UNITED STATE DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

STEPHEN DEL SESTO, AS RECEIVER AND ADMINISTRATOR OF THE ST. JOSEPH HEALTH SERVICES OF RHODE ISLAND RETIREMENT PLAN, et al	:	
Plaintiffs,	:	
v.	:	C. A. No. 18-cv-00328-WES-LDA
PROSPECT CHARTERCARE, LLC, et al.	:	
Defendants.	:	

DEFENDANT THE ANGELL PENSION GROUP, INC.'S MOTION TO DISMISS

The Angell Pension Group, Inc. ("Angell") hereby moves for dismissal, with prejudice, of all claims asserted against it in Plaintiffs' First Amended Complaint pursuant to Fed. R. Civ. 12(b). The First Amended Complaint should be dismissed as to Angell because:

1. The Plaintiffs have failed to join an indispensable party—the Pension Benefit Guaranty Corporation;
2. The Class Plaintiffs lack standing to assert the claims in the First Amended Complaint;
3. The First Amended Complaint fails to state a claim upon which relief can be granted as to Angell;
4. The Plaintiffs have failed to plead fraud related claims with the requisite particularity; and
5. The Plaintiffs state law claims are preempted by federal law.

For these reasons, set forth in detail in the accompanying memorandum of law, Angell requests that the Court dismiss all claims asserted against Angell in Plaintiffs' First Amended

Complaint, with prejudice. Angell requests oral argument on this motion and anticipates that argument will take ninety minutes.

THE ANGELL PENSION GROUP, INC.

By its attorneys,

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CERTIFICATE OF SERVICE

I hereby certify that on the 4th day of December, 2018, I have caused the above motion and accompanying memorandum of law to be filed with the Court via the ECF filing system. As such, this document will be electronically sent to the registered participants identified on the Notice of Electronic Filing (NEF).

/s/ Steven J. Boyajian
Steven J. Boyajian

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MEMORANDUM OF LAW IN SUPPORT OF DEFENDANT THE ANGELL PENSION GROUP, INC.'S MOTION TO DISMISS THE FIRST AMENDED COMPLAINT

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Comes now, The Angell Pension Group, Inc. ("Angell"), one of the Defendants herein, and submits this memorandum of law in support of its motion to dismiss the First Amended Complaint ("FAC") filed by Plaintiff Del Sesto ("Del Sesto") and Plaintiffs Major, Zompa, Bryden, Willner, Short, Boutelle and Levesque (the "Class Plaintiffs") (collectively with Del Sesto, the "Plaintiffs") pursuant to Fed. R. Civ. P. 12(b).

INTRODUCTION

Plaintiffs bring this lawsuit because they believe the St. Joseph Health Services of Rhode Island ("SJHSRI") Retirement Plan (the "Plan") was misclassified as a "Church Plan" exempt from the Employee Retirement Income Security Act of 1974, as amended, ("ERISA").[1] Plaintiffs assert that, because the Plan was misclassified as a Church Plan, the Plan is now "grossly underfunded" on an ERISA basis.

Plaintiffs filed their original Complaint on June 18, 2018. Angell moved to dismiss all counts alleged against it on numerous grounds. Rather than oppose that motion, Plaintiffs instead chose to file the First Amended Complaint ("FAC"). Though Plaintiffs added 31 *new* paragraphs to an already lengthy 527-paragraph complaint, Plaintiffs did not correct *any* of the defects Angell identified in its motion. Plaintiffs still have not joined an indispensable party, the Pension Benefit Guaranty Corporation ("PBGC"). Nor have they addressed the fact that none of the Class Plaintiffs have constitutional standing to bring the claims they assert.

Moreover, Plaintiffs still have not stated a plausible claim against Angell – the Plan's actuary. Plaintiffs seek to hold certain defendants, but not Angell, responsible for violating

[1] As used herein, "ERISA Plan" refers to an employee benefit plan governed by ERISA, 29 U.S.C. § 1001, *et seq.* "Church Plan" refers to an employee benefit plan exempt from ERISA's requirements because it is established and/or maintained by a church or affiliated organization. 29 U.S.C. § 1003(b)(2); 29 U.S.C. § 1002(33)(A).

ERISA's minimum funding requirements. But Plaintiffs do not, and cannot, allege that Angell was ever required to make contributions to the Plan. And, nowhere do Plaintiffs suggest, in any way, that any of Angell's calculations were inaccurate, or that any specific Actuarial Standards of Practice ("ASOP") were violated.[2] Rather, Plaintiffs complain that the amounts calculated by Angell were not actually contributed to the Plan by those who had responsibility to fund the Plan.

Plaintiffs do not allege that Angell ever advised on the status of the Plan as a Church Plan or participated in any of the so-called "secret" meetings to hide the Plan's true status as an ERISA Plan. Nor do they allege that Angell had any discretion over what to communicate to participants about the Plan, as opposed to simply conveying the information it was instructed by its client to provide. Though Plaintiffs repeatedly try to "impute" statements made by other defendants to Angell,[3] Plaintiffs have not alleged a single false or misleading statement actually made by Angell. And, other than purely conclusory allegations, Plaintiffs have not alleged a single communication to or from Angell that would allow for an inference that Angell knowingly participated in any conspiracy to commit fraud.

To the contrary, Plaintiffs' allegations show that Angell was *not* conspiring to hide the true funded status of the Plan. Plaintiffs allege that Angell repeatedly advised SJHSRI, in writing, that "recommended" contributions of varying amounts were needed to fund the Plan, but SJHSRI disregarded Angell's funding recommendations and made no contributions to the Plan. Plaintiffs allege that Angell provided SJHSRI and other parties with a plethora of projections, each one showing the Plan to be less than 100% funded, and each one showing that the Plan would run out of money absent additional contributions. Some of these projections showed future contributions,

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[2] Actuarial Standards of Practice or "ASOPs" are published by the Actuarial Standards Board and can be found at: http://www.actuarialstandardsboard.org/standards-of-practice/.

[3] *E.g.*, FAC ¶¶ 318, 338, 340, 342, 345, 354, 355, 361, 362, 370, 372.

and others showed disastrous scenarios without future contributions, but none of them, as detailed in the FAC, show a future in which the Plan survives without future contributions.

For the reasons set forth in more detail below, Plaintiffs have failed to state a claim against Angell, and the FAC should be dismissed against Angell in its entirety and with prejudice.

PLAINTIFFS' ALLEGATIONS REGARDING ANGELL

Plaintiffs' 558-paragraph, 23-Count FAC portrays a soap-operatic tale of wrongdoing.[4] Plaintiffs spin tales of secret, backroom meetings dating as far back as 1973 wherein certain defendants supposedly conspired to fraudulently: (1) conceal the Plan's true status as an ERISA Plan, not a Church Plan (FAC ¶¶ 58-318); (2) assure Plan participants of the solvency of the Plan (*id.*); and (3) persuade regulators and the Rhode Island Superior Court ("Superior Court") to approve the conversion of two hospitals into for-profit entities (the "2014 Asset Sale") (*id.* ¶¶ 319-409). Despite Plaintiffs' bald accusation that Angell "played a key role in the common fraud and conspiracy" (*id.* ¶ 312), the factual allegations regarding Angell are extremely limited. Indeed, Angell did not even begin providing actuarial services to the Plan until 2005 – more than 30 years after the inception of this supposed fraudulent scheme. (*Id.* ¶ 29.)

[4] Plaintiffs have included Angell as a defendant in eleven (11) of the twenty-three (23) counts alleged including: Count III (Aiding and Abetting Fiduciary Breach under ERISA); Count VII (Fraud through Intentional Misrepresentations and Omissions); Count VIII (Fraudulent Scheme); Count IX (Conspiracy); Count X (Actuarial Malpractice); Count XVI (Rhode Island Hospital Conversion Act); Count XVIII (R.I. Gen. Laws § 11-18-1); Count XIX (R.I. Gen. Laws § 11-41-4); Count XXI (Rhode Island Law, Breach of Fiduciary Duty); Count XXII (Rhode Island Law, Aiding and Abetting Breaches of Fiduciary Duty); and Count XXIII (Declaratory Judgment, Liability and Turn Over of Funds, State Law).

I. THE ALLEGED FRAUD TO CONCEAL THE PLAN'S TRUE STATUS AS AN ERISA PLAN

Plaintiffs' claims turn on the threshold determination of whether the Plan is properly classified as a Church Plan or an ERISA Plan. It can only be one or the other. Indeed, Plaintiffs concede that this Court does not have federal jurisdiction if the Plan is a Church Plan. (FAC ¶¶ 30-32, 52.)

Plaintiffs devote 153-paragraphs of their 558-paragraph FAC describing a series of meetings and communications between and among various defendants related to the Plan's classification and qualification as a "Church Plan." (FAC ¶¶ 58-210.) Plaintiffs specifically identify which parties were supposedly present at each of these meetings and Angell is not identified at any of them. (*Id.* ¶¶ 115, 138, 140-143, 153, 158-159, 163, 166-168, 181, 239, 435.) Indeed, there is only *one* factual allegation related to Angell in this entire drama. Plaintiffs allege that, in May 2013, Defendant CharterCARE Community Board ("CCCB") (through Darlene Souza) asked Angell how the Plan could remain a church plan if SJSHRI became a shell corporation, and how SJHSRI could remain in the Official Catholic Directory. (*Id.* ¶¶ 136-137.) But nowhere do Plaintiffs allege that Angell ever answered this supposed "multi-million dollar question." (*Id.*)

Plaintiffs do not allege that Angell – the Plan's *actuary* – had any expertise on this purely *legal* issue, key components of which only became clear after the Supreme Court's 2016 decision in *Advocate Health Care Network v. Stapleton,* 137 S. Ct. 1652 (2016) regarding the "church plan" exemption from ERISA.[5] Rather, Plaintiffs simply allege that Angell "knew" about the

[5] Many components of the "church plan" exemption from ERISA still remain unclear after *Advocate*. *E.g., Medina v. Catholic Health Initiatives,* 877 F.3d 1213, 1221 (10th Cir. 2017) (noting *Advocate* expressly declined to address key issues of the exemption citing 137 S.Ct. at 1657 n.2, 1658 n.3).

fundamental legal principle cited above – "if the Plan ceased to qualify as a Church Plan, it would become subject to ERISA." (FAC ¶ 114.) Based solely on its knowledge of this well-known legal principle, Plaintiffs then summarily allege that Angell was part of a "conspiracy" with the other Defendants to misrepresent the Plan's qualification as a Church Plan. (*Id.* ¶¶ 65, 179, 205.)[6]

II. THE ALLEGED FRAUD TO ASSURE PLAN PARTICIPANTS OF THE PLAN'S SOLVENCY

Plaintiffs' alleged conspiracy to convince Plan participants of the solvency of the Plan apparently started 45 years ago – in *1973*.[7] (FAC ¶ 265.) Plaintiffs allege that this conspiracy was carried out for years with the assistance of *other* actuarial firms. (*Id.* ¶¶ 256, 258 (referencing Watson Worldwide).) Plaintiffs also allege a long series of supposedly misleading statements (none of which were actually untrue) made during the 32 years *prior to* Angell's involvement with the Plan in 2005. (*Id.* ¶¶ 258, 265-269, 271-275, 277-279, 281, 284.)

Though Plaintiffs do not actually attach Angell's service agreement, Plaintiffs summarily allege that "Angell agreed to act on behalf of SJHSRI in dealing directly with Plan participants." (FAC ¶ 288.) This is demonstrably untrue. Angell's service agreement shows that Angell's responsibilities were limited only to calculating Plan benefits and performing the administrative task of communicating additional information provided by its client. (Ex. A.)[8]

Plaintiffs also allege that Angell "participated in" PowerPoint presentations on April 29 and 30 of 2014. (FAC ¶ 292.) Again, however, Plaintiffs do not attach the actual PowerPoint presentation. (Ex. B.) Nor do they allege that Angell drafted any of the statements contained in

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[6] Plaintiffs' reference to Msg. Kenneth A. Angell in paragraph 62 of the FAC is misleading. Msg. Angell is not alleged to be, and is not, connected with The Angell Pension Group.

[7] Plaintiffs' imaginary conspirators showed remarkable foresight. ERISA was enacted in 1974.

[8] All Exhibits ("Ex.") are attached hereto, and the subject to Angell's Request for Judicial Notice pursuant to Fed. R. Evid. 201 filed concurrently herewith.

the presentation. Instead, Plaintiffs inexplicably complain about four, isolated statements from the 14-page presentation:

- "[The MOA signed on January 28, 2014] includes a $14 Million contribution to the Pension Plan to stabilize plan assets." (FAC ¶ 292; Ex. B, at 4.)
- A sample benefit statement which stated that "[y]our pension benefit is an important part of your future retirement income." (FAC ¶ 292; Ex. B, at 6.)
- "The Hospital pays the entire cost of the Plan." (FAC ¶ 292; Ex. B, at 8.)
- References to payment options that include annuity payments for life. (FAC ¶ 292; Ex. B, at 9.)

The FAC is not clear as to what, specifically, Plaintiffs contend could possibly be untrue or misleading about any of these statements. The MOA ***did*** include the cited provision, the pension benefit ***is*** an important part of the Plan participants' retirement income, the Hospital ***does*** cover the cost of the Plan, and the Plan ***does*** promise annuities for life.

Plaintiffs then go on to detail the many ways in which Angell clearly conveyed the need for future contributions to its own client and, through them, to other parties. For example, SJHSRI provided bar graphs prepared by Angell to the nurses' union, showing two scenarios, both of which indicated the need for future contributions (with and without the $14 million stabilization payment). (FAC ¶ 300.) Angell's graph indicated that the Plan would be underfunded by nearly 30% even after the $14 million payment.[9] (*Id.* ¶ 301.) Angell prepared another graph showing that the Plan would run out of money in 2032 with no future contributions. (*Id.* ¶ 302.)

Plaintiffs then allege that, two months *after* the closing of the 2014 Asset Sale, Angell sought instructions from Prospect Healthcare on how it "should respond to Plan participants who were seeking information concerning the solvency of the Plan." (*Id.* ¶ 306.) Plaintiffs allege that

[9] Plaintiffs describe it as "more than 70% funded" as if this could possibly deceive anyone into thinking that an additional 30% is *not* needed.

Brenda Ketner of Prospect Healthcare "instructed" Angell to say: "[W]e can't speak to the future solvency of the plan." (*Id.* ¶¶ 306-311.) But nowhere do Plaintiffs allege that Angell actually communicated this warning to any Plan participant.

Plaintiffs then allege that Angell "worked with" other defendants to prepare and make another PowerPoint presentation in April 2016, two years *after* the sale of the hospital and all regulatory approvals. (*Id.* ¶¶ 315-318.) Regarding this presentation, Plaintiffs complain that the statement, "the hospital pays the entire cost of the Plan" was no longer accurate because SJHSRI no longer owned the hospital. (*Id.* ¶ 316). However, Plaintiffs again conveniently fail to attach the actual document, which shows that this statement was contained in a reproduction of a statement issued two years prior, when the statement was true. (Ex. C, at 7.) Moreover, the entirety of the presentation (about the mechanics of Plan benefits and the application process) did not hide who was responsible for Plan funding, as it also stated that "[t]he Plan is entirely paid for by St. Joseph Health Services of Rhode Island." (Ex. C, at 5.)

III. THE ALLEGED FRAUD TO CONVINCE THE REGULATORS AND THE SUPERIOR COURT TO APPROVE THE 2014 ASSET SALE

Plaintiffs allege a fraudulent conspiracy to convince the regulators and the Superior Court to approve the conversion of two hospitals into for-profit entities. Plaintiffs allege that Angell was CCCB's and SJHSRI's "consultant" in connection with the application for regulatory approval of the 2014 Asset Sale. (*Id.* ¶ 323.) However, there are no allegations that Angell – the Plan's actuary – had any particular experience, expertise or qualification to advise or "consult" anyone on such regulatory matters. In that regard, there are no allegations that Angell ever advised any party on the structure of the deal or what to tell the regulators or the Superior Court about the funding status of the Plan. Rather, Plaintiffs simply allege that Angell provided its client with pension calculations and various graphs, exhibits and spreadsheets showing the results of those

calculations.

On the contrary, Plaintiffs' allegations make clear that Angell did nothing to hide the need for future contributions, and provided its client with all the necessary information to bring that issue to light. Specifically, Plaintiffs allege Angell provided CCCB and SJHSRI with a projection showing that with a contribution of only $14 million (and no additional contributions) the Plan would run out of money in 2034, and authorized SJHSRI and CCCB to share the projection with "Ken Belcher and any other party who would benefit from this analysis." (*Id.*¶ 325.) Angell subsequently provided updated projections showing the Plan running out of money between 2030 and 2036. (*Id.* ¶ 326.)[10]

Plaintiffs' key allegation against Angell is that on April 11, 2014, SJHSRI asked Angell to prepare a projection of the Plan's funded status (at 94.9%) in 2014 after a contribution of $14 million, with no other information shown, and Angell did so (the "94.9% Projection"). (*Id.* ¶¶ 330-336.) Plaintiffs suggest that this one projection would somehow trick the regulators into believing no additional contributions would be needed. However, Plaintiffs' allegations fall far short of establishing that the 94.9% Projection was fraudulent, for several reasons:

First, and most obviously, 94.9% is less than 100%. If the Plan is only 94.9% funded, then clearly additional contributions are needed.

