are members of the RAM Cooperative can choose to offer any or all of the six products.

According to DOI filings, premiums for the RAM product are 3% lower than the rates for the Steward Community Care product.[113] The basis for the lower rates is the wellness program that is part of the RAM product. According to the filing, the "RAM cooperative adjustment of 0.9700 is based on assumed savings from additional wellness activities and programs that RAM is offering to groups enrolling in their cooperative. The adjustment is based on research regarding various Workplace Wellness programs that have been shown in studies to achieve a 3.25:1 return on investment."[114]

As more data becomes available on the take-up and financial performance of these Steward-focused limited network products, we will incorporate such data into our impact monitoring review. With such data, we can begin to analyze how this prong of Steward's business strategy interplays with other elements of its operations, including the impact of these products on Steward's financial and competitive performance.

D. System Financial Performance

This section examines the financial performance of the Steward system as a whole in its first year of operations. We present updated FY11 metrics for the same three areas of performance examined for Caritas in Part III.D: (1) operating performance; (2) sources and uses of cash; and (3) special non-operating areas affecting financial performance. For FY11, the special non-operating areas include, in addition to pension expenses and liabilities, extraordinary expenses associated with Steward's acquisition of Caritas and other providers. In comparing Steward's FY11 performance to Caritas's baseline results, our review reinforces previous findings that Steward acquired a system in deteriorating financial condition. From the outset of the Caritas transaction, Steward has stated that implementation of its business model is a multiyear process requiring significant investments in its care delivery system. One year of

[112] RAM Application Amendment, *supra* note 110.

[113] Fallon Cmty. Health Plan, Group Purchasing Coop. Rate Adjustment Factor Filing for Retailers Assoc. of Mass., SERF Tracking Number FCHC-128336948 (May 11, 2012) (on file with the MA DOI).

[114] *Id.* The RAM premium was calculated by applying a 3.25% reduction to the projected medical expenses for RAM Cooperative members. However, a 3.25:1 return on investment ("ROI") is not equivalent to a 3.25% reduction in medical expenses. While there is literature that supports the 3.25:1 ROI cited in the rate filing, this literature does not provide a basis for assuming a 3.25% reduction in total medical costs. *See, e.g.*, Steven Aldana, *Financial Impact of Health Promotion Programs: A Comprehensive Review of the Literature,* 15 AM. J. HEALTH PROMOTION 296, 316 (2001).

mature performance information does not provide a reasonable basis to predict or draw conclusions about Steward's ongoing performance or future success in meeting its business objectives. By adding more years of data in future reports, the AGO will be able to analyze performance trends more effectively than is possible with one post-transaction data point.

1. Operating Performance

Table 22 summarizes standard metrics of Steward's profitability, liquidity, solvency, and age of plant in FY11. For comparison purposes, we present Caritas's performance in FY10.

Table 22 – Steward Financial Condition (FY2011)

	Steward FY11 Unaudited Financials 10/1/10 - 9/30/11[115]	Steward FY11 Audited Financials 11/6/10 - 9/30/11[116]	Caritas FY10 Audited Financials 10/1/09 - 9/30/10[117]
Surplus (Deficit)	($68.2 million)	($56.9 million)	$24.7 million
Total Margin	-4.7%	-4.3%	1.8%
Operating Margin[118]	-1.8%	-1.1%	1.1%
Current Ratio	0.85	0.85	0.86
Days Cash on Hand[119]	9.0	9.1	61
Equity Financing	0.14	0.14	0.29
Debt Service Coverage	1.37X	4.07X	2.19X
Average Age of Plant	12.67	13.75	14.1

At the end of its first fiscal year of operations, Steward reported an operating loss of $14.6 million, a total deficit after extraordinary expenses of $56.9 million, and a current ratio below 1.0. The decline in operating profitability from Caritas in FY10 to Steward in FY11 is most clearly reflected in Steward's FY11 unaudited financial statements (which cover a pro forma 12 month period, whereas the audited financials cover the 11 month period under Steward ownership). These statements show that, while 12 month operating revenue increased over FY10 by $108 million (8%), operating expenses (excluding those categorized in this Report as "extraordinary") increased by $149 million (11%), driving an operating loss of $26 million

[115] *See* Steward Health Care Sys. LLC, Mass. Hosp. Industry Annual Reporting to Att'y Gen. for Annual Period Ended Sept. 30, 2011, at 01435-40 (Feb. 1, 2012) [hereinafter Steward FY11 Unaudited Financials].
[116] STEWARD FY11 AFS, *supra* note 69, at 39–42.
[117] CARITAS FY10 AFS, *supra* note 19, at 41–48.
[118] As further discussed in Part IV.D.3 below, we adjusted Steward's operating margin to exclude reorganization and acquisition-related expenses that totaled $39.5 million in FY11. *See* STEWARD FY11 AFS, *supra* note 69, at 40.
[119] Based on cash plus unrestricted investments (board designated/undesignated assets). Note that it is common for investor-owned systems to minimize the amount of cash on their balance sheets. Unlike nonprofit health systems, which face pressures from tax-exempt bond rating agencies to maintain high cash balances, in the for-profit world, high cash balances are considered an inefficient use of investors' cash.

(compared to a $14.6 million operating profit reported by Caritas in FY10).[120] Operating profitability declined from FY10 levels at each principal operating subsidiary of the system, with the exception of St. Anne's and the employed physician subsidiaries. The largest decline was at St. Elizabeth's, although some of this decline was due to Steward shifting the reporting of a major managed care contract from St. Elizabeth's financials to the parent's financial statement.

Regarding changes in reporting practices, it is important to note that part of the difference in financial ratios between FY10 and FY11 is due to changes in accounting policies and assumptions between Caritas and Steward. For example, Caritas reduced its reported operating expenses by roughly $12 million in FY10 by scaling back contributions to its defined benefit pension plans. Similarly, different reporting requirements apply to Caritas versus Steward regarding recognizing unfunded liabilities for the Caritas Christi Retirement Plan. Additionally, Caritas reduced its net reserves for third party settlements by $18.2 million in FY10 (which improves revenue), while Steward reduced these reserves by only $6.3 million. If Caritas's financial ratios were adjusted for these differences in reporting policy, its FY10 performance would have been closer to the FY11 Steward profile.

Like operating profitability, total profitability declined for Steward in FY11. Primarily because of "reorganization" and "acquisition-related" expenses totaling $39.5 million, which we categorize in this Report as extraordinary non-operating expenses, total profit declined more than operating profit.

During FY11, Steward borrowed $96.3 million under a revolving bank line of credit for "large-scale capital improvements at certain hospitals, acquisitions of new hospitals, and for general working capital needs."[121] A combination of net losses and increased debt (described in further detail in the next subsection) resulted in a highly leveraged capital structure at FYE11, as reflected in Steward's equity ratio of 14%.[122]

2. Sources and Uses of Cash

Our analysis of cash flow during FY11 indicates that Steward spent heavily on capital investments and on hospital and physician practice acquisitions, including legal and accounting expenses in connection with the formation of the Steward system and the acquisition of Caritas Christi and other providers. To support this spending, the system supplemented the initial Cerberus Capital equity investment of $246 million with a revolving bank line of credit.

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[120] *Compare* Steward FY11 Unaudited Financials, *supra* note 115, at 01435, *with* CARITAS FY10 AFS, *supra* note 19, at 43.

[121] STEWARD FY11 AFS, *supra* note 69, at 20.

[122] The Caritas system reported an equity ratio of 29% in FY10. Note, however, that Steward had to recognize liability for the underfunded portion of all three Caritas pension plans, while Caritas recognized the liability for only the Good Samaritan and Norwood plans. *See id.* at 2. If Caritas had recognized the equivalent liability for all the pension plans, its 2010 equity ratio on a pro forma basis would have been approximately 7%.

In June 2011, Steward arranged a five-year secured revolving line of credit of $150 million with three banks. The system pledged substantially all its assets as collateral for this credit facility. The immediate parent of Steward Health Care System (the "Holdings" company) guaranteed the obligations of all co-borrowers. This credit line requires interest-only payments for five years, with the outstanding balance payable at maturity in June 2016. As of FYE11, borrowings had reached $96.3 million.[123]

The cash flow statement included in Steward's FY11 AFS is summarized in Table 23.