Second, Plaintiffs fail to allege that Angell's other projections *weren't* provided to the regulators, or of any communication to Angell that would have put it on notice of such omission if it indeed occurred.

[10] Plaintiffs' suggestion that Angell was somehow conspiring to deceive participants about the need for future contributions is completely nonsensical. Every statement attributed to Angell indicates that future contributions *were* needed.

Third, the regulators clearly had access to other projections, and knew that additional funding would be needed. Indeed, the President of CCCB testified at a public hearing on April 8, 2014 (three days before the supposedly fraudulent 94.9% Projection) and was asked about a concern raised by Moody's Investor Services related to the funded status of the Plan. (FAC ¶ 341.) The FAC also shows that the Attorney General was concerned about the need for future contributions, asking, "what is the plan going forward to fund the liability?" (*Id.* ¶ 343.) Similarly, Plaintiffs allege that other calculations prepared by Angell were provided to the Attorney General, showing the effect of ongoing annual contributions of $600,000 to $1,390,000. (*Id.*¶¶ 347-352.) Plaintiffs also allege that the Project Review Committee knew that investment returns below 7.75% could result in inadequate funding of the Plan. (*Id.* ¶ 355.) The Attorney General sought proof that Roger Williams Hospital's ("RWH") assets would be used to fund the shortfall. (*Id.* ¶ 357.)

Fourth, as with all other relevant documents, Plaintiffs fail to attach the actual projection provided. Angell has requested this Court to take judicial notice of the 94.9% Projection as provided, which shows Plaintiffs' selective description to be shockingly misleading. (Ex. D.)

To begin with, the 94.9% Projection provided by Angell includes the following "Disclosures," which Plaintiffs conveniently fail to mention:

> The results contained in this analysis are for illustrative purposes only and are estimates based on the census data and asset information provided by St. Joseph Health Services of Rhode Island to prepare the annual actuarial valuation of the Plan. **The results do not reflect all possible future funding and accounting costs. The actual results at a future date will be based on the demographics of the covered population, asset values on the date of the valuation, and the related assumptions applicable for that plan year**. Unless stated otherwise, the methods and actuarial assumptions in the most recently completed actuarial valuation report are used in preparing this analysis.

(Ex. D, at 1 (emphasis added).)

In addition, Plaintiffs allege that Angell failed to disclose that the assumed rate of return of 7.75% was 68% greater than 4.6%. However, the two page projection shows the 7.75% assumed rate of return on both page 1 and page 2. (Ex. D, at pp. 1, 2.)

Plaintiffs also conveniently fail to disclose that the 94.9% Projection shows that the recommended annual contribution *after the $14 million contribution* will be $1,391,000, with the further disclosure that, "the recommended contribution is an estimate that is subject to change based on the Plan assets and Plan's discount rate." (Ex. D, at 2.)

The only other communication to or from Angell that Plaintiffs cite as evidence of Angell's participation in or knowledge of an alleged conspiracy to defraud the regulators is an e-mail exchange on April 11, 2014, regarding the Attorney General's question: "what is the plan going forward to fund the liability?" (*Id.* ¶ 343.) According to Plaintiffs, Angell was copied on this e-mail, but Plaintiffs do not allege that Angell ever responded or assisted in the preparation of an answer. Nor do Plaintiffs ever allege any communication to or from Angell from which it could be inferred that Angell knew that no future contributions would be made.[11]

[11] Plaintiffs repeatedly use the phrase "other Defendants" or "other entities" throughout the Complaint, and it is unclear whether such references are intended to apply to Angell. (*E.g.*, FAC ¶¶ 64, 203, 222, 340, 426.) In each of these cases where Angell is not specifically mentioned, the Court should assume that Angell is not one of the "other" Defendants or entities. *Laurence v. Wall,* No. CA08-109ML, 2010 WL 4137444, at *2 (D.R.I. Sept. 30, 2010) ("although the Complaint includes allegations against 'defendants' as a group, these sweeping allegations fail to provide adequate specificity to be deemed sufficient allegations against the Moving Defendants") (footnote omitted); *Levi Chicoine v. Gulliver's Tavern Inc.,* No. 15-216 S, 2016 WL 552469, at *3 n.2 (D.R.I. Feb. 10, 2016) ("general 'reference to Defendants throughout 'Amended Complaint No. 2,' does not satisfy the requirement of pleading specific and plausible allegations.' 'Without some semblance of factual allegations and an indication of which Defendant acted and when, that ties the Defendants' specific action to a recognized cause of action,' Plaintiffs have not alleged claims against the individual defendants for which relief can be granted.") (internal citation omitted) (quoting *Schofield v. U.S. Bank N.A.,* No. CA 11-170-M, 2012 WL 3011759, at *5 (D.R.I. July 23, 2012)).

STANDARD OF REVIEW

Fed. R. Civ. P. 8 "demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). A complaint does not "suffice if it tenders 'naked assertion[s]' devoid of 'further factual enhancement.'" *Id.* (citations omitted). Rather, in order "[t]o survive a motion to dismiss, a complaint must contain *sufficient factual matter*, accepted as true, to 'state a claim to relief that is *plausible* on its face.'" *Id.* (emphasis added) (citations omitted).

"The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Iqbal,* 556 U.S. at 678. In short, "Rule 8(a)(2) requires a "*showing*, rather than a blanket assertion, of entitlement to relief," and the "*[f]actual allegations* must be enough to raise a right to relief above the speculative level." *Twombly*, 550 U.S. at 555-56, n.3 (emphasis added). "Something beyond the mere possibility [] must be alleged lest a plaintiff with a largely groundless claim be allowed to take up the time of a number of other people, with the right to do so representing an *in terrorem* increment of the settlement value." *Twombly*, 550 U.S. at 557-58 (internal quotations omitted). Indeed, to the extent a complaint fails to meet this threshold level of plausibility, "this basic deficiency should . . . be exposed at the point of minimum expenditure of time and money by the parties and the court." *Id.*

In addition to the face of the complaint, the court may consider documents "integral to or explicitly relied upon in the complaint, even though not attached to the complaint . . ." *Clorox Co. P.R. v. Proctor & Gamble Commercial Co.*, 228 F.3d 24, 32 (1st Cir. 2000) (citation omitted). Moreover, it is well settled that the Court may consider matters susceptible to judicial notice and matters of public record in deciding a Rule 12(b) motion without converting the motion into one for summary judgment. *See Greene v. Rhode Island*, 398 F.3d 45, 48-49 (1st Cir. 2005) (collecting

cases); *see also Boateng v. InterAmerican Univ., Inc.*, 210 F.3d 56, 60 (1st Cir. 2000) ("a court ordinarily may treat documents from prior state court adjudications as public records.").

ARGUMENT

I. THE PBGC IS AN INDISPENSABLE PARTY UNDER FED. R. CIV. P. 19

The PBGC's duties "consist primarily of furthering the statutory purposes of Title IV [of ERISA] identified by Congress" which, in pertinent part, are "(1) to encourage the continuation and maintenance of voluntary private pension plans for the benefit of their participants" and "(2) to provide for the timely and uninterrupted payment of pension benefits to participants and beneficiaries under plans to which this subchapter applies." *Pension Ben. Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 648 (1990) citing 29 U.S.C. § 1302(a). Thus, when a covered ERISA pension plan terminates with insufficient assets to satisfy its pension obligations, "the PBGC becomes trustee of the plan." *Id.* at 637. After using available plan assets to cover benefit obligations, the PBGC then uses "its own funds to ensure payment of most of the remaining 'non-forfeitable' benefits . . . which participants have earned entitlement under the plan terms as of the date of termination." *Id.* at 637-38 citing 29 U.S.C. §§ 1301(a)(8), 1322(a) and (b).

If this Court decides the Plan is an ERISA Plan, then that judicial determination must be binding on the PBGC so the PBGC will step in and pay the guaranteed benefits owed to the Plan participants. Otherwise, all parties – including the Plan participants – bear the risk that the PBGC could conversely claim the Plan is a Church Plan and refuse to pay the benefits owed. Moreover, if Defendants prevail on Plaintiffs' claims, they could still face the same claims being made by the PBGC when it becomes trustee of the Plan, and will have to litigate the same alleged conduct twice. Such risk for inconsistent judgments is exactly what Rule 19 was intended to prevent. Fed. R. Civ. P. 19(a)(1) ("A person who is subject to service of process and whose joinder will not deprive the court of subject-matter jurisdiction ***must be joined as a party*** if: (A) in that person's

absence, the court cannot accord complete relief among existing parties; or (B) ***that person claims an interest relating to the subject of the action and is so situated that disposing of the action in the person's absence may***: (i) as a practical matter impair or impede the person's ability to protect the interest; or (ii) ***leave an existing party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations because of the interest***.") (emphasis added).

Accordingly, the FAC should be dismissed pursuant to Fed. R. Civ. P. 12(b)(7) for failure to join an indispensable party – the PBGC. *See, e.g., Z & B Enters., Inc. v. Tastee-Freez Int'l, Inc.*, 162 F. App'x 16, 20 (1st Cir. 2006) (affirming dismissal for failure to join an indispensable party where franchisor's purported agents were necessary parties because "we may not be able to grant complete relief" and defendant "could be subject to inconsistent or double obligations" without such parties).[12]

II. THE CLASS PLAINTIFFS LACK CONSTITUTIONAL STANDING TO BRING THIS LAWSUIT

To have standing under Article III of the Constitution, a plaintiff must satisfy three elements: *First,* "the plaintiff must have suffered an 'injury in fact' – an invasion of a legally protected interest which is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical." *Lujan v. Def. of Wildlife*, 504 U.S. 555, 560 (1992) (citations and quotations omitted). An injury is concrete if it "actually exists," and a mere statutory violation, without more, does not amount to a concrete injury. *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540, 1548-49 (2016). *Second,* "there must be a causal connection between the injury and the conduct complained of – the injury has to be 'fairly traceable to the challenged action of the defendant.'"

[12] A more extensive analysis of the reasons for dismissal pursuant to Fed. R. Civ. P. 12(b)(7) is contained in the memorandum of law to be submitted concurrently with this memorandum by Defendant Prospect Medical Holdings, Inc. and four other defendants (collectively, "Prospect Entities"). To avoid duplication, Angell adopts and incorporates by reference the arguments of Prospect Entities with respect to ripeness and dismissal for failure to join the PBGC.

Lujan, 504 U.S., at 560 (citations omitted). *Third,* it must be "likely," not merely "speculative," that the injury will be "redressed by a favorable decision." *Id.* at 561 (citations omitted).

ERISA does not require that defined benefit plans maintain full funding, instead permitting plans to make contributions designed to address any underfunding over a period of years. 29 U.S.C. § 1082(c). Here, Plaintiffs repeatedly claim that the Plan is "grossly underfunded." (FAC ¶¶ 55, 63, 205, 270, 282, 296, 309, 311, 313, 336, 362, 402.) Even if the Plaintiffs have adequately alleged that the Plan is technically "underfunded" on an ERISA basis, underfunding alone is not sufficient to establish constitutional standing. *Spokeo,* 136 S. Ct. at 1549 (noting that a "bare procedural violation, divorced from any concrete harm" does not satisfy Article III standing); *Lee v. Verizon Commc'ns, Inc.*, 837 F.3d 523, 530 (5th Cir. 2016) ("We . . . decline to conflate the concepts of statutory and constitutional standing by holding that incursion on a statutorily-conferred interest in proper plan management is sufficient in itself to establish Article III standing.") (citations and quotations omitted).

Plaintiffs speculate that, due to the alleged underfunding, the Class "Plaintiffs pensions ***will be*** lost or at least severely reduced." (FAC ¶ 458 (emphasis added).)[13] However, the FAC is devoid of ***any*** allegation that ***any*** Class Plaintiff, or ***any*** participant in the Plan, has actually failed to receive a single penny of benefits due or otherwise has actually been harmed in any way. Plaintiffs have not alleged that, in the event the Plan terminates or runs out of money, the PBGC will fail to pay all of the benefits promised by the Plan. The lack of such an allegation could have been an oversight in the original complaint. However, Angell's motion to dismiss the original complaint

[13] Plaintiffs allege that the Plan was placed into receivership with the request that the Superior Court approve a "virtually immediate 40% across-the-board reduction in benefits." (FAC ¶ 54.) But the FAC does not allege that this "request" was approved, nor that there has been a reduction to a single participant's benefits as a result of this "request."

prominently highlighted the failure of Plaintiffs to include an allegation that any participant will lose even one dollar after the PBGC steps in. Thus, it is clear why Plaintiffs still have not alleged any loss to any Plan participant – they cannot.

Such speculative allegations of risk do not constitute an injury suffered by Class Plaintiffs (or any member of the putative class) – let alone an injury that is concrete and particularized, and actual or imminent. *See, e.g., Lee*, 837 F.3d at 546 ("[Plaintiff's] allegations do not further allege the realization of risks which would create a likelihood of direct injury to participants' benefits. To wit, [Plaintiff] does not allege a plan termination, an inability by Verizon [sic] address a shortfall in the event of a termination, or a direct effect thereof on participants' benefits."); *see also Sheedy v. Adventist Health Sys.*, No. 616CV1893ORL31GJK, 2018 WL 3538441, *4 (M.D. Fla. July 23, 2018) ("[Plaintiff] does not explain what benefit she is entitled to under the [plan], or when that benefit is due. She does not indicate whether the [plan] has ever failed to make a required payment, nor does she indicate when the [plan] will need additional funding in order to meet its payment obligations. The Plaintiff has not adequately pleaded that she faces a substantial, rather than merely speculative, risk of future injury. Thus, the Plaintiff lacks standing to bring Count III with respect to the [plan]."); *Perelman v. Perelman*, 793 F.3d 368, 374 (3d Cir. 2015) ("[E]ven if the defendants' dealings resulted in a diminution in Plan assets, they are insufficient to confer standing upon [plaintiff] absent a showing of individualized harm."); *David v Alphine*, 704 F.3d 327, 338 (4th Cir. 2013) ("We find on this record the alleged risk [to plan funding] to be insufficiently 'concrete and particularized' to constitute an injury-in-fact for Article III standing purposes.").

III. PLAINTIFFS FAIL TO ALLEGE THAT ANGELL CAUSED ANY HARM

In addition, Plaintiffs have failed to allege any conduct by Angell that *caused* any "injury in fact" to any of the Plaintiffs. *Lujan*, 504 U.S., at 560. Plaintiffs do not (and cannot) allege that

Angell was a fiduciary to the Plan, or that Angell was responsible for funding the Plan. Moreover, Plaintiffs allege that Angell repeatedly advised SJHSRI of the need to contribute more money to the Plan, and those recommendations were disregarded. (FAC ¶¶ 238-240, 244-247, 249, 252-253, 270.)

In paragraph 55 of the FAC, Plaintiffs outline the four ways in which Plaintiffs were supposedly harmed:

First, Plaintiffs contend that SJHSRI used the Plan as a marketing tool to hire and retain employees for nearly fifty years. (FAC ¶ 55(a).) However, as Plaintiffs allege, Angell had no involvement with the Plan or SJHSRI until 2005 (*id.* ¶ 29),[14] and Plaintiffs have alleged no actions Angell took in furtherance of this employment marketing effort other than to perform the ministerial function of distributing materials drafted by SJHSRI which had already been in use for decades prior to Angell's involvement. Plaintiffs have alleged no facts, other than pure conclusions of law, which would cause Angell to know, or have any duty to warn employees, that their employment was obtained under false pretenses. And, none of the Plaintiffs have alleged that they would have taken a different job or taken any other concrete action had they known the Plan was a Church Plan or that it was underfunded.[15]

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[14] The earliest reference in the FAC to specific work performed by Angell is that it prepared the 2006 actuarial valuation report. (FAC ¶ 230.) All references to earlier actuarial work show that work to be performed by other actuarial firms.

[15] Paragraph 260 contains the FAC's only allegation supporting detrimental reliance, and reads, in its entirety: "The Plan participants relied upon those statements to their detriment." Not revealed is what specific actions any Plan participant might have taken in reliance on statements made, "on different occasions, in many different contexts, over many years," none of which are alleged with any specificity. (FAC ¶ 259.) Plaintiffs then attempt to overcome this basic failure with the false legal conclusion that detrimental reliance can be "presumed" and "proof of individualized reliance on specific representations is not necessary." (*Id.* ¶ 261.) Plaintiffs seemingly rely on the line of cases presuming reliance in the *securities fraud* context, "which are not necessarily applicable to the common law fraud claims at issue here. *See Yarger v. ING Bank*,

Second, Plaintiffs allege that SJHSRI grossly underfunded the Plan in the past ten years, contrary to Angell's repeated recommendations to fund the Plan, and that several defendants conspired to conceal the underfunding through fraudulent misrepresentations and material omissions. (FAC ¶ 55(b).) However, Plaintiffs have not pointed to a single communication that was actually from Angell that was fraudulent or misleading. Nor have Plaintiffs explained how this concealment harmed Plaintiffs.

Third, and most bizarrely, Plaintiffs allege that other defendants (not including Angell) secretly sought for many years to terminate the Plan, but never actually did so. (FAC ¶ 55(c).) Plaintiffs do not explain how secretly seeking to take an action harmed them when the action was never taken.

Fourth, Plaintiffs allege that Angell participated in a "scheme" to transfer SJHSRI's assets

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285 F.R.D. 308, 327 (D. Del. 2012); *Aubrey v. Sanders*, 346 Fed. Appx. 847, 849–50 (3d Cir. 2009) (rejecting application of fraud-on-the-market theory for common law fraud claims); *McLaughlin v. Am. Tobacco Co.*, 522 F.3d 215, 223 (2d Cir. 2008) (refusing to apply "presumption of reliance" in putative class action where defendants had conducted "national marketing campaign," noting that "reliance on the misrepresentation [ ] cannot be the subject of general proof"). Numerous courts have denied class certification of claims where reliance is an element based on their conclusion that proving reliance would cause individual issues to predominate over common questions. *See, e.g., Yarger*, 285 F.R.D. at 328 ("Proving that members of the Proposed Class relied on ING's allegedly misleading advertisements will require the Court to examine if each class member was given any additional information through phone conversations or other media that are not common to the entire class. Even presuming that all class members received the same communications, reliance still raises individual questions regarding the subjective state of mind of each class member. Because reliance is a central question that goes to the heart of the merits of the Proposed Class's fraud claims and must be proven through individualized evidence, the predominance requirement is not met with respect to the fraud claims."); *Castano v. Am. Tobacco Co.,* 84 F.3d 734, 745 (5th Cir. 1996) ("[A] fraud class action cannot be certified when individual reliance will be an issue."); *Gaffin v. Teledyne, Inc.,* 611 A.2d 467, 474 (Del. 1992). ("A class action may not be maintained in a purely common law or equitable fraud case since individual questions of law or fact, particularly as to the element of justifiable reliance, will inevitably predominate over common questions of law or fact"). Thus Plaintiffs' fraud-based claims would never be certifiable under the class action rubric in any event.

to entities controlled by SJHSRI's parent company, thereby denying the Plan a source of future contributions. (FAC ¶ 55(d).) However, despite their entirely conclusory allegations that Angell was a co-conspirator, Plaintiffs have not alleged a single fact that could be used to infer that Angell was aware of this scheme or that Angell took any action in furtherance of this scheme. Indeed, none of the sub-paragraphs of FAC ¶ 55(d) mention Angell at all.

The bedrock of this supposed scheme was convincing the regulatory agencies and the Superior Court that there would be future revenue available to fund the Plan's underfunding, which was clearly disclosed to, and known by, both the regulators and the Superior Court. For example, several defendants, not including Angell, are alleged to have assured the regulators that future contributions would be made based on recommendations of the Plan's actuaries. (FAC ¶ 233.) Plaintiffs fail to explain how Angell would know about the lack of future revenue when the regulators and the Superior Court were unable to detect this problem. There is no allegation that Angell provided any advice with respect to the structuring of the transaction, other than to provide projections of pension funding which either: (i) assumed future contributions, (ii) showed the disastrous effects of not having future contributions, or (iii) showed that the Plan was, at the time, not fully funded.

Plaintiffs rest their case against Angell on a projection provided to SJHSRI on April 11, 2014, showing that the Plan's funding would be "stabilized" at 94.9% after a contribution of $14 million. (FAC ¶¶ 330-336.) However, Plaintiffs failed to attach a copy of the projection itself in a futile attempt to mischaracterize its contents. Contrary to Plaintiffs' assertions that this projection would trick regulators into believing that no further contributions were required, the projection: (i) does not use the term "stabilized," (ii) repeatedly warns of the need for future contributions of unknown amount, estimated at $1,291,000 per year, (iii) shows that the Plan will

continue to be underfunded after the $14 million contribution, and (iv) carefully discloses that investment returns of less than 7.75% will result in a change in the required annual contribution. Plaintiffs' contention that this projection prepared by Angell could have lulled regulators into complacency about the need for future contributions is palpably false.

Thus, Plaintiffs present no plausible way that any alleged action or inaction by Angell *caused* the Plan to be underfunded or *caused* any attendant harm to any of the Plan's participants.

IV. PLAINTIFFS FAIL TO STATE A CLAIM FOR RELIEF UNDER ERISA AGAINST ANGELL

A. There is no cause of action against a non-fiduciary under ERISA for "aiding and abetting" a fiduciary breach (Count III).

ERISA assigns a number of detailed duties and responsibilities to fiduciaries, makes fiduciaries liable for breach of these duties, and specifies the remedies available against them. 29 U.S.C. §§ 1104, 1109(a). However, these provisions are limited, by their terms, to *fiduciaries.* Plaintiffs do not allege that Angell – the Plan's actuary – is a "fiduciary" to the Plan, as that term is defined under ERISA§ 3(21). Nor can they. An actuary who renders actuarial or consulting services is not a fiduciary to an ERISA plan solely by virtue of the rendering such services. 29 C.F.R. § 2509.75-5, D-1. And Angell's service agreement makes clear that it is not a fiduciary under ERISA. (Ex. A, at 1.)[16]

Instead, Plaintiffs claim that Angell – a non-fiduciary – should be held liable for supposedly "aiding and abetting" breaches of fiduciary duty under ERISA. (*See* Count III.) However, "no provision [of ERISA] explicitly requires [non-fiduciaries] to avoid participation (knowing or unknowing) in a fiduciary's breach of fiduciary duty." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254 (1993); *Reich v. Rowe*, 20 F.3d 25, 26 (1st Cir. 1994) ("Although ERISA may allow for some

[16] Notably, Plaintiffs expressly identify SJHSRI and CCCB as the Plan's fiduciaries (FAC ¶ 463), and Angell is not named as a defendant to Count II - ERISA, Breach of Fiduciary Duty.

types of actions against non-fiduciaries, it does not authorize suits against non-fiduciaries charged solely with participating in a fiduciary breach."); *see also Nieto v. Ecker*, 845 F.2d 868, 871 (9th Cir. 1988) ("The plain language of section 409(a) limits its coverage to fiduciaries, and nothing in the statute provides any support for holding others liable under that section.") "It is unlikely [] that this was an oversight, since ERISA *does* explicitly impose 'knowing participation' liability on co-fiduciaries." *Mertens,* 508 U.S. at 254 (citing 29 U.S.C. § 1105(a)) (emphasis in original).

In *Mertens*, the Supreme Court expressly held that a non-fiduciary actuary could not be held liable under ERISA § 502(a)(3) for money damages for knowingly assisting in a breach by a fiduciary. 508 U.S. at 251-53. Though the Supreme Court has not expressly opined on whether ERISA provides for a cause of action against non-fiduciaries who assist in a fiduciary's breach of duty,[17] other courts have held that 29 U.S.C. § 1132(a)(3) simply does not authorize suit against non-fiduciaries for participating in a fiduciary breach. *See, e.g., Renfro v. Unisys Corp.,* 671 F.3d 314, 325 (3d Cir. 2011) ("In light of *Reich*, and interpreting identical language, we find *Mertens* persuasive and hold that 29 U.S.C. § 1132(a)(3) does not authorize suit against 'non-fiduciaries charged solely with participating in a fiduciary breach.' Because, as previously discussed, the Fidelity entities did not act as fiduciaries with respect to the alleged breach, they may not be sued under this section for acts taken in a non-fiduciary role.") (citation omitted); *Lash v. Reliance Standard Life Ins. Co.*, No. 16-235, 2016 WL 3362060, at *3 (E.D. Pa. June 17, 2016) ("Plaintiff cannot assert a claim against Matrix under 29 U.S.C. § 1132(a)(3) unless Matrix has acted as a

[17] *Pharm. Care Mgmt. Ass'n v. Rowe,* 429 F.3d 294, 300 n.4 (1st Cir. 2005) ("In *Mertens*, the Supreme Court expressly reserved the question as to whether ERISA provides for a cause of action against non-fiduciaries who assist in a fiduciary's breach of duty. The Court, however, did resolve the question as to whether a non-fiduciary in such a suit would be subject to monetary damages.").

fiduciary.")[18]

B. Plaintiffs have not stated a plausible claim for equitable relief under ERISA § 502(a)(3) against Angell.

Plaintiffs have not stated a claim against Angell that is "plausible on its face." *Iqbal*, 556 U.S. at 678. The FAC is replete with allegations that Angell affirmatively, and repeatedly, advised the Plan's fiduciaries to make the minimum funding contributions, but these recommendations were ignored or "disregarded."[19] This is fundamentally inconsistent with any notion that Angell was "aiding," "abetting," or otherwise "participating" in any breach by the Plan's fiduciaries. Similarly, Angell provided its client with numerous calculations and projections – none of which are alleged to be inaccurate – but Plaintiffs attempt to hold Angell responsible for ensuring that its client provide all of the projections to regulators in connection with the asset sale. (FAC ¶¶ 324-338.) Indeed, if this court were to accept Plaintiffs' theory, then any non-fiduciary lawyer, actuary

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[18] The Supreme Court has held that ERISA § 502(a)(3) authorizes suits against non-fiduciaries for participating in a transaction prohibited by ERISA § 406(a). *Harris Tr. & Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000). However, the *Harris Trust* decision is limited to prohibited transaction claims under ERISA § 406(a), and does not specifically address the broader question of whether ERISA § 502(a)(3) provides a cause of action against non-fiduciaries for participating in breaches of fiduciary duty by plan fiduciaries under ERISA §§ 404 or 409. *See, e.g., McDannold v. Star Bank,* 261 F.3d 478, 486 (6th Cir. 2001) (noting the "narrow reach" of *Harris Trust*); *Davidson v. Hewlett-Packard Co.,* No. 5:16-cv-01928-EJD, 2017 WL 106398, at *2 (N.D. Cal. Jan. 11, 2017) (granting motion to dismiss § 502(a)(3) claim because defendants were not fiduciaries under ERISA and plaintiff "has not alleged that the three doctors or Does 1–50 engaged in transactions barred under § 406(a). As such, *Harris Trust* offers no basis for naming them as individual defendants.").

[19] *See* FAC ¶ 63 ("At various times during the period from 1995 to the present, SJHSRI did not fund the Plan in accordance with the requirements of ERISA and the recommendations of the Plan's actuaries, with the result that the Plan is grossly underfunded."); ¶ 270 (". . . although actuaries throughout the life of the Plan annually calculated the amount of money that SJHSRI should pay into the Plan, based upon the contribution requirements of ERISA and the Plan, SJHSRI routinely disregarded their recommendations and in many years chose to make no annual contributions whatsoever, with the result that the Plan became more and more underfunded over time."); ¶ 309 ("SJHSRI for years had been disregarding Angell's funding recommendations and making no contributions."); ¶ 346 (noting that no contributions had been made "contrary to the recommendations of the Plan's actuarial advisors").

or consultant who provides advice to a Plan fiduciary that is ignored, could subsequently be liable for "aiding and abetting" a fiduciary breach.[20]

Further, Count III purports to state a claim under 29 U.S.C. § 1132(a)(3). That provision only authorizes injunctive or "other appropriate equitable relief" to redress violations, or enforce the provisions, of the terms of the plan or subchapter I of ERISA. *Id.* at *9 n.14. Count III identifies no provisions of the Plan or subchapter I of ERISA that Plaintiffs contend Angell violated. The only apparent violation of ERISA, or the Plan terms, alleged in the FAC is the assertion that certain Defendants, but not Angell, violated ERISA's minimum funding requirements. Of course, Plaintiffs do not, and cannot, allege that Angell – the Plan's actuary – was ever required to make contributions to the Plan. As Plaintiffs acknowledge, that responsibility rested solely with *SJHSRI*.[21]

Finally, ERISA § 502(a)(3) limits plaintiffs to "appropriate equitable relief." 29 U.S.C. § 1132(a)(3). Here, Plaintiffs' multitude of theories for recovery in Count III fail to state a claim. Plaintiffs are not seeking identifiable, traceable funds from Angell. Thus, Plaintiffs are not entitled to any monetary recovery from Angell. *See, e.g., Great-W. Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 214 (2002) ("The basis for petitioners' claim is not that respondents hold particular

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[20] *See, e.g., Mellon Bank, N.A. v. Levy*, No. 01-1493, 2002 WL 664022, at *11 (W.D. Pa. Apr. 22, 2002) ("This very type of professional service has been expressly excluded from liability by Nieto and other courts under the ERISA fiduciary analysis. Thus, it is not the type of non-fiduciary 'participation' that forms the basis for ERISA liability. In the end, Mellon's party in interest claims boil down to a thinly veiled attempt to circumvent the rule prohibiting fiduciary liability against professional service providers who act within the scope of their usual professional duties. Permitting the Plaintiff to state a party in interest claim based on the same allegations that fail under the fiduciary analysis would do nothing more than create an end run around the ERISA fiduciary liability analysis, thereby swallowing the rule. The Plaintiff can state no claim for party in interest or nonfiduciary liability, and the Defendant's Motion to Dismiss should be granted.")

[21] *See* FAC ¶ 455 ("As the employer maintaining the plan, SJHSRI was responsible for making the contributions that should have been made pursuant to 29 U.S.C. § 1082, at a level commensurate with ERISA's requirements.")

funds that, in good conscience, belong to petitioners, but that petitioners are contractually entitled to some funds for benefits that they conferred. The kind of restitution that petitioners seek, therefore, is not equitable — the imposition of a constructive trust or equitable lien on particular property — but legal — the imposition of personal liability for the benefits that they conferred upon respondents."); *Montanile v. Bd. of Trs. of Nat. Elevator Indus. Health Benefit Plan*, 136 S. Ct. 651, 660 (2016) ("as a general rule, plaintiffs cannot enforce an equitable lien against a defendant's general assets"). Furthermore, Plaintiffs' requests for reformation of the Plan and equitable estoppel to fund the Plan do not apply to Angell, which indisputably has no funding obligation with respect to the Plan.

Because Plaintiffs have identified no factual basis for "equitable relief" against Angell for violations of the Plan terms or subchapter I of ERISA, Count III fails to state a claim against Angell.

V. PLAINTIFFS FAIL TO STATE A CLAIM FOR RELIEF UNDER STATE LAW AGAINST ANGELL

A. Plaintiffs fail to state a claim against Angell for actuarial malpractice (Count X).

Count X is labelled as a claim for "actuarial malpractice." The actual allegations only assert the conclusion that Angell did not conform to the required "standard of care," without including any factual allegations about what Angell did, or failed to do, that supposedly constituted "negligence."

1. The Class Plaintiffs do not have standing to assert an actuarial malpractice claim against Angell.

As a preliminary matter, none of the Class Plaintiffs even have the ability to raise an actuarial malpractice claim against Angell. Most courts that have considered this issue have held that a party must be in privity of contract with a professional, or that a party must be the direct and

intended beneficiary of a professional's services, to sue for professional malpractice. *See, e.g., Clark v. Feder Semo & Bard, P.C.,* 634 F. Supp. 2d 99, 108 (D.D.C. 2009) (retirement plan participant was not in privity of contract with actuarial consulting firm hired by employer to provide actuarial services related to employer's retirement plan or a direct and intended beneficiary of the actuarial consulting firm's services, as required to state a claim for professional malpractice against actuarial consulting firm based on actuarial services the firm provided related to the retirement plan); *Dill v. Wood Shovel & Tool Co.,* No. 4110, 1972 WL 795, at *5 (S.D. Ohio Apr. 20, 1972) (noting that a professional is not liable for ordinary negligence to a third person with whom he has no professional contractual relationship and that "this rule is equally applicable to the liability of an actuary for alleged negligence in failing to advise its employer as to the correct amount of contributions required to make a pension fund actuarially sound.").

Here, SJHSRI hired Angell to assist it with the Plan. The Class Plaintiffs were merely participants in the Plan. (FAC ¶¶ 3-9.) None of the Class Plaintiffs have alleged that they were in privity of contract with Angell, nor have they alleged facts that they were the direct and intended beneficiary of Angell's actuarial services. Accordingly, the Class Plaintiffs do not have standing to sue Angell for actuarial malpractice. *E.g., Clark,* 634 F. Supp. 2d at 108.