Table 23 – Steward Sources and Uses of Cash (FY2011)[124]

Sources of Cash	
Cerberus equity investment	$246 million
Revolving credit borrowing (net of capital lease repayments)	$95 million
Total sources	**$341 million**
Uses of Cash	
Loss from operations, including net working capital changes and extraordinary expenses described below	$32 million
Cash paid for acquisitions	$89 million[125]
Deposits for acquisitions	$43 million[126]
Purchase of property and equipment	$142 million[127]
Cash balance addition	$35 million
Total uses	**$341 million**

3. Special Non-Operating Areas Affecting Financial Performance

Extraordinary Expenses

During FY11, Steward formed a complex corporate organization, completed multiple hospital and physician practice acquisitions, and pursued several additional acquisitions. These initiatives involved legal, accounting, and related expenses that Steward reported on its FY11 income statement as "reorganization" and "acquisition-related" expenses totaling $39.5

[123] Steward was in compliance with all covenants of the revolving credit as of FYE11. In FY12, the bank lenders agreed to increase the revolver commitment to $200 million, and Steward borrowed an additional $41.3 million. *See id.* at 20–21, 36–37.
[124] *Id.* at 5.
[125] Caritas ($56 million), Essent ($22 million), and other acquisitions ($11 million).
[126] Escrow deposits and loan for Morton, Quincy, and Landmark acquisitions. STEWARD FY11 AFS, *supra* note 69, at 36–37.
[127] Steward has reported new emergency rooms at Good Samaritan, Holy Family, and St. Anne's totaling $38.8 million; $15.5 million for surgery suites at Carney and St. Anne's; $10.5 million for radiation oncology at St. Elizabeth's; and $4.2 million for a catheterization laboratory at Norwood. *See also* Steward FY11 Unaudited Financials, *supra* note 115, at 01442 (noting $24.5 million in information technology spending).

million. In our analysis of Steward's financial performance, we treat these expenses as extraordinary losses based on their non-recurring nature, and in order to show operating results on a comparable basis to FY10.

Pension Commitment

As noted at the outset of Part IV, the three defined benefit plans covering approximately 13,000 current and former Caritas employees in 2010 were substantially underfunded when Steward acquired Caritas and became responsible for this underfunded liability. This was a significant factor in the AGO's determination that Steward's acquisition of Caritas's assets served the public interest. Steward's FY11 audited financials show that the value of its pension obligation increased in 2011, as presented in Table 24 below.

Table 24 – Steward's Estimated Pension Liability[128]

	At Closing (11/6/10)	At FYE11 (9/30/11)
Benefit Obligation ($000)	$560,821	$598,149
Fair Value Plan Assets ($000)	$347,276	$334,157
Underfunded Amount ($000)	**$213,545**	**$263,992**

As a for-profit organization, Steward is subject to the federal Employee Retirement Income Security Act ("ERISA"), which governs the operation of private sector pension plans.[129] ERISA requires a minimum annual cash contribution by each employer offering a defined benefit plan. This minimum contribution is actuarially determined based on a number of factors, including the extent to which a plan is fully funded or underfunded. The minimum required contribution is the cost of benefits earned during the year, plus the amount necessary to amortize any underfunded portion over seven years.[130]

Steward's FY11 audited financials indicate that Steward made $8.6 million in pension contributions in FY11, and that in FY12, its expected contributions will increase to $15.2 million.[131] These FY11 and FY12 contributions reflect the ERISA amortization requirement as to the Good Samaritan and Norwood Plans. Once the transfer of the Caritas Christi Plan from the RCAB to Steward is complete, Steward will become subject to ERISA rules with respect to this third, largest plan.

[128] STEWARD FY11 AFS, *supra* note 69, at 25. *See also supra* note 68 (noting differences in standards and assumptions for estimating pension plan liabilities).
[129] Employee Retirement Security Act of 1974, 29 U.S.C. §§ 1001–1461 (2006).
[130] *See* 26 U.S.C. 415 (2006).
[131] STEWARD FY11 AFS, *supra* note 69, at 25, 27.

Ongoing Provider Acquisitions

During FY11, Steward completed the acquisition of the Essent hospitals and signed contracts to buy three additional hospital systems. Steward's May 2011 acquisition of Merrimack Valley Hospital and Nashoba Valley Medical Center involved a cash payment of $21.7 million and an assumption of $3.4 million in liabilities, for a total consideration of $25.1 million.[132]

Also during FY11, Steward agreed to purchase the assets and assume the liabilities of 154-bed Morton Hospital in Taunton, MA, and 196-bed Quincy Medical Center, in Quincy, MA. These transactions closed on October 1, 2011, just after the close of the 2011 fiscal year. Steward negotiated a third acquisition in FY11, for Landmark Health System, including a 214-bed acute care hospital in Woonsocket, RI and an 82-bed rehabilitation hospital in North Smithfield, RI, but that deal has since fallen through.[133] For these acquisitions, Steward made cash escrow deposits and a loan, for a combined cash outlay of $45.2 million, reported on its FY11 balance sheet as "other noncurrent assets."[134] In the APAs for Morton and Quincy, Steward further agreed to certain minimum levels of capital expenditures for the benefit of each hospital, within specified timeframes as summarized in Table 25 below.

Table 25 – Capital Expenditure Commitments for Ongoing Acquisitions (FY2011)[135]

	CAPEX in First Year	Total CAPEX Within Five Years
Morton ($000s)	$25,500	$85,000
Quincy ($000s)	$15,000	$34,000
Total ($000s)	$40,500	$119,000

[132] *Id.* at 10.

[133] *See, e.g.*, *Landmark Purchase Deal Appears Dead*, BOSTON.COM (Sept. 26, 2012), http://www.boston.com/news/local/rhode-island/2012/09/26/landmark-purchase-deal-appears-dead/ikNe3U2OwXwIdOlVtWFL3L/story.html.

[134] STEWARD FY11 AFS, *supra* note 69, at 36–37.

[135] *See* Morton Hosp. & Med. Ctr., Inc. et al. & Steward Med. Holdings Subsidiary Three, Inc., APA § 11.6 (Mar. 29, 2011), *available at* http://www.mass.gov/ago/docs/nonprofit/morton/complaint-exhibit-a.pdf; Quincy Med. Ctr., Inc. et al. & Steward Med. Holdings Subsidiary Five, Inc. et al., APA § 8.20 (June 30, 2011), *available at* http://www.mass.gov/ago/docs/nonprofit/quincy/exhibit-a.pdf. Not included in this table are the capital commitments Steward made in connection with its acquisition of the Essent hospitals. For example, Steward signed an agreement with the City of Haverhill to make a minimum $10 million capital investment in Merrimack Valley Hospital. However, Steward did not provide a timeline for these expenditures. *See* 4/13/11 PHC Meeting, *supra* note 78. Steward's commitments for acquisitions it initiated after the close of FY11, such as the acquisition of New England Sinai Hospital in FY12, are not included in this Report.

V. METRICS FOR CONTINUED MONITORING

The organizational, market, and financial performance of Steward Health Care System is in a state of change, with significant levels of new investment in people, systems, insurance products, property, and equipment. This Report provides a snapshot of the system's performance at the end of FY11 and identifies key metrics to monitor going forward. We outline below a blueprint for continued monitoring of Steward's medical system, market position, and financial performance over the next several years.

A. Medical System

Our initial findings regarding Steward's medical system, summarized in Part II.A above, point to the following areas for continued monitoring:

- Operating profitability of Steward's acute care system. We will continue to monitor whether Steward successfully integrates the hospitals it has acquired into a high-performing acute care system. Key metrics to monitor include changes in patient volume by major service category; changes in payer mix, including whether Steward successfully grows volume from payers featuring its limited network product, and any changes in the mix of higher margin versus lower margin payers; and trends in financial results. Additional metrics under DPH's oversight include the clinical quality and patient satisfaction performance of the system's providers.

- Growth in and operating profitability of Steward's physician network.
  - Regarding growth, monitoring questions include whether continued physician acquisitions materially change how important insurers view the Steward system to their respective networks, the competitive impact of Steward's physician recruitment practices, and how Steward's strategy for growing its physician network interplays with changes in its patient volume and financial performance.
  - Regarding profitability, Steward Medical Group derives revenue from both patient services and payments from Steward's hospitals. We will continue to measure the role of patient revenue and intra-system payments in driving changes in SMG's profitability. Beyond our current metrics, two additional areas may merit further review: (1) the terms by which insurers pay Steward for its physician services, including the level of payments, the timing of payments, how payments are structured, and any quality or other incentives tied to payment, and (2) the terms by which Steward pays its physicians, including the competitive impact of any growth in physician rates, and whether efficiency incentives are flowing from the system through to the physicians.