2. Plaintiffs have not stated a plausible claim for actuarial malpractice.

The gist of Plaintiffs' FAC is that the annual maximum and minimum contributions to the Plan recommended by Angell each year were not actually contributed to the Plan by those who had responsibility to fund the Plan. (FAC ¶¶ 63, 270, 309, 346.) However – to be clear – ***it is not Angell's responsibility, as the Plan's actuary, to ensure that any such funding obligations are met.*** *See, e.g., Bd. of Trs. New Orleans Emp'rs Int'l Longshoremen's Ass'n v. Gabriel, Roeder, Smith & Co.,* 529 F.3d 506 (5th Cir. 2008) (actuary who provided actuarial services for union pension board did not commit actuarial malpractice under ASOP of the Actuarial Standards Board

in failing to affirmatively state her opinion on whether board should adopt proposals for additional benefits; once actuary provided the board with estimates regarding actuarial cost of paying the additional benefits, and advised the board it should take into account recent market decline in making its decision, she met her duty under the ASOP). And nowhere do Plaintiffs suggest, in any way, that any of Angell's calculations were inaccurate.

Instead, Plaintiffs complain that Angell "negligently communicated directly with Plan participants concerning the Plan and the interests of Plan participants concerning the Plan." (FAC ¶ 509.) Plaintiffs are unclear on which communications are supposedly negligent, but presumably they are: (i) the truthful warning that Angell could not speak to the future solvency of the Plan, which Angell agreed to give over the phone if asked, but which Plaintiffs have not alleged was ever given to any Plan participant; (ii) the PowerPoint presentations of 2014 and 2016; or (iii) the statements given to participants estimating their benefits in the Plan. Each of these communications is discussed in detail in Section (C), *infra*, relating to supposedly fraudulent communications. For the same reasons that these communications were not fraudulent or harmful, they also do not constitute actuarial malpractice, and caused Plan participants no harm that is alleged in the FAC.

It appears that Plaintiffs also challenge particular actions taken when Angell supposedly acted as CCCB's and SJHSRI's actuarial "consultant" in connection with the application for regulatory approval of the conversion of the hospitals to for-profit entities in 2014. (FAC ¶ 323.) Specifically:

- Plaintiffs allege that in 2013 Angell had provided CCCB and SJHSRI with calculations demonstrating that – if $14 million were contributed to the Plan, and assuming a future rate of return of 7.75% – the Plan would run out of funds in 2034 with over $99 million in unpaid liabilities. (*Id*. ¶ 325.)

- Plaintiffs allege that in early 2014 Angell provided CCCB and SJHSRI with an

updated calculation based on slightly higher value of Plan assets at the beginning of 2014 (which showed the Plan would run out of funds in 2036), and also provided an "alternative" calculation that used a lower rate of return of 5.75% (under which the Plan would run out of assets in 2030). (*Id*. ¶ 326.)

- Plaintiffs allege CCCB and SJHSRI "asked Angell to modify that calculation for submission to the Attorney General and the Department of Health" to utilize *only* the higher projected rate of 7.75%, delete all calculations post-2014, and show *only* the stabilization effect in 2014 of the incoming $14 million to the Plan without further information. (*Id*. ¶ 330.)

- Plaintiffs claim that Angell was being asked to present the 2014 funding level in isolation, so that it could be provided *by other defendants* to the Attorney General and the Department of Health, knowing it would be "misleading." (*Id.* ¶¶ 332-333.)

- Plaintiffs allege that Angell did, in fact, provide the "requested new calculation" showing the immediate effect of the $14 million contribution would be to increase the funding percentage of the Plan to 94.9% (the "94.9% Projection"). (*Id.* ¶ 333.)

Plaintiffs then seemingly challenge two aspects of Angell's conduct in connection with this request from CCCB and SJHSRI.

- *Use of 7.75% as the rate of return*

First, Plaintiffs contend that the calculation did not disclose that the Plan's projected rate of return (7.75%) was "over 68% greater than the market rate of 4.6%." (*Id.* ¶ 334.) However, Plaintiffs do not allege any ASOP was violated by using 7.75% as the Plan's projected rate. And, the 94.9% Projection did disclose the 7.75% rate twice, as well as the fact that the rate of return assumption was selected by SJHSRI, not by Angell. (Ex. D, at 1.) In addition, Angell also provided projections using a return of 5.75%. (FAC ¶ 326.) There is no allegation that supports the proposition that Angell would know, better than anyone else, what future investment returns would be. Angell was hired to perform actuarial calculations, not predict the future of the stock market.

- *94.9% Projection*

Second, Plaintiffs contend that Angell should not have provided the 94.9% Projection to

SJHSRI, unattached to their other calculations, knowing that projection would be given to the regulators. (FAC ¶¶ 333-334.) In this regard, it appears that Plaintiffs do not contest the accuracy of any of the information provided by Angell, but only its completeness. Plaintiffs complain that Angell should have disclosed, "the fact that the use of any funding level percentage as a measure of the Plan's funding progress was contrary to and deviated from the standards of actuarial practice, that according to those standards the funding progress of a pension plan should not be reduced to a funding percentage at a single point in time, [and] that pension plans should have a strategy in place to attain and maintain a funded status of 100% or greater over a reasonable period of time, not merely at a single point in time." (*Id.* ¶ 335.)

However, a mere glance at the actual 94.9% Projection, which Plaintiffs conveniently omit, shows that the funding progress of the Plan is ***not*** reduced to a single point in time. The 94.9% Projection, upon which Plaintiffs rest virtually their entire case against Angell, is shockingly misrepresented in the FAC. To begin with, it shows the funded percentage in three successive years, not at a single point in time. (Ex. D, at 2.) It also shows a future annual funding requirement of $1,291,000 *after* the $14 million contribution. (*Id.*) It also contains within it "disclosures" that the results are "for illustrative purposes only and are estimates," and that the "results do not reflect all possible future funding and account costs," and that "the actual results at a future date will be based on" future demographics, asset values and assumptions. (*Id.* at 1.) Thus, Plaintiffs' complaints about lack of disclosure are frivolous.

Furthermore, the allegations show that Angell provided numerous scenarios and measures to its client, as well as using multiple projected rates of return, and covering a projection period going at least to the year 2036. (FAC ¶¶ 325-333.) And, the regulators clearly knew that future contributions would be required. *See supra*, at pp. 7-10. And, there is simply no allegation that

Angell had discretion or responsibility to decide what information should be provided to the regulators.

Further, the 94.9% funding level plainly and obviously indicates that the $14 million contribution was nevertheless insufficient to pay 100% of Plan benefits. In case the fact that 94.9% is less than 100% might have been too subtle for the regulators, the 94.9% Projection *also* showed that the "unfunded actuarial accrued liability" after the $14 million contribution would be $9,442,000 under the assumptions used; *and* that the recommended annual contribution would still be $1,291,000; *and* that "the recommended contribution is an estimate that is subject to change based on the Plan assets. . . " (Ex. D, at 2.) Thus, it is impossible to see how this revised 94.9% Projection could have deceived *anyone* into thinking the Plan would *not* run out of money absent future contributions.

B. Plaintiffs' state law claims are preempted by ERISA.

Plaintiffs contend that the Plan is governed by ERISA. (FAC ¶ 30.) By its plain terms, ERISA broadly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (ERISA preemption is "conspicuous for its breadth."). "The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C. § 1144(c)(1). In adopting 29 U.S.C. § 1144(a), Congress deliberately rejected narrower preemption language directed at "state laws relating to the *specific subjects* covered by ERISA," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) (emphasis added), choosing instead to supplant all state laws that "relate to" ERISA-regulated plans.

In *Shaw,* the Supreme Court observed that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. Indeed, ERISA preempts a state law that has a connection with or refers to an ERISA-

regulated benefit plan, "even if the law is not specifically designed to affect such plans, or the effect is only indirect, and even if the law is consistent with ERISA's substantive requirements." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 (1992) (internal quotation marks and citations omitted); *see also Rosario-Cordero v. Crowley Towing & Transp. Co*., 46 F.3d 120, 123 (1st Cir. 1995) ("[A] state law may relate to an employee benefit plan even though the law does not conflict with ERISA's own requirements. . . . ").

While not always clearly specified, Plaintiffs apparently rely on Rhode Island law in bringing their remaining claims against Angell. (*See* Counts VII, VIII, IX, XVI, XVIII, XIX, XXI, XXII, XXIII.) However, these Counts all relate to work Angell did for the Plan, including information that Angell provided regarding the Plan's funded status and/or communications between Angell and Plan participants about benefits. (*Id.*) Thus, to the extent Plaintiffs attempt to rely on state law to support these Counts, such laws are preempted as all of the conduct at issue directly "relates to" the Plan, which Plaintiffs claim is subject to ERISA. 29 U.S.C. § 1144(a); *see, e.g., Carlo v. Reed Rolled Thread Die Co.,* 49 F.3d 790, 794 (1st Cir. 1995) (misrepresentation claim was preempted by ERISA because a computation of damages would require the court's "inquiry must be directed to the plan."); *Vartanian v. Monsanto Co.,* 14 F.3d 697 (1st Cir. 1994) (state-law claim of misrepresentation was preempted by ERISA because in order for the plaintiff to prevail the court would have to find that a plan existed); *Pemental v. Sedgwick Claims Mgmt. Sys., Inc.,* No. 14-45-M, 2014 WL 2048279, at *5 (D.R.I. May 19, 2014) ("the Plan is 'related to' the cause of action and [therefore] ERISA preempts [plaintiff's] fraud claim"); *Lemanski v. Lenox Sav. Bank*, No. 95-30074-MAP, 1996 WL 253315, at *13 (D. Mass. Apr. 12, 1996) ("Plaintiff's breach of contract, declaratory judgment and injunction claims are expressly preempted by ERISA because in order to prevail he must plead, as he has, and the court must find, as it does, that an

ERISA plan exists.").

Further, it is well established that ERISA's civil remedies provision provides the exclusive remedies for violations of the conduct regulated by ERISA. In *Pilot Life Ins. Co. v. Dedeaux*, the Supreme Court concluded that "[t]he deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive." 481 U.S. 41, 54 (1987). The Supreme Court explained:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. (state law claims for, *inter alia,* breach of fiduciary duties and fraud in the inducement were preempted by ERISA).

In this regard, courts within this Circuit have routinely found that state common law claims (such as those specific claims asserted against Angell here) fall within ERISA's exclusive civil enforcement regime and are preempted. *See, e.g., Mauser v. Raytheon Co. Pension Plan for Salaried Emps.*, 239 F.3d 51, 58 (1st Cir. 2001) (ERISA preempted breach of fiduciary duty claim); *Stamp v. Metro. Life Ins. Co.*, 466 F. Supp. 2d 422, 429 (D.R.I. 2006) ("to the extent Plaintiff asserts a common law breach of fiduciary duty claim, that claim is preempted by ERISA"); *Stenmark v. Bank of Am. Corp.,* No. 05-312 ML, 2006 WL 2474871, at *2 (D.R.I. Aug. 24, 2006) (state-law claims of fraud and negligent misrepresentation preempted by ERISA); *Simmons v. Serv. Credit Union*, No. 17-cv-159-PB, 2018 WL 1251628, at *4 (D.N.H. Mar. 12, 2018) ("Because [plaintiff's] breach of contract and declaratory judgment claims seek to enforce rights

provided under that plan, his claims are completely preempted by ERISA.").[22]

C. Plaintiffs fail to state a claim against Angell for fraud or conspiracy.

Rule 9(b) governs a claim "where the core allegations effectively charge fraud." *N. Am. Catholic Educ. Programming Found., Inc. v. Cardinale*, 567 F.3d 8, 15 (1st Cir. 2009). Rule 9(b) requires Plaintiff to state with particularity "the circumstances constituting fraud or mistake." *Id.* at 13. Even if not preempted, Plaintiffs' allegations fall far short of any plausible implication that Angell participated in, or was a co-conspirator in, any fraud.

1. Angell did not make any fraudulent misrepresentations to participants (Count VII).

In Paragraph 259 of the FAC, Plaintiffs generally allege that a group of Defendants:

> . . . made or provided statements to Plan participants, on different occasions, in many different contexts, over many years, and using plain language, that assured Plan participants that the Plan was an earned benefit of their employment, that the contributions necessary to properly fund the Plan were being made, that it was management's policy, practice and duty to do so, and that SJHSRI and not the Plan participants bore the risk of Plan assets not earning expected returns or incurring investment losses.

(FAC ¶ 259.) However, Plaintiffs do not include any specific factual allegations tying these "statements" made "on different occasions, in many different contexts" to any particular Defendant(s). (*Id.* at ¶¶ 259, 283; *see also* ¶ 279 (discussing a pamphlet provided to Plan participants without identifying the sender).) Plaintiffs' generalized references to "statements" or other types of communications without specifically identifying the pertinent facts surrounding the "who, what, where, and when" the communication was sent (and by whom), does not meet the heightened pleading standards for fraud under Rule 9(b). *Doyle v. Hasbro, Inc.,* 103 F.3d 186, 194 (1st Cir. 1996). Further, grouping the Defendant(s) together in this manner fails to satisfy the requirement that the "who" be pled with specificity. *See King v. Wells Fargo Home Mortg.,* No.

[22] To avoid duplication, Angell also adopts and incorporates by reference the arguments of Prospect Entities with respect to ERISA preemption.

11-10781-GAO, 2013 WL 1196664, at *2 (D. Mass. Mar. 25, 2013) (lumping parties all together as "defendants" is "not sufficient"); *Archdiocese of San Salvador v. FM Int'l, Inc.,* No. 05-cv-237-JD, 2006 WL 437493, at *7-8 (D.N.H. Feb. 23, 2006) (noting that when a the complaint "group[s] all claimed wrongdoers together in a single set of allegations," it is insufficient under Rule 9(b)).

In this regard, the vast majority of the supposedly misleading statements were allegedly made by individuals and entities *other* than Angell, and long before Angell began providing actuarial services for the Plan in 2005. (*See* FAC ¶¶ 265-287.) For example, Plaintiffs allege that certain representations were made in various "booklets" (*id.* ¶¶ 265-266, 268-269), but these "booklets" were allegedly drafted and revised by SJHSRI (*id.* ¶ 271), *not* Angell. Plaintiffs also allege various other statements or representations were made by SJHSRI (*id.* ¶¶ 273-274, 280, 281, 284, 285, 286, 287), SJHSRI's Presidents (*id.* ¶¶ 267, 274-275), the Diocese Retirement Board (*id.* ¶ 272), the Bishop (*id.* ¶¶ 276-278) and the Diocese (*id.* ¶¶ 276-278). None of these statements allegedly made by other individuals and entities can be "attributed" to Angell simply by implication.[23]

There are just ***three*** specific types of participant communications alleged in the FAC that even remotely reference Angell, and none of them meet the elements for a "fraudulent misrepresentation." *See Francisco v. U.S. Marshalls Serv.*, No. 11-23IL, 2014 WL 652147, at *13 (D.R.I. Feb. 19, 2014) (elements for fraudulent misrepresentation are "a [misrepresentation] intending thereby to induce plaintiff to rely thereon' and that the plaintiff justifiably relied thereon

[23] *E.g., Potter v. Retail Automation Prods.,* Inc., No. 13-cv-4506 (GBD), 2014 WL 494521, at *2 (S.D.N.Y. Feb. 5, 2014) ("Where allegations of fraud involve multiple defendants, the complaint must set forth allegations specifically attributable to each individual defendant."); *Angermeir v. Cohen,* 14 F. Supp. 3d 134, 147 (S.D.N.Y. 2014) ("a bare allegation of an individual defendant's affiliation with entities allegedly committing fraudulent acts is not enough to satisfy Rule 9(b).")(collecting cases).

to his or her damage.").

- *Participant Statements*

Plaintiffs allege that *Angell* provided Plan participants with "statements" setting forth "specific projected lifetime benefits," despite knowing that the Plan was underfunded. (FAC ¶ 291; *see also* Ex. E.) However, as the FAC makes clear, the participant statements begin by saying, "*St. Joseph Health Services of Rhode Island* is pleased to give you this statement showing your estimated benefits." (FAC ¶ 280.) (emphasis added). There is no allegation that Angell was in in any way responsible for the text in the statements provided *by SJHSRI*.

Further, Plaintiffs highlight the fact that these participant statements included the following language: "Benefits are paid from a secure trust fund" and "The Plan is entirely paid for by St. Joseph Health Services of RI. There is no cost to you." (*Id.* ¶ 280.) Such statements are accurate and, therefore, cannot form the basis of any misrepresentation claim. Moreover, the statements expressly state: "These figures are not a promise or guarantee of any future benefits." (Ex. E, at 1.) Such language was conveniently omitted from Plaintiffs' FAC. Plaintiffs cannot seriously contend these participant statements were part of a conspiracy to fraudulently convince participants that their benefits *are* guaranteed.[24]

Finally, as shown on the face of these statements, they clearly identified that the projections were "estimates." (Ex. E.) Such "estimates" are merely "opinions" and "cannot form the basis for a misrepresentation claim" as a matter of law. *In re Frusher*, 146 B.R. 594, 597 (Bankr. D.R.I. 1992), *aff'd sub nom.*, *Frusher v. Baskin-Robbins Ice Cream Co.*, 43 F.3d 1456 (1st Cir. 1994); *see also 514 Broadway Inv. Tr., UDT 8/22/05 ex rel. Blechman v. Rapoza,* 816 F. Supp. 2d 128,

[24] Plaintiffs contend that the reference "lifetime benefits" is fraudulent. This makes no sense. The plan promises benefits for life in various payment forms, all of which promise payments lasting at least as long as the participant lives. No other description would be accurate.

139 (D.R.I. 2011) ("[an] action for common-law fraud, or deceit, requires a showing of a false statement of fact, not an opinion or estimate . . ."); *St. Paul Fire & Marine Ins. Co. v. Russo Bros.,* 641 A.2d 1297, 1299, n.2 (R.I. 1994) ("The general rule is that a misrepresentation should take the form of an expression of fact and not the offering of an opinion or estimate."). Nor can Plaintiffs plausibly demonstrate any reasonable reliance on such "estimates." *Livick v. The Gillette Co.,* 524 F.3d 24, 32-33 (1st Cir. 2008) (affirming defense summary judgment on basis that employee could not reasonably rely on erroneous pension benefit "estimates"); *Green v. ExxonMobil Corp.,* 413 F. Supp. 2d 103, 113 (D.R.I. 2006) (". . . no reasonable person would have depended on the prospect of a payment labeled an 'estimate.' Accordingly, there was no reasonable detrimental reliance by Plaintiffs on the April 11th letter.").

- *PowerPoint Presentations*

Plaintiffs allege that Angell, and other Defendants, "participated" in PowerPoint presentations to SJHSRI employees in April 2014 intending to reassure them that the sale of the hospital to Prospect Medical would not affect their pension benefits. (FAC ¶ 292; Ex. B.) Plaintiffs challenge four statements from the 14-page presentation:

- "[The MOA signed on January 28, 2014] includes a $14 Million contribution to the Pension Plan to stabilize plan assets." (FAC ¶ 292; Ex. B, at 4.)
- A sample benefit statement which stated that "[y]our pension benefit is an important part of your future retirement income." (FAC ¶ 292; Ex. B, at 6.)[25]
- "The Hospital pays the entire cost of the Plan." (FAC ¶ 292; Ex. B, at 8.)
- References to payment options that include annuity payments for life. (FAC ¶ 292; Ex. B, at 9.)[26]

[25] Plaintiffs' repeated complaints about this statement are inexplicable. If anything, the FAC as a whole emphasizes the fact that the pension benefit ***is*** important to the Plan participants.

[26] Once again, Plaintiffs' repeated complaints about this statement are inexplicable. The Plan ***does*** promise annuities for life. How else could the benefits be described?

None of the statements are false. To the extent they are in any way misleading, it is only because of the inability of the Plan sponsor to make future contributions to the Plan. Plaintiffs have not alleged any facts from which it could be inferred that Angell knew that future contributions would not be forthcoming. And even if these statements were false, Plaintiffs allege only that Angell "participated" in the presentation, but do not allege that Angell actually made any particular statements. This is insufficient to state a claim against Angell under Rule 9(b). *See* cases cited *supra* at pp. 31-32.

Plaintiffs then allege that Angell "worked with" other Defendants to prepare and make another PowerPoint presentation in 2016, two years after the sale of the hospital and all regulatory approvals. (*Id.* ¶¶ 315-318.) Regarding this presentation, Plaintiffs complain that the statement, "the hospital pays the entire cost of the Plan" was no longer accurate because SJHSRI no longer owned the hospital. (*Id.* ¶ 316). However, Plaintiffs again conveniently fail to attach the actual document, which shows that this statement was contained in a reproduction of a statement issued two years prior, when the statement was true. (Ex. C, at 7.) Moreover, the entirety of the presentation (about the mechanics of Plan benefits and the application process) did not hide who was responsible for Plan funding, as it also stated that "[t]he Plan is entirely paid for by St. Joseph Health Services of Rhode Island." (Ex. C, at 5.)

Plaintiffs also allege that the 2016 PowerPoint was fraudulent in failing to alert Plan participants that their Plan benefits were not protected by ERISA. (*Id.* ¶ 317.) However, this allegation is particularly bizarre, considering that:

- Plaintiffs do not allege that any defendant ever represented to any Plan participant that the Plan *was* covered by ERISA; and
- Plaintiffs also allege that Plan benefits *are* protected by ERISA.

It cannot possibly be fraudulent to fail to make an untrue statement. Since Plaintiffs allege that the Plan benefits *are* protected by ERISA, it cannot be fraudulent to fail to state that they are *not* protected by ERISA.

- *Telephone Calls*

Plaintiffs allege that, two months *after* the sale, the Prospect Entities "instructed" Angell not to provide Plan participants with the information they were seeking concerning the solvency of the Plan. (FAC ¶¶ 306, 308.) According to Plaintiffs, the Prospect Entities "instructed" Angell to tell Plan participants that:

> . . . while we [Angell] can't speak to the future solvency of the plan, we can share that the plan administrators review the annual recommended funding as advised by the plan's actuaries each year. There is also an investment committee that reviews and monitors the plan on an ongoing basis.

(*Id.*)

Plaintiffs do not identify any specific individual or participant who was "told" this statement, or specific contents of any such conversation, and Plaintiffs do not allege that Angell ever made the statement to anyone. Therefore, this allegation cannot form the basis of any "fraudulent misrepresentation" claim because Plaintiffs have not alleged that the statement was ever made, nor have Plaintiffs alleged the "who, what, where, and when" to meet the heightened pleading standards for fraud under Rule 9(b). *Doyle*, 103 F.3d at 194.

Furthermore, despite Plaintiffs' conclusory allegation to the contrary (FAC ¶ 309), these statements are demonstrably ***true***. Angell was not authorized to speak to the future solvency of the Plan, because it was instructed not to do so. The Plan administrators did review the annual recommended funding as advised by the Plan's actuaries each year and there was an investment committee that reviews and monitors the Plan on an ongoing basis. (*Id* ¶¶ 233, 240-247.)

Moreover, it is unclear how these statements would lull participants into complacency

about the concerns they already had about the Plan's solvency. The three representations taken together are more likely to be alarming than comforting. They pointedly do not suggest the Plan will be solvent, or even that the Hospital was making the recommended contributions. If anything, such statements are a clear signal that Angell was *not* assuring participants of the solvency of the Plan.

2. Angell did not conceal information from participants (Count VII).

Plaintiffs also claim that Angell "never" informed participants about the Plan's underfunded status. (FAC ¶¶ 288-290). However, Angell had no legal duty to inform participants of anything. *Francisco*, 2014 WL 652147, at *13 ("Fraudulent concealment also requires intent to induce reliance and detrimental reliance, but it is grounded on the failure to disclose a material fact as opposed to an affirmative misrepresentation. A claim of fraudulent concealment is not actionable absent a duty to disclose."). Plaintiffs do not allege that Angell is a fiduciary to the Plan and, therefore, Angell does not have a fiduciary duty to make "disclosures" concerning the Plan. (FAC ¶ 289.). And Angell does not have a contract with the participants such that they are owed any "duty [by Angell] to exercise reasonable care." (*Id.*) Further, Plaintiffs do not allege that Angell had any discretion over what to communicate to participants about the Plan, as opposed to simply conveying the information it was instructed to provide. (*Id.* ¶ 306 (noting that Angell "sought *instructions* from Prospect Chartercare (through Brenda Ketner) as to how Angell should respond to Plan participants who were seeking information concerning the solvency of the Plan.").) Furthermore, the alleged telephonic response ("we [Angell] can't speak to the future solvency of the plan") (*id.* ¶ 308) *explicitly* put participants on notice of what was *not* being disclosed – the future solvency of the Plan. So, there was no concealment.

Finally, Plaintiffs have not alleged any particular damage resulting from any of these communications. Plaintiffs have not alleged that any of them would have gotten a different job

with a more secure pension, or taken any other alternative action, had they known more about the funding status of the Plan. Any such allegation would be purely speculative in any event.

3. <u>There are no facts suggesting Angell's participation in any civil conspiracy (Count IX).</u>

Plaintiffs' attempt to assert a claim against Angell for civil "conspiracy" falls woefully short. Civil conspiracy is "rarely pleaded." *Read & Lundy, Inc. v. Washington Tr. Co. of Westerly*, No. PC99-2859, 2002 WL 31867868, at *17 (R.I Super. 2002) *aff'd* 840 A.2d 1099, 1102 (R.I. 2004). A civil conspiracy is an "agreement between two or more parties . . . to accomplish an unlawful objective or to accomplish a lawful objective by unlawful means." *Smith v. O'Connell*, 997 F. Supp. 226, 241 (D.R.I. 1998), *aff'd sub nom. Kelly v. Marcantonio*, 187 F.3d 192, 203 (1st Cir. 1999). "A civil conspiracy claim requires the specific intent to do something illegal or tortious." *Guilbeault v. R.J. Reynolds Tobacco Co.*, 84 F. Supp. 2d 263, 268 (D.R.I. 2000). Significantly, "conspiracy claims must be pled with some degree of specificity." *Prall v. Bush*, No. CA 10–16 S, 2010 WL 717780, at *2 (D.R.I. Mar. 1, 2010) (Smith, J.) (citations omitted).

Here, Plaintiffs have attempted to plead a "conspiracy" between and among certain Defendants to supposedly conceal from Plan participants that the Plan was really an ERISA Plan (not a Church Plan), and that SJHSRI was not making necessary contributions to the Plan, "through fraudulent misrepresentations and material omissions." (FAC ¶ 55(b); Count IX.) However, there are no factual allegations that Angell "agreed" to violate the law, or had any "specific intent" to do so. Nor is there any allegation that Angell carried out a single act in furtherance of any such "conspiracy." *Read*, 2002 WL 318867868, at *17 ("The mere common plan, design or even express agreement is not enough for liability in itself, and there must be acts of a tortious character in carrying it into execution.") (citations omitted). Rather, as discussed above, Plaintiffs have not

alleged any specific misrepresentation by Angell at any specific time or to any specific person, nor have Plaintiffs alleged any particular omission by Angell at any time, to any person; nor have Plaintiffs plausibly alleged any reason that Angell would be obligated to inform anyone other than its own client, which knew that it was not making contributions. Plaintiffs' FAC is simply devoid of any factual allegations supporting Angell's participation in any such "conspiracy."[27]

On the contrary, the facts alleged demonstrate that Angell made no effort – let alone had any specific intent – to violate the law. Plaintiffs repeatedly allege that Angell *advised* SJHSRI to meet necessary funding obligations. (FAC ¶¶ 63, 64, 233, 240, 244-247, 273, 308, 309, 346, 352.) Such factual allegations demonstrate that Angell was acting with a *lawful* purpose –*i.e.,* advising its client to *comply* with the law, not *disobey* it. *Read*, 2002 WL 318867868, *20 ("Evidence that is equally consistent with a lawful purpose as with an unlawful one is simply insufficient to establish a claim of civil conspiracy.")

Plaintiffs' reason for including Angell in this "conspiracy" count is clear. Plaintiffs are trying to hold Angell "jointly liable" for the acts and statements made by *other* participants in the alleged conspiracy.[28] *Guilbeault,* 84 F.Supp.2d at 268 (civil conspiracy is a "means of establishing

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[27] *Prall,* 2010 WL 717780, *3 (Smith, J.) citing *Slotnick v. Garfinkle*, 632 F.2d 163, 166 (1st Cir. 1980) (noting that plaintiff's complaint "neither elaborates nor substantiates its bald claims that certain defendants 'conspired' with one another"); *Johnson v. Reese*, C.A. No. 2:08–CV–830–TMH, 2008 WL 5111200, at *4 (M.D. Ala. Dec. 3, 2008) (noting that "merely 'stringing together' acts, without showing parties 'reached an understanding' to violate plaintiff's rights, is insufficient to demonstrate the existence of a conspiracy" and stating that "[o]ther than his suppositious allegation, [the plaintiff] presents nothing, nor can this court countenance any evidence, which would indicate that the defendants entered into a conspiracy to deprive [the plaintiff] of his constitutional rights")(quoting *Harvey v. Harvey*, 949 F.2d 1127, 1133 (11th Cir. 1992)); *Dozier v. Price*, Civil Action No. 2:08cv762–WHA, 2008 WL 4808857, at *4 (M.D.Ala. Oct. 31, 2008) (noting that "assertions made by [the plaintiff] are self-serving, purely conclusory allegations that fail to assert those material facts necessary to establish the existence of a conspiracy between the defendants").

[28] *E.g.*, FAC ¶¶ 318, 338, 340, 342, 345, 354, 355, 361, 362, 370, 372.

joint liability for tortious conduct.") But bare, conclusory accusations of participation in a "conspiracy" are not sufficient to pass muster under Rule 9(b). Such allegations must be pled with more facts and particularity, otherwise the requirement to plead fraud with particularity would be illusory. *Hayduk v. Lanna*, 775 F.2d 441, 444 (1st Cir. 1985) ("[M]ere allegations of fraud, corruption or conspiracy, averments to conditions of mind, or referrals to plans and schemes are too conclusional to satisfy the particularity requirement, no matter how many times such accusations are repeated."); *see also Slotnick*, 632 F.2d at 165 ("allegations of conspiracy must nevertheless be supported by material facts, not merely conclusory statements.") (internal citation omitted); *Johnson,* 2008 WL 5111200, at *4 ("A conspiracy claim justifiably may be dismissed because of the conclusory, vague and general nature of the allegations.")

Thus, Plaintiffs' conclusory claim for "conspiracy" against Angell fundamentally fails and should be dismissed.

4. <u>There is no independent cause of action for a so-called "fraudulent scheme" (Count VIII).</u>

Count VIII purports to state a claim for "fraudulent scheme." However, Plaintiffs fail to identify any supporting legal authority that this is a stand-alone cause of action, independent from their claims for fraud (Count VII) and conspiracy (Count IX). Rather, any supposed "fraudulent scheme" is simply an element of, and subsumed by Counts VII and IX. *See, e.g. Sheet Metal Workers Local No. 20 Welfare & Benefit Fund v. CVS Health Corp.*, 221 F. Supp. 3d 227, 239 (D.R.I. 2016) ("Because the Court finds that Plaintiffs have sufficiently alleged a fraudulent scheme, the unjust enrichment claim may also go forward."); *W. Reserve Life Assur. Co. of Ohio v. Caramadre*, 847 F. Supp. 2d 329, 341 (D.R.I. 2012) ("Plaintiffs are correct that the Sponsors' orchestration of the fraudulent scheme may support a claim for civil conspiracy."). Thus, Count VIII should be dismissed for this reason alone.

In any event, for the reasons set forth above, Plaintiffs have not alleged with any particularity Angell's role in any "fraudulent scheme" to satisfy Rule 9(b). *See supra* at pp. 31-40.

D. Plaintiffs fail to state a claim for violation of the Rhode Island Hospital Conversions Act (Count XVI).

Count XVI purports to state a claim against Angell under R.I. Gen. Laws § 9-1-2 which creates a civil cause of action, against an "offender," for damages suffered as a result of the commission of a crime. The FAC alleges that "Defendants' conduct constituted crimes or offenses under R.I. Gen. Laws § 23-17.14-30" for failure to comply with Rhode Island's Hospital Conversions Act ("HCA"). (FAC ¶ 533.) Notwithstanding this general allegation, Count XVI fails because the Plaintiffs do not allege any violation of the HCA ***by Angell***.[29]

As set forth in more detail above, the FAC alleges that Angell: (1) acted as a "consultant" to SJHSRI and CCCB in connection with the application for approval of the conversion of Fatima and Roger Williams Hospitals to for-profit facilities (FAC ¶ 323); (2) prepared a March 27, 2014 calculation estimating that, after a $14,000,000 contribution to the Plan and at an assumed rate of return of 7.75%, the Plan would run out of assets in 2036 with $98 million in remaining liabilities (*id.* ¶ 326);[30] and (3) as requested, provided this calculation to SJHSRI and CCCB independently of other calculations that had been provided previously (*id.* ¶¶ 330, 333). The FAC goes on to allege that SJHSRI, CCCB and certain of their officers made intentionally misleading statements

[29] A more extensive analysis of the reasons that Plaintiffs have no claim relating to HCA is contained in the memorandum of law to be submitted concurrently with this memorandum by Defendants Roman Catholic Bishop of Providence, Diocesan Administration Corporation, and Diocesan Service Corporation (collectively, "Diocesan Defendants"). To avoid duplication, Angell adopts and incorporates by reference the arguments of Diocesan Defendants with respect to Count XVI and the HCA.

[30] As explained below, state regulators were well aware that the rate of return on Plan assets could be less than 7.75%.

regarding the Plan's funding status to the Project Review Committee evaluating the HCA applications. (*Id.* ¶¶ 339, 341, 344.) Critically, the FAC does not identify a single statement made by Angell to any regulator, let alone an intentionally false or incorrect statement which would constitute a violation of the HCA. *See* R.I. Gen. Laws § 23-17.14-30. Indeed, according to the FAC the alleged false statements made to regulators were made by Defendants *other than Angell* who indicated that they *would* comply with Angell's funding recommendations while not intending to do so. (*Id.* ¶¶ 345, 352, 353, 355.)