- Operating profitability of Steward's post-acute care system. We will continue to monitor measures of patient utilization and financial results for Steward's post-acute care sector. Monitoring home health volume, including service mix, provides information on whether Steward is retaining more post-acute business within its

system, whether Steward is focused on growth of particular services, and whether Steward is achieving greater care coordination across a continuum of services. Material changes in volume or service mix may also signal a need to monitor referral, discharge, and other business practices that are associated with observed changes in home health volume. In future years, we anticipate expanding our review beyond Steward Home Care to other post-acute services in Steward's network (e.g., in FY12, Steward acquired New England Sinai, a long-term acute care hospital in Stoughton, MA).

B. Market Position

Our review of Steward's market position in its first year of operations, summarized in Part II.B above, points to the following areas for continued monitoring:

- Market share and service mix. We will continue to monitor trends in inpatient discharges. Based on anticipated improvements in market transparency, we will seek to monitor market share in other major service categories. Factors to watch include:
  - Significant changes in the market share of Steward hospitals.
  - Changes in Steward's service mix.
  - How any changes in Steward's market share and service mix may impact patient access, Steward's competitors, and overall costs in each of its markets. This includes monitoring the financial condition of competitors that serve as safety-net hospitals.

- Patient referral patterns. We will continue to monitor patient referral patterns, including whether Steward successfully retains more care within its system, whether there are trends in the types of services that Steward retains, and the referral practices associated with observed changes in referral patterns.

- Prices and TME. We will continue to monitor trends in Steward's prices and TME, including the price and TME of each of the major physician groups that comprise the Steward network, which often operate in different geographies. In future years, we will seek to include the TME of public payers, as well as support the development of approaches to track the TME of providers' PPO patients, to understand medical spending trends for the PPO half of the market.

- New limited network products. These products offer employers and consumers important benefits such as lower premiums. They also raise important monitoring questions, such as:
  - Whether these products affect volume at Steward facilities, and if so, in which local markets and in which service categories.
  - The financial performance of these products, including whether they lower medical spending and whether their costs support insurers' initial pricing assumptions. If their medical costs do not support initial pricing assumptions, this may trigger a deeper review, particularly if Steward has taken on significant financial risk in these products.

- Steward's quality performance and patient satisfaction under these products. For example, if we observe materially higher rates of disenrollment for these products compared to other limited and broad network products, this may trigger a deeper review of underlying causes, including whether employers and members adequately understand the terms of these products, and whether the products provide members with appropriate, non-disruptive access to high quality care, both within and, as appropriate, outside the Steward system.

C. System Financial Performance

The results of our first year of review, summarized in Part II.C above, point to the following areas for continued monitoring:

- Operating Performance. Because Steward's FY11 results reflect only the first year of what Steward has consistently described as a multiyear process, this Report draws no conclusions from this first year of information with respect to Steward's future performance or success in meeting its stated objectives. We will continue to monitor the system's operating performance and the factors relevant to a return to operating profitability.

- Sources and uses of cash. We will continue to monitor how Steward generates and spends cash, and how it organizes its cash resources to meet its expenses (including whether it shifts cash between entities to meet expenses). We will also monitor the extent to which cash from operations supports Steward's spending, or whether it will rely upon additional debt financing or seek other sources of funding.

- Special Non-Operating Areas Affecting Financial Performance. Steward's $39.5 million in extraordinary expenses in FY11 were a significant factor in its reported loss of $56.9 million. While the system would still have reported a loss without these expenses, it would have generated a positive cash flow from operations. We will continue to monitor how any future extraordinary expenses affect Steward's long-term financial performance.

This Report reflects the AGO's commitment to monitoring Steward's impact on the provision of health care services to the communities Steward serves. In future years of monitoring, we look forward to building on the framework presented in this initial Report, and to hearing from Steward and other market participants regarding the direction and content of our monitoring efforts. Over time, with increased market transparency, the AGO and our entire health care system will benefit from improved ability to assess and compare the performance and impact of all provider organizations.

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Attachment 1

Acute Hospital Financial Performance, By Hospital System: FY11

(continued on next page)

Multi-Hospital Systems

Hospital Name	Type		Total Margin	Operating Margin	Non-Operating Margin	Profit (Loss)
Baystate Health Inc., and Subsidiaries						**$25,587,000**
Baystate Franklin Medical Center		D	-4.57%	-5.24%	0.67%	($3,517,000)
Baystate Mary Lane Hospital			-4.60%	-5.50%	0.90%	($1,371,000)
Baystate Medical Center	T	D	3.48%	3.66%	-0.18%	$30,475,000
Berkshire Health System						**$23,495,842**
Berkshire Medical Center	T	D	6.20%	4.20%	2.01%	$21,016,770
Fairview Hospital			5.72%	4.09%	1.62%	$2,479,072
Cape Cod Health Care and Affiliates						**$45,173,073**
Cape Cod Hospital		D	7.59%	6.94%	0.65%	$31,470,229
Falmouth Hospital		D	9.21%	8.04%	1.17%	$13,702,844
Care Group						**$95,347,747**
Beth Israel Deaconess Hospital - Needham			-1.36%	-1.98%	0.62%	($746,816)
Beth Israel Deaconess Medical Center	T		4.50%	3.48%	1.02%	$62,250,000
Milton Hospital			0.30%	-0.53%	0.84%	$207,563
Mount Auburn Hospital	T		7.94%	6.46%	1.49%	$24,971,000
New England Baptist Hospital			4.27%	2.69%	1.58%	$8,666,000
Partners Healthcare						**$342,314,136**
Brigham and Women's Hospital	T		5.18%	5.29%	-0.11%	$121,961,000
Faulkner Hospital	T		-2.29%	-2.25%	-0.04%	($4,145,000)
Martha's Vineyard Hospital (FY12Q2)*			1.57%	3.33%	-1.76%	$485,136
Massachusetts General Hospital	T		7.38%	6.95%	0.43%	$223,913,000
Nantucket Cottage Hospital			-19.96%	-24.88%	4.92%	($5,402,000)
Newton-Wellesley Hospital			4.95%	5.20%	-0.26%	$19,633,000
North Shore Medical Center		D	-3.34%	-3.42%	0.08%	($14,131,000)
Steward Health Care System						**($38,907,801)**
Carney Hospital, Inc.	T	D	-1.16%	-1.16%	0.00%	($1,281,000)
Good Samaritan Medical Center		D	0.06%	0.06%	0.00%	$107,824
Holy Family Hospital		D	-1.43%	-1.43%	0.00%	($2,198,259)
Merrimack Valley Hospital		D	-5.16%	-5.16%	0.00%	($1,165,861)
Morton Hospital and Medical Center		D	-2.46%	-3.64%	1.18%	($3,088,540)
Nashoba Valley Medical Center			-1.12%	-1.12%	0.00%	($193,648)
Norwood Hospital			-2.75%	-2.75%	0.00%	($4,276,764)
Quincy Medical Center		D	-18.81%	-17.53%	-1.28%	($18,545,553)
Saint Anne's Hospital		D	7.74%	7.74%	0.00%	$12,664,000
St. Elizabeth's Medical Center	T	D	-7.93%	-7.93%	0.00%	($20,930,000)
Umass Memorial Health Care Inc., and Affiliates						**$56,154,704**
Clinton Hospital		D	3.38%	2.65%	0.74%	$891,000
Health Alliance Hospital			5.49%	5.63%	-0.14%	$9,230,580
Marlborough Hospital			1.66%	0.91%	0.76%	$1,273,000
UMass Memorial Medical Center	T	D	3.12%	3.30%	-0.17%	$42,852,124
Wing Memorial Hospital		D	2.08%	1.80%	0.28%	$1,908,000
Vanguard Health System						**($2,886,421)**
MetroWest Medical Center (FY12Q1)*			-7.13%	-7.24%	0.11%	($4,355,441)
Saint Vincent Hospital (FY12Q1)*	T	D	1.87%	1.87%	0.00%	$1,469,020

Key: T: Teaching Hospital, D: Disproportionate Share Hospital

Notes: Profitability percentages may not add due to rounding

* Most calculations on this page use data reported by hospitals on an October 1 to September 30 fiscal year. Hospitals noted with an asterisk use alternative fiscal year periods.