These allegations, held alongside the HCA, show that the Plaintiffs have failed to state a claim against Angell under R.I. Gen. Laws § 9-1-2. The HCA criminalizes three types of conduct: (1) knowing violations of the act; (2) willingly or knowingly providing false or incorrect information to regulators; and (3) the giving of false testimony under oath to the legislature, the Department of Health or the Attorney General in connection with a conversion application. *See* R.I. Gen. Laws §§ 23-17.14-17 and 23-17.14-30.

There is no allegation that Angell provided sworn testimony to the legislature, the Attorney General or the Department of Health in connection with the HCA proceedings, and, therefore, Angell could not have violated R.I. Gen. Laws § 23-17.14-17. The only conceivably remaining predicate act to support a claim under RI. Gen. Laws § 9-1-2 would be that Angell willingly or knowingly provided false or incorrect information. *See* R.I. Gen. Laws § 23-17.14-30. However, such a claim necessarily fails for two reasons: (1) the FAC does not allege that Angell gave any information to regulators in connection with the HCA proceedings, let alone information that was known to be false or inaccurate; and (2) the FAC does not allege that any calculation performed by Angell was inaccurate.

With respect to information that was given to regulators, the FAC only alleges that, on April 9, 2014, CCCB asked Angell for assistance in answering an inquiry from the Attorney General who had asked for "documentation as to the determination that $14 m will stabilize the plan." (FAC ¶ 324). The next day, CCCB and SJHSRI requested that Angell "show only the stabilization effect of the incoming $14M to the plan with no other information shown" (FAC ¶ 330) which, stripped of histrionics, is simply a request that Angell perform the calculation necessary for the HCA applicants to answer a direct and specific question. The result is the 94.9% Projection that the Plaintiffs grossly mischaracterize in the FAC. Angell is not alleged to have given the 94.9% Projection to any regulator reviewing the pending applications under the HCA. Rather, the FAC alleges only that Angell performed the calculation requested by its clients (SJHSRI and CCCB) and provided it to them. (FAC ¶ 333). Angell's *clients* are the ones who allegedly provided the calculation to regulators considering the HCA applications. (*Id.*)

With respect to whether Angell's calculations were knowingly false or inaccurate, the 94.9% Projection accurately showed that the contribution of $14 million to the Plan would result in the Plan being less than fully funded such that it would necessarily run out of money if the assumptions used in the calculations proved correct. (FAC ¶¶ 333, 342.) Plaintiffs complain that Angell did not specifically disclose that the assumed rate of return used in its calculation was higher than that used to calculate the unfunded liability of other pension plans. (*Id.* ¶ 334.) However, the FAC itself shows that this does not make the calculation provided false or inaccurate. The assumed rate of return (7.75%) was disclosed in the 94.9% Projection, and the committee of regulators evaluating the HCA applications specifically inquired regarding the "investment risk" that is inherent in any calculation of future Plan liabilities, and asked what would happen if "investment returns don't match up to ***predictions***." (*Id.* ¶ 355.) (emphasis added). A prediction

cannot be knowingly false or incorrect since it is, by its very nature, an unknown. *See In re Frusher*, 146 B.R. at 597; *see also 514 Broadway Inv. Tr., UDT 8/22/05 ex rel. Blechman,* 816 F. Supp. 2d at 139; *St. Paul Fire & Marine Ins. Co.,* 641 A.2d at 1299, n.2 ("The general rule is that a misrepresentation should take the form of an expression of fact and not the offering of an opinion or estimate.").

Plaintiffs also complain that Angell somehow deceived regulators by calculating a funding percentage of the Plan at a given point in time. (FAC ¶ 335). But the disclosures contained in the 94.9% Projection plainly warned any potential readers of its limitations noting that the analysis was "for illustrative purposes only," that it did not account for "future funding and accounting costs," and that the future funding status of the Plan would depend upon participant demographics, asset values and assumptions. (Ex. D, at 1.) Critically, the 94.9% Projection made obvious to any reader that future funding of the Plan was required and included a recommended contribution of $1,391,000 for the Plan year beginning July 1, 2014. (*Id.* at p. 2.) Plaintiffs' mischaracterization of the 94.9% Projection as a basis for its claims against Angell under the HCA simply defies explanation.

In short, there is not a single factual allegation to support a claim that *Angell* violated the HCA. For these reasons, Plaintiffs have failed to state a claim against Angell under the HCA and R.I. Gen. Laws § 9-1-2.

E. Plaintiffs fail to state a claim for civil liability for violation of R.I. Gen. Laws § 11-18-1 (Count XVIII).

Similarly, Plaintiffs' claim against Angell under R.I. Gen. Laws §§ 9-1-2 and 11-18-1 (Count XVIII) is founded on a mischaracterization of documents in the Plaintiffs' possession that are predictably not attached to the FAC. R.I. Gen. Laws § 11-18-1 generally "prohibits anyone from knowingly giving to agents of public or private entities a document that contains a

materially false or erroneous statement, and which the person knows is intended to mislead *the public or private entity to which it is transmitted* in a material manner." *State v. Salvatore*, 763 A.2d 985, 990 (R.I. 2001). The claim that Angell is civilly liable under R.I. Gen. Laws § 9-1-2 for a violation of this statute fails for two reasons. First, the FAC does not allege that Angell distributed any documents that it knew to be false, erroneous or defective in any way. *See* R.I. Gen. Laws § 11-18-1. Second, the FAC does not allege that those documents that were given by Angell to others were intended to deceive a principal that was a public or private entity as required for culpability under R.I. Gen. Laws § 11-18-1.

The FAC is unclear with respect to which documents form the basis of Plaintiffs' claims against Angell, but Plaintiffs appear to allege that Angell provided four documents to others: (1) Participant Statements (FAC ¶ 291); (2) the PowerPoint presentations (*id.* ¶ 292); (3) a set of bar graphs showing various forecasts of Plan funding status under various funding scenarios (*id.* ¶¶ 300-302); and (4) the 94.9% Projection (*id.* ¶¶ 330-333). None of these documents can serve as the foundation for Plaintiffs' R.I. Gen. Laws § 11-18-1 claim against Angell because: (1) none of the documents are false, erroneous or defective, and (2) none of the documents were provided to an agent or employee with the intent to deceive a principal that was a public or private entity. Each of the documents is addressed in turn.

- *The Participant Statement*

As explained above (*supra* at pp. 33-34), the Participant Statements are not false, misleading or defective in any important particular. The Participant Statements accurately informed Plan participants that pension benefits were paid from a secure trust fund funded solely by SJHSRI, and that participants were not responsible for funding. (Ex. E.) These statements are true and the fact that they could have been misinterpreted as a guaranty that the Plan was, and

would remain, fully funded cannot form the basis of a claim that the Participant Statement was false within the meaning of R.I. Gen. Laws § 11-18-1. *See United States v. Good*, 326 F.3d 589, 592 (4th Cir. 2003) (dismissing an indictment under 18 U.S.C. § 1001 where defendants allegedly false statements were literally true); *see also Salvatore*, 763 A.2d at 990 (relying upon federal court decisions concerning 18 U.S.C. § 1001 to interpret the analogous provisions of R.I. Gen. Laws § 11-18-1).

The Participant Statements cannot support Plaintiffs' claim under R.I. Gen. Laws § 11-18-1 for the additional and independent reason that Participant Statements were not intended to deceive the employer of the employees receiving them. R.I. Gen. Laws § 11-18-1 is intended to protect public and private entities from deceit by way of documents provided to the agents and employees of those entities. *Salvatore*, 763 A.2d at 990. The Participant Statements were generated by SJHSRI, the entity employing the Plan participants to whom they were sent. (FAC ¶ 280) (noting that the Participant Statements begin by saying, "[SJHSRI] is pleased to give you this statement.") For Plaintiffs' R.I. Gen. Laws § 11-18-1 claim to succeed, they would have to establish an impossible set of facts, *i.e.,* that SJHSRI deceived itself by providing the Participant Statements to its employees. Even assuming that Plaintiffs' theory is that Angell made the alleged misstatements in the Participant Statement, which it did not, the FAC fails to allege that the Participant Statements were sent with an intent to deceive the employer or principal of the Plan participants, *i.e.,* SJHSRI.

- *The PowerPoint Presentations*

The PowerPoint presentations cited in the FAC are similarly insufficient to support Plaintiffs' claims under R.I. Gen. Laws § 11-18-1. First, as explained above (*supra* at pp. 34-36), the statements contained in the PowerPoint presentations were truthful, and therefore could not be

false, erroneous or defective in any "important particular." *See* R.I. Gen. Laws § 11-18-1. The PowerPoint presentations accurately conveyed that $14 million would be contributed to the Plan, but did not indicate in any manner that future funding of the Plan was unnecessary. (Ex. B). As explained above, the sample Participant Statement included in the PowerPoint presentations included the truthful statements that the Plan participants' benefits were an important part of their retirement income, that payment options of participants included lifetime annuity payments and that the Plan was employer, as opposed to employee, funded. (*Id.*) Because the contents of the PowerPoint presentations were accurate, they cannot support the Plaintiffs' claims under R.I. Gen. Laws § 11-18-1. *See Good*, 326 F.3d at 592; *see also Salvatore*, 763 A.2d at 990.

Furthermore, as with the Participant Statements, Plaintiffs have not alleged and cannot establish that the PowerPoint presentations were given to Plan participants in order to deceive the participants' employer or principal. The FAC alleges that the PowerPoint presentations were delivered to participants by "representatives of Angell . . . SJHSRI, RWH and CCCB" on April 29 and 30, 2014. (FAC ¶ 292.) Plaintiffs further allege that "Angell . . . SJHSRI, RWH and CCCB" knew the presentation was "grossly misleading and false on multiple levels." (*Id.* ¶ 293.) In the context of the Plaintiffs' R.I. Gen. Laws § 11-18-1 claims, these allegations would have to be taken to mean that SJHSRI, RWH and CCCB participated in a presentation to their employees with the intent to deceive themselves. This is a completely circular and nonsensical theory such that the PowerPoint presentations cannot form the basis of the Plaintiffs' R.I. Gen. Laws § 11-18-1 claims.

- *The Bar Graphs*

Plaintiffs' allege that Angell prepared a series of bar graphs showing the effect on the Plan of various funding scenarios to include: (1) continuing recommended contributions to the Plan; (2) an initial $14 million contribution followed by future recommended contributions; and (3) a $14

million contribution without future contributions (the "Bar Graphs"). (FAC ¶¶ 300, 302.) The Plaintiffs allege that these Bar Graphs were prepared by Angell "on behalf of" SJHSRI, RWH and CCCB. (*Id.* ¶ 300.) Plaintiffs allege that Christohper Callaci, an attorney for the United Nurses and Allied Professionals, "received" graphs showing the first two funding scenarios, but not the third. (*Id.* ¶ 300.) The FAC contains no allegations concerning who provided these graphs to Mr. Callaci.

The Bar Graphs cannot support Plaintiffs' R.I. Gen. Laws § 11-18-1 claims against Angell because there is no allegation that the graphs were false, erroneous or defective in any material respect. As explained above (*supra* at p. 6), all of the Bar Graphs plainly disclosed a need for future funding of the Plan. Plaintiffs cannot credibly claim that Mr. Callaci was deceived or misled in that regard by a graph showing that the Plan would remain underfunded by 30% even after a contribution of $14 million. Indeed, Plaintiffs do not allege that there was any inaccuracy in the Bar Graphs at all. That a recipient of the Bar Graphs may have misunderstood them is insufficient to support Plaintiffs' R.I. Gen. Laws § 11-18-1 claim against Angell. *See Good*, 326 F.3d at 592; *see also Salvatore*, 763 A.2d at 990.

Additionally, the fact that Angell prepared accurate graphs that were potentially misunderstood by someone who later "received" them cannot be the basis for liability under R.I. Gen. Laws § 11-18-1. Plaintiffs do not allege that Angell knew how, or with whom, the Bar Graphs would be shared. Plaintiffs similarly do not allege that Angell knew the Bar Graphs to be false, erroneous or defective in any way. The lack of such allegations is fatal to any claim against Angell under R.I. Gen. Laws § 11-18-1 that is based upon the Bar Graphs. Plaintiffs have not, and cannot, allege that Angell had the requisite intent to deceive a public or private entity by preparing accurate Bar Graphs demonstrating that future funding of the Plan would be required in

order to fully pay participants' benefits. *See State v. Smith*, 662 A.2d 1171, 1177 (R.I. 1995) (holding that R.I. Gen. Laws § 11-18-1 is only violated when a false document "is intended to mislead.")

- *The 94.9% Projection*

The last document upon which Plaintiffs *might* base their R.I. Gen. Laws § 11-18-1 claim against Angell is the 94.9% Projection that they have wantonly mischaracterized. Plaintiffs' calculated effort to gloss over the actual contents of the document, ironically as they accuse Angell of intending to mislead, can only advance their R.I. Gen. Laws § 11-18-1 claim if the Court ignores the allegedly false document that is the *sine qua non* of such a claim. Stated simply, the 94.9% Projection is accurate. A cursory review of the projection reveals a transparent description of the limitations of the analysis presented. (Ex. D, at 1.) Most importantly, the 94.9% Projection discloses the assumed rate of return on Plan investments and the fact that future funding of the Plan is required. (*Id.*) (noting that the results presented in the 94.9% Projection "do not reflect all possible future funding costs.") Indeed, the 94.9% Projection plainly includes a recommended future contribution for the year beginning July 1, 2014 of $1,391,000 and indicates that this estimated contribution would change based upon, among other things, the change in the assumed rate of return on Plan assets. (*Id.* at p. 2.) In order for Plaintiffs to prevail on their R.I. Gen. Laws § 11-18-1 claim based upon the 94.9% Projection, they "must negat[e] any reasonable interpretation that would make" the projection correct. *See United States v. Anderson*, 579 F.2d 455, 460 (8th Cir. 1978), *cert. denied*, 439 U.S. 980 (1978); *see also Salvatore*, 763 A.2d at 990 (relying upon federal court decisions concerning 18 U.S.C. § 1001 to interpret the analogous provisions of R.I. Gen. Laws § 11-18-1). Plaintiffs cannot negate every reasonable interpretation that would make the 94.9% Projection factually accurate. To the contrary, there is a singular

reasonable interpretation of the 94.9% Projection – that future contributions to the Plan would be required to fully fund it and the amount of the contributions would depend upon the future value of, and rate of return on, the Plan's assets. For these reasons, any R.I. Gen. Laws § 11-18-1 claim founded upon the 94.9% Projection must fail.

F. Plaintiffs fail to state a claim for civil liability for obtaining money or property under false pretenses (Count XIX).

Plaintiffs' claim that Angell obtained money or property under false pretenses in violation of R.I. Gen. Laws § 11-41-4 (Count XIX) is unsupported by any allegations in the FAC. In order to prove a claim under R.I. Gen. Laws § 11-41-4, a plaintiff must demonstrate: "that the accused: (1) obtain[ed] [money] from another designedly, by any false pretense or pretenses; and (2) with the intent to cheat or defraud." *State v. Grant*, 840 A.2d 541, 549 (R.I. 2004) *citing State v. Henshaw*, 557 A.2d 1204, 1207 (R.I. 1989) (citations and quotations omitted). The FAC simply does not contain a single allegation concerning Angell's receipt of money or property. The insufficiency of Count XIX with respect to Angell is so egregious as to raise the question of whether Plaintiffs actually intended to include Angell as a defendant with respect to the count.

G. Plaintiffs fail to state a claim for breach of fiduciary duty or aiding and abetting a breach of fiduciary duty (Counts XXI and XXII).

Count XXI purports to state a claim against Angell for "breach of fiduciary duty," presumably under Rhode Island law. Plaintiffs do not explicitly allege that Angell is a "fiduciary" but simply allege, in conclusory fashion, that Angell "owed Plaintiffs fiduciary duties." (FAC ¶¶ 551-53.) Such bare allegations are insufficient under *Iqbal/Twombly.* And Plaintiffs' allegations are belied by Angell's service agreement which expressly disclaims any fiduciary status. (Ex. A, at 1.)

Moreover, it is well-established that actuaries are *not* fiduciaries as a matter of law. *Geo. Knight & Co., Inc. v. Watson Wyatt & Co.,* 170 F.3d 210, 217 n.14 (1st Cir. 1999); *cf. United*

Teachers Assocs. Ins. Co. v. MacKeen & Bailey, Inc., 99 F.3d 645, 646–50 (5th Cir. 1996) (rejecting the notion that actuaries are, as a matter of law, fiduciaries). Rather, something "more" needs to be established "before elevating actuaries and accountants to fiduciary or other special status." *Erlich v. Oulette, Labonte, Roberge and Allen, P.A.*, 637 F.3d 32, 36 (1st Cir. 2011) (citing *Watson Wyatt & Co.*, 170 F.3D AT 215–16 (holding, under Massachusetts law, that an actuary did not occupy a position of trust and confidence with its client retirement plan in part because there was "nothing in the record to suggest that [the plan's] trust in [the actuary] resulted in its ceding control of [the plan's] management or assets to [the actuary]")); *Fleet Nat'l Bank v. H & D Entm't, Inc.*, 926 F. SUPP. 226, 242 (D. MASS. 1996), *aff'd*, 96 F.3D 532 (1ST CIR. 1996) (stating that, in the context of accountant-client relationship under Massachusetts law, "the weight of legal precedent — and common sense — stands for the proposition that an accountant takes on fiduciary obligations only where he or she recommends transactions, structures deals, and provides investment advice, such that he or she exercises some managerial control over the assets in question," not merely when "tasks performed . . . were ministerial in nature" and did not involve "management advice" or "discretionary control") (internal quotation marks, citations, and brackets omitted).

For all of the reasons discussed above, Plaintiffs have not alleged that Angell had any control over the Plan's management or assets to "elevate" Angell to fiduciary status. Angell did not fund the Plan, make decisions regarding the Plan's administration, or have any discretionary control over participant communications. Thus, Count XXI for fiduciary breach fails as alleged against Angell.

Moreover, as discussed above: (1) Angell had no "duty" other than to its client (SJHSRI) which it fully informed about the funding status of the Plan; (2) Angell was not involved in any

secret "meetings" or decisions; and (3) Angell had no discretion over communications with participants. Thus, Count XXII for "aiding and abetting a fiduciary breach" similarly fails as alleged against Angell.

H. Plaintiffs fail to state a claim for declaratory judgment (Count XXIII).

Plaintiffs have no right to a declaratory judgment under Rhode Island law (Count XXIII) because this action was filed in federal court. Federal courts proceeding under diversity or supplemental jurisdiction apply federal procedural law and state substantive law. *E.g., Essex Ins. Co. v. Westerly Granite Co.*, No. 14-241 ML, 2014 WL 4996693, at *1 (D.R.I. Oct. 7, 2014); *Keating v. Diamond State Ins. Co.*, No. 11-179S, 2013 WL 638929, at *2 (D.R.I. Feb. 20, 2013). "'Since the Declaratory Judgment Act is procedural in nature, federal law controls the question of whether a district court may grant declaratory relief in a given case.' Thus, the Court need not address the parties' contentions made pursuant to the Rhode Island Declaratory Judgment Act, R.I. Gen. Laws § 9–30–1 et seq." *Essex Ins. Co.*, 2014 WL 4996693, at *1 (internal citations omitted). Plaintiffs have already pled a claim for declaratory relief under federal law (Count IV, ERISA, Declaratory Relief), and such claim is their only possible declaratory relief claim. *See Sidou v. Unumprovident Corp.*, 245 F. Supp. 2d 207, 220 (D. Me. 2003) (construing declaratory judgment claim as a request for declaratory relief pursuant to ERISA). Accordingly, Count XXIII (Declaratory Judgment, Liability and Turn Over of Funds, State Law) should be dismissed with prejudice.

Moreover, to the extent Plaintiffs bring this claim pursuant to the Rhode Island Declaratory Judgment Act ("RIDJA"), then the PBGC must be joined as a party to this action. R.I. Gen. Laws § 9-30-11 (requiring that "all persons shall be made parties who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not

parties to the proceeding.") To that end and, for the reasons discussed in Section I *supra* at p. 12, this case should be dismissed pursuant to Fed. R. Civ. P. 12(b)(7) and 19 for failure to join the PBGC as a necessary party.

VI. THE COURT SHOULD GRANT THE MOTION TO DISMISS WITH PREJUDICE

Dismissal of Plaintiffs' FAC should be with prejudice. *See Hochendoner v. Genzyme Corp.*, 823 F.3d 724, 736 (1st Cir. 2016) ("the normal presumption is that a Rule 12(b)(6) dismissal is with prejudice. After all, such a judgment constitutes 'a final decision on the merits.'") citing Fed. R. Civ. P. 41(b). "A district court is under no obligation to [sua sponte] offer a party leave to amend when such leave has not been requested by motion." *Id.* at 735-736 (citations omitted).

"This does not mean, however, that a trial court must mindlessly grant every request for leave to amend." *Aponte–Torres v. Univ. of Puerto Rico*, 445 F.3d 50, 58 (1st Cir. 2006). In *Aponte-Torres*, the district court had arranged for plaintiffs to have access to key files and ordered the plaintiffs to inspect them and decide whether they wished to move forward with the case. *Id.* The plaintiffs canvassed those files, took note of their contents, and subsequently composed an amended complaint. *Id.* In affirming dismissal of that amended complaint with prejudice, the First Circuit held that the district court had a "sound reason to deny" leave to amend:

> Having afforded the plaintiffs an ample opportunity to put their best foot forward, the district court was not obliged to grant them yet another opportunity to state a claim. Plaintiffs must exercise due diligence in amending their complaints. As a corollary of that principle, busy trial courts, in the responsible exercise of their case management functions, may refuse to allow plaintiffs an endless number of trips to the well.

Id.

This case is no different. As receiver to the Plan, Plaintiff Del Sesto and his counsel, Max Wistow, have access to 800,000 pages of documents regarding the Plan and its administration. *See* Request for Judicial Notice filed concurrently herewith. Yet even with that ample discovery in their possession, *and* with the benefit of viewing the arguments set forth in *all* of the Defendants'

motions to dismiss the original complaint, Plaintiffs still fail to state *any* claim against Angell upon which relief can be granted. Plaintiffs should not be permitted to try to reformulate their allegations, yet again, to avoid their legal and factual deficiencies. Any proposed amendment "would serve no useful purpose, the district court need not allow it." *Aponte–Torres*, 445 F.3d at 58.

CONCLUSION

For all of the foregoing reasons, the FAC should be dismissed as to Angell with prejudice

This 4th day of December, 2018.

THE ANGELL PENSION GROUP, INC.

By its attorneys,

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-and-

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EXHIBIT A

SERVICE AGREEMENT

This Service Agreement (the "Agreement") is entered into as of November 1, 2011 by and between The ANGELL Pension Group, Inc. ("APG") and St. Joseph Health Services of Rhode Island (the "Plan Administrator").

WHEREAS, the Plan Administrator desires that APG perform certain administrative services as the third party contract administrator for the St. Joseph Health Services of Rhode Island Retirement Plan, a retirement plan sponsored by the Plan Administrator (the "Plan") commencing with the Plan Year ending June 30, 2012; and

WHEREAS, APG has agreed to perform certain administrative services as the third party contract administrator for the Plan;

NOW THEREFORE, APG and the Plan Administrator agree as follows:

1 *Administrative Services*

APG agrees to perform the administrative services and only those services set forth in Exhibit A attached hereto.

2. *Fees*

The Plan Administrator agrees to pay APG, in accordance with the payment terms set forth on any invoice of APG, the fees set forth in Exhibit A attached hereto. In addition to the fees set forth in Exhibit A, the Plan Administrator agrees to pay APG for any extraordinary services performed by APG, if such services are requested by the Plan Administrator or are required for the effective administration of the Plan. The fees set forth in Exhibit A are subject to adjustment by APG from time to time with the consent of the Plan Administrator It is our understanding at the current time the administration fee will be paid from plan assets.

3. *Term of the Agreement*

This Agreement shall become effective as of the date set forth above and shall continue in effect until terminated by either APG or the Plan Administrator APG shall not be responsible for maintaining the Plan Administrator's files after the date of the termination of this Agreement.

4. *Additional Provisions*

Pursuant to this Agreement, APG is serving as the third party contract administrator for the Plan. APG is not the plan administrator, as such term is defined in the Employee Retirement Income Security Act of 1974, as amended, and the Internal Revenue Code of 1986, as amended, for the Plan and is not a fiduciary with respect to the Plan. The Plan Administrator specifically acknowledges that APG provides no investment advice whatsoever

IN WITNESS WHEREOF, the parties hereto, by their duly authorized officers, have caused this Agreement to be executed on the _____ day of _____, 2011

THE ANGELL PENSION GROUP, INC.

By: _____

ST. JOSEPH HEALTH SERVICES OF RHODE ISLAND

By: _____

EXHIBIT A

This Exhibit A sets forth the administrative services to be performed by APG under the terms and conditions of the Service Agreement to which it is attached.

APG will perform the following administrative services for the Defined Benefit Plan:

Administration – Employer Service Bureau

1. APG will interface with payroll vendor(s) for historical data and custodians to coordinate year end census data for plan reconciliation. (Please note, APG will not have direct access to payroll information)
2. APG will update inactive and retiree participant status and reconcile custodian benefit payments with direct interface with the custodian which includes monitoring scheduled future benefit changes and ensuring those payments were in fact changed accurately at the appropriate time.
3. Conduct a death audit twice a year for participants who elect a Qualified Joint and Survivor benefit.
4. Conduct a locator audit once a year after non-deliverable mail is returned.
5. APG will interface directly with plan custodian on all benefit processing issues. (Please note the custodian may require a Plan Sponsor signature regarding distribution election forms. We anticipate an electronic signature by St. Joseph Health Services of Rhode Island will provide an efficient solution. This procedure should be verified by the custodian.)
6. Consolidate census information into a valuation prepared database.
7. Interface directly with the Plan Auditor on the financial reports of the Plans. (Please note this may require APG to have direct payroll access.)
8. Prepare and distribute directly to all participants all required participant Notices, SPD's, and SMM's regarding disclosure regulations.

Participant Interface Service Bureau

1. APG will maintain a participant database with census information, retiree/beneficiary and spousal information including participant addresses and phone numbers.
2. APG will maintain a 1-800 number and dedicated e-mail address to field all active, vested terminated, and retiree inquiries and questions regarding plan options and distribution election packages (based upon EST 8:30am to 5pm.)
   - Delivery standard: 24-hour response time
3. APG will maintain a work log and database with updated participant status and workflow information for St. Joseph Health Services of Rhode Island access.
4. APG will prepare the distribution package for each eligible participant. This will include a relevant cover letter explaining the plan options, the distribution form, and benefit information pamphlet.
   - Delivery standard: 5-business days after all information is complete
5. APG will mail participant packages to the home address of each participant with APG's corresponding return address.
   - Delivery standard: 1-business day after distribution package is completed.
6. APG will review the distribution forms regarding completeness. (If incomplete, APG will contact the participant to make the appropriate changes).
   - Delivery standard: 1 business day
7 APG will forward the distribution election packages to the custodian for processing.
   - Delivery standard: 2 business days
8. APG will ensure all payments commence on a timely and accurate basis.
   - Delivery standard: 1 business day

Service Model

- APG will appoint a single point of contact (Mary Pat Moran) regarding the participant, custodial, and Plan Sponsor interface. There will also be a dedicated backup trained for purposes of vacation, sick time, etc. Additionally, the Manager of the Defined Benefit Department (Albert Krayter) will oversee all workflow, communications, and delivery standards to ensure both Plan Sponsor and Participant satisfaction.

Assumptions

1. Necessary tax withholding and reporting (i.e., IRS Form 945 and 1099R) Federal and State will be provided by the custodian.

2. APG will act as third party administrator but will not have fiduciary discretion under Title I of ERISA.

3. Authorization for APG to process distributions on behalf of St. Joseph Health Services of Rhode Island will be given by St. Joseph Health Services of Rhode Island and/or its affiliates.
4. File layout will be given electronically to APG from payroll vendor and custodians.

Fee Considerations

The fee consideration is $30,000 annually. The administration fee is billed on a quarterly basis (on or about March 1, June 1, September 1 and December 1). Please note, benefit calculations are billed separately and not included in this service bureau fee quotation. Additionally, APG is not charging a data conversion fee. However, APG reserves the right revisit this issue, once an assessment of the process is completed.

It is our understanding at the current time the administration fee will be paid from plan assets.

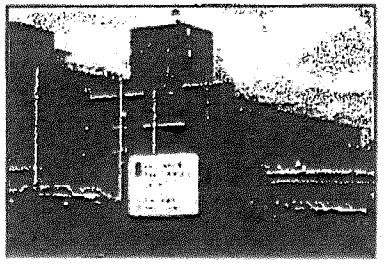
Please note: These fees do not include any fees charged by the investment company.

EXHIBIT B

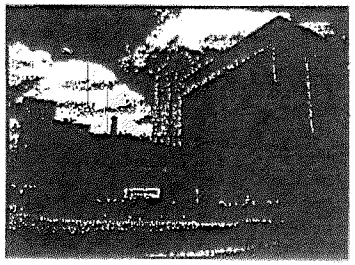
St. Joseph Health Services of Rhode Island

Retirement Benefit Informational Sessions

April 29, 2014 and April 30, 2014



St. Joseph Health Services of Rhode Island



CharterCARE HEALTH PARTNERS

Items to review

- SJH Defined Benefit Plan; the Pension Plan
  - Current plan
  - Plan freeze
  - Normal retirement / early retirement
  - Final benefit statements
  - Benefit formula and payment options

- Replacement plan – 401(k) Defined Contribution Plan
  - Eligibility
  - Employer contribution

SJH Pension Plan

- Date of hire before October 1, 2008 (after this date employees were eligible to participate in the SJH Defined Contribution Plan.
- Regular full-time and/or part-time employee
- Completion of 1,000 or more hours of service during the first plan year (July 1st to June 30th) following date of hire
- Vesting – 5 years of service
- Plan year – July 1st through June 30th each year

SJH Pension Plan – freezing of the plan

- MOA signed on January 28, 2014, included a contract extension through July 31, 2016
- Terms of agreement included "freezing" of the St. Joseph Health Services of Rhode Island Retirement Plan (the "Pension Plan") upon closing of the Joint Venture with CharterCARE Health Partners and Prospect Medical Holdings scheduled for June 1, 2014
- This includes a $14 Million contribution to the Pension Plan to stabilize plan assets
- Participants will cease accrual of benefits under the Pension Plan, but will immediately be eligible for participation in an alternative retirement vehicle – the 401(k) plan

SJH Pension Plan – normal retirement and early retirement

- Normal Retirement Date:
  - The 1st day of the month following the later of your 65th birthday and five years of participation

- Early Retirement Date:
  - If employed as of Plan freeze date (6/1/14) with at least 85 points as of this date, and have attained age 55 as of this date – you qualify for unreduced early retirement
  - If you have not accumulated 85 points, and / or you are not at least 55 years of age as of Plan freeze date (6/1/14) - you do not qualify for unreduced early retirement
  - You will qualify for a reduced early retirement upon the attainment of age 55

SJH Pension Plan, sample final benefit statement

Sample Participant

Social Security #:	xxx-xx-9999
Date of Birth:	1/1/1950
Date of Hire:	7/1/2004
Normal Retirement Date:	1/1/2015
Credited Service:	10.00

St. Joseph Health Services of Rhode Island

St. Joseph Health Services of Rhode Island is providing you this statement showing your estimated benefits in the St. Joseph Health Services of Rhode Island Retirement Plan as of June 1, 2014, the date of the ceasing of further benefit accruals under the Plan. Your pension benefit is an important part of your future retirement income, along with Social Security, your retirement savings plan, and your other personal savings. Some key features of this Plan are:

- ***Simplicity***—Participation in the Plan is automatic. You do not have to enroll or do anything until you retire.
- ***Security***—Benefits are paid from a secure trust fund.
- ***Company Paid***— The Plan is entirely paid for by St. Joseph Health Services of Rhode Island. There is no cost to you.

You may retire on your Normal Retirement Date or current date, if later, and receive a benefit, which is payable at age 65 provided you have 5 years of service. The monthly amount of pension benefit that you have earned through June 1, 2014 is shown below. Accrued benefits are frozen effective June 1, 2014.

It is important to note that your benefit has been calculated using the Plan's definition of compensation, which is the highest one year of the last five years for Social Security purposes. Your benefit *may* be higher after submitting *actual* Social Security earnings.

Frozen Monthly Accrued Benefit as of June 1, 2014 payable at Normal Retirement Date or current date, if later

Frozen Monthly Accrued Benefit:	$1,000.00
Normal Retirement Date or current date, if later:	January 1, 2015

SJH Pension Plan, sample final benefit statement

As of June 1, 2014, you are 100% vested in this benefit, which means that you may receive this benefit at normal retirement even if you terminate employment before then.

You may retire early when you have met the requirements for Early Retirement, as described in the Plan. Estimated *monthly* benefit amounts begin when you retire and continue for the rest of your life.

For any participant who has experienced a prior termination of employment and has since been rehired, the following information may not be exact. The following reflects the data as of June 1, 2014:

	Age	Estimated Monthly Benefit
■ At the later of attained age, or earliest Early Retirement:	64.42	$ 961.11

SJH Pension Plan, final benefit statement - benefit formula

The Hospital pays the entire cost of the Plan. In addition, the Hospital contributes to the Social Security System an amount equal to what you contribute to the Social Security System.

Your Accrued Benefit at Normal Retirement Date is 50% of Final Average Earnings (five highest consecutive rates of annual earnings over the last ten years of employment) minus 50% of your Social Security Benefit, both multiplied by a fraction not greater than one, the numerator of which is the number of years and months of Credited Service, and the denominator of which is the greater of thirty or the number of your years of Credited Service as of age 60. Accrued Benefits are frozen effective June 1, 2014. You will not earn additional Credited Service after June 1, 2014.

		Example	
A	Final average monthly compensation	$7,500	Based on 5 highest consecutive in past 10 years; in this example it would be $90,000 per year divided by 12
B	Credited service	10	
C	Future service at age 60	30	greater of 30 or number of credited years as of age 60
D	SS Benefit	$1,500	
Formula:			
E	(A) minus (D) x 50%	$3,000	
F	$1,000 x [(B) credited service divided by (C) future service]	$1,000	Monthly benefit amount

SJH Pension Plan – payment options

- Life Annuity
- Life Annuity with guarantee of 120 monthly payments
- Joint and Survivor annuity
- Postponed payment

Once payments have begun, you can not change the payment option

Benefits Under the Defined Contribution Plan Note: details of new plan still pending

Benefits of a Defined Contribution Plan...

- Contributions and earnings grow on a tax-deferred basis
- Employee may contribute up to $17,500 per year without restriction
- Age 50 and older, at anytime during year, can make additional contributions up to $5,500
- Employee has control over investment direction
- Loan Provision (unlike the Pension Plan with no provision for loans)
- Portability (can take it with you and/or roll it over into another plan or IRA)

Defined Contribution Plan, highlights...

- Current plan features require employees to contribute 3% in order to be eligible for an employer contribution
- Employees are able to make pre-tax contributions into the plan
- Employee receives credit for past service (1,000 hour plan year requirement in effect)

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Questions?

Additional Resources

Benefits Department: 456-3469

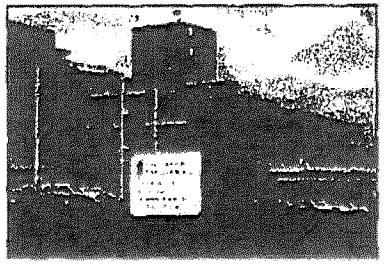
Angell Pension Group:
Mary Pat Moran 1-800-439-2410 x516

EXHIBIT C

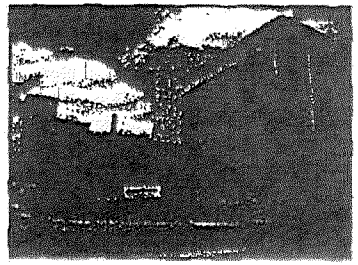
St. Joseph Health Services of Rhode Island

Retirement Benefit Informational Sessions

April 13, 2016



St. Joseph Health Services of Rhode Island



CharterCARE HEALTH PARTNERS

Items to review

- SJH Defined Benefit Plan; the Pension Plan
  - Who is eligible
  - Normal retirement / early retirement
  - Final benefit statements
  - Benefit formula and payment options
  - Application/Retirement Process

SJH Pension Plan

- Date of hire prior October 1, 2008 were eligible (after this date employees were eligible to participate in the SJH Defined Contribution Plan only).
- Regular full-time and/or part-time employee
- Completion of 1,000 or more hours of service during the first plan year (July 1st to June 30th) following date of hire
- Vesting – 5 years of service
- Plan year – July 1st through June 30th each year

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SJH Pension Plan – normal retirement and early retirement

- Normal Retirement Date:
  The 1st day of the month following the later of your 65th birthday and five years of participation.

- Late Retirement Date:
  Participant may receive an actuarially increased benefit if they commence after normal retirement date.

- Early Retirement Date:
  Participant can retire any time after age 55 if you have 5 or more years of continuous service. You will receive payments in a reduced amount to reflect the fact that benefits are paid prior to Normal Retirement, unless you meet the Rule of 85 requirements.

- 85 Point Rule: Age at the earlier of termination or freeze date (minimum age of 55)+ Service = 85 or greater No reduction in benefit
  - Non Union Freeze Date – September 30, 2009
  - FNHP Freeze Date – September 30, 2011
  - UNAP Freeze Date – June 1, 2014

SJH Pension Plan, sample final benefit statement

Sample Participant

Social Security #:	xxx-xx-9999
Date of Birth:	1/1/1950
Date of Hire:	7/1/2004
Normal Retirement Date:	1/1/2015
Credited Service:	10.00

St. Joseph Health Services of Rhode Island

St. Joseph Health Services of Rhode Island is providing you this statement showing your estimated benefits in the St. Joseph Health Services of Rhode Island Retirement Plan as of June 1, 2014, the date of the ceasing of further benefit accruals under the Plan. Your pension benefit is an important part of your future retirement income, along with Social Security, your retirement savings plan, and your other personal savings. Some key features of this Plan are:

- ***Simplicity***—Participation in the Plan is automatic. You do not have to enroll or do anything until you retire.
- ***Security***—Benefits are paid from a secure trust fund.
- ***Company Paid***— The Plan is entirely paid for by St. Joseph Health Services of Rhode Island. There is no cost to you.

You may retire on your Normal Retirement Date or current date, if later, and receive a benefit, which is payable at age 65 provided you have 5 years of service. The monthly amount of pension benefit that you have earned through June 1, 2014 is shown below. Accrued benefits are frozen effective June 1, 2014.

It is important to note that your benefit has been calculated using the Plan's definition of compensation, which is the highest one year of the last five years for Social Security purposes. Your benefit *may* be higher after submitting *actual* Social Security earnings.

Frozen Monthly Accrued Benefit as of June 1, 2014 payable at Normal Retirement Date or current date, if later

Frozen Monthly Accrued Benefit:	$1,000.00
Normal Retirement Date or current date, if later:	January 1, 2015

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SJH Pension Plan, sample final benefit statement

As of June 1, 2014, you are 100% vested in this benefit, which means that you may receive this benefit at normal retirement even if you terminate employment before then.

You may retire early when you have met the requirements for Early Retirement, as described in the Plan. Estimated ***monthly*** benefit amounts begin when you retire and continue for the rest of your life.

For any participant who has experienced a prior termination of employment and has since been rehired, the following information may not be exact. The following reflects the data as of June 1, 2014:

	Age	Estimated Monthly Benefit
■ At the later of attained age, or earliest Early Retirement:	64.42	$ 961.11

SJH Pension Plan, final benefit statement - benefit formula

The Hospital pays the entire cost of the Plan. In addition, the Hospital contributes to the Social Security System an amount equal to what you contribute to the Social Security System.

Your Accrued Benefit at Normal Retirement Date is 50% of Final Average Earnings (five highest consecutive rates of annual earnings over the last ten years of employment) minus 50% of your Social Security Benefit, both multiplied by a fraction not greater than one, the numerator of which is the number of years and months of Credited Service, and the denominator of which is the greater of thirty or the number of your years of Credited Service as of age 60. Accrued Benefits are frozen effective June 1, 2014. You will not earn additional Credited Service after June 1, 2014.

		Example	
A	Final average monthly compensation	$7,500	Based on 5 highest consecutive in past 10 years; in this example it would be $90,000 per year divided by 12
B	Credited service	10	
C	Future service at age 60	30	greater of 30 or number of credited years as of age 60
D	SS Benefit	$1,500	
Formula:			
E	(A) minus (D) x 50%	$3,000	
F	$1,000 x [(B) credited service divided by (C) future service]	$1,000	Monthly benefit amount

SJH Pension Plan – payment options

- Life Annuity
- Life Annuity with guarantee of 120 monthly payments
- Joint and Survivor annuity
- Postponed payment

Once payments have begun, you can not change the payment option

Application/Retirement Process

- The first step in the process is to request an application form from The Service Bureau at Angell at 1-800-439-2410 x516.
  - The application form should be requested approximately 90 days prior to your desired benefit commencement date. Once you receive the application, you can contact the Service Bureau for assistance in completing the form.
- Once the completed form is received a calculation will be performed and you will be mailed a benefits election package for completion.
  - The benefits election package will contain all the optional forms of payment available to you, as well as the amounts of these optional forms, along with tax election and direct deposit forms. These forms must be completed and returned in order for payments to begin.
- Once in pay any updates/changes should be provided to the Service Bureau
  - Examples are address changes, tax changes, direct deposit changes

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Questions?

Additional Resources

Angell Pension Group:

Service Bureau 1-800-439-2410 x516

EXHIBIT D

St. Joseph Health Services of Rhode Island Retirement Plan

Projection Assumptions

Basis of Projections:	Projections have been based on July 1, 2012 census and valuation.
Discount Rate for Liabilities:	7.75% based on October 1, 2012 Long Term Rate of Return Assumption
Rate of Return on Investments:	7.75% This assumption has been selected by St. Joseph Health Services of Rhode Island consistent with direction from the Plan's investment manager regarding long-term expectations for the Plan's rate of return based on the current investment allocation.
Market Value of Assets:	**December 31, 2013** with an assumed contribution of $14,000,000 made for Plan Year Ending June 30, 2014.
ERISA Effective Date:	It is assumed that the Plan will remain a non-electing Church Plan and will not become subject to ERISA.
Actuarial Value of Assets:	Asset averaging smoothing gains/losses over last five (5) years.
Recommended Contribution:	Based on a 10-year open amortization of the unfunded liability.
DB Plan Freeze:	Benefit accruals under the Plan for non-union participants ceased effective September 30, 2009. Benefit accruals under the Plan for FNHP union participants ceased effective September 30, 2011. Benefit accruals under the Plan for UNAP participants will cease effective **June 1, 2014**.
Disclosures:	The results contained in this analysis are for illustrative purposes only and are estimates based on the census data and asset information provided by St. Joseph Health Services of Rhode Island to prepare the annual actuarial valuation of the Plan. The results do not reflect all possible future funding and accounting costs. The actual results at a future date will be based on the demographics of the covered population, asset values on the date of the valuation, and the related assumptions applicable for that Plan Year. Unless stated otherwise, the methods and actuarial assumptions in the most recently completed actuarial valuation reports are used in preparing this analysis. Where exact amounts are known they are represented to the nearest $1. Where amounts are estimated they are rounded to the nearest $1,000.

St. Joseph Health Services of Rhode Island Retirement Plan

Hard Freeze 6/1/2014 - Church Plan

Cash Funding Projections - Based on and subject to Projection Assumptions set forth on page 1

Plan Year Beginning	7/1/2012	7/1/2013	7/1/2014*
Discount Rate:	8.00%	7.75%	7.75%
Return on Investment Assumed:	n/a	7.75%	7.75%
Market Value of Assets (including receivables)	$85,872,858	$88,802,000	$107,227,000
Actuarial Value of Assets	93,201,405	88,167,000	103,506,000
Actuarial Accrued Liability	108,357,275	113,217,000	112,948,000
Unfunded Actuarial Accrued Liability (UAAL)	15,155,870	25,050,000	9,442,000
Normal Cost	$738,922	$737,000	$0
10-Year Amortization of UAAL	2,091,363	3,426,000	1,291,000
Interest Cost	226,423	323,000	100,000
Recommended Contribution	**$3,056,708**	**$4,486,000**	**$1,391,000**
Total Plan Year Contribution Assumed	**$0**	**$14,000,000**	**N/A**
Funding Percentage at Beginning of Plan Year (MVA / AAL)	79.2%	78.4%	94.9%

* For the Plan Year beginning 7/1/2014, the recommended contribution is an estimate that is subject to change based on the Plan assets and the Plan's discount rate.

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EXHIBIT E

[redacted]

Social Security #:
Date of Birth: [redacted]
Date of Hire: April 7, 1980
Normal Retirement Date: August 1, 2013
Credited Service: 24.17

St. Joseph Health Services of Rhode Island

St. Joseph Health Services of Rhode Island is pleased to give you this statement showing your estimated benefits in the Retirement Plan as of July 1, 2004. Your pension benefit is an important part of your future retirement income, along with Social Security, your 403(b) savings, and your other personal savings. You automatically become a participant in the plan once you have completed 12 months of employment and worked at least 1,000 hours. Some key features of this plan are:

- ***Simplicity***—Participation in the plan is automatic. You do not have to enroll or do anything until you retire.
- ***Security***—Benefits are paid from a secure trust fund.
- ***Company Paid***— The plan is entirely paid for by St. Joseph Health Services of RI. There is no cost to you.

You may retire on your Normal Retirement Date and receive a benefit, which is payable at age 65 and 5 years of service. The monthly amount of pension benefit that you have earned to date and the amount you are projected to receive if you continue to work until your Normal Retirement Date, August 1, 2013, are shown below.

It is important to note that your benefit has been calculated using the plan's definition of highest one year of the last five years for Social Security purposes. Your benefit *may* be higher after submitting *actual* Social Security earnings.

[redacted]

$1,532	$2,022
August 1, 2013	August 1, 2013

As of July 1, 2004, you are 100% vested in this benefit, which means that you may receive this benefit at retirement even if you terminate employment before then.

You may retire early when you have met the requirements for Early Retirement, as described in the Plan. Estimated ***monthly*** benefit amounts begin when you retire and continue for the rest of your life.

For any participant who has experienced a prior termination from the plan and has since been rehired, the following information may not be exact. The following reflects the data as of July 1, 2004:

	Age	Projected Monthly Benefit
■ At age 55 with 5 years of service:	55.92	$ 813
■ When you accumulate 85 "points":	58.42	$ 1,786
■ At the later of age 60 or 30 years of service or Normal Retirement Age:	61.75	$ 2,011

This statement has been prepared to let you know the status and value of your pension plan benefit. These figures are not a promise or guarantee of any future benefits. They are only estimates based on the assumption that you continue to work and earn service credit each year until the indicated retirement date at your current compensation rate. Information in this statement is subject to provisions of the plan document in effect on July 2004. At retirement, your benefit will be calculated exactly based on the plan provisions in effect at that time. Since there is always the possibility of error in data, you should contact the Human Resource Department if any information appears incorrect.

Prepared especially for:

[redacted]

Portsmouth RI 02871

SUMMARY OF PLAN PROVISIONS:

St. Joseph Health Services of Rhode Island Retirement Plan provides you with:

a) A monthly income payable for life when you retire, in addition to your Social Security benefits.

b) The right to retire as early as age 55 if you have completed at least 5 years of continuous service.

c) The right to future pension benefits if you leave the Hospital after 5 or more years of continuous service.

d) Death benefits payable to your surviving spouse or beneficiary if you die while still employed after completing 5 years of continuous service.

The Hospital pays the entire cost of the plan. In addition, the Hospital pays into the Social Security System an amount equal to what you pay.

Your Accrued Normal Retirement Benefit is 50% of Final Average Earnings (five highest consecutive rates of annual earnings over the last ten years of employment) minus 50% of Social Security Benefit, all multiplied by a fraction but not greater than one, the numerator being the number of years and months of Credited Service and **the denominator being the greater of thirty or number of years of Credited Service as of age 60.**

You may begin to receive benefits on your:

a) Normal Retirement Date: The first day of the month following the later of your 65th birthday or your fifth anniversary of participation.

b) Late Retirement Date: If you continue to work for the Hospital past your Normal Retirement Date, you may not begin to collect retirement benefits until you actually retire.

c) Early Retirement Date: You can retire any time after age 55 if you have 5 or more years of continuous service. You will receive payments in a reduced amount to reflect the fact that benefits are paid prior to Normal Retirement, unless you meet the Rule of 85 requirements.

For early retirement, the above benefit is reduced by 5/9 of 1% for each month prior to age 65 for the first 60 months and by 5/18 of 1% for each additional month by which commencement of benefits precedes Normal Retirement Date. If your age plus continuous service is at least 85 as of your termination date, no reduction will be applied to your benefit for starting payments prior to your Normal Retirement Date.

If you terminate employment with the Hospital before you are eligible for a retirement benefit and you have 5 years of continuous service, you are eligible for a Normal Retirement benefit using earnings, service, and Social Security offset calculated as of your Termination Date. You can begin receiving this benefit at Normal Retirement Date or in a reduced amount after you have attained age 55 and have completed at least 5 years of continuous service.

The spouse of an active participant (employee) who dies after completing 5 or more years of continuous service shall be eligible to receive a benefit commencing on the participant's Normal Retirement Date. The amount of benefit is equal to 50% of the benefit the participant would have received if he or she terminated employment on the date of death, survived to age 65, and elected benefits in the form of a 50% joint and survivor annuity.

For Social Security benefit information, refer to the estimated benefits statement provided by the Social Security Administration, which is mailed approximately three months prior to your birthday each year once you attain age 25 and is based on your actual lifetime work history.

All possible care was taken in completing this statement. However, the benefits actually payable under any circumstance shall be based on the governing provisions of the plan and on complete and accurate information obtained at the time of final determination of the benefit. Should you have any questions about the Retirement Plan, please contact the Human Resources Department